STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	C 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	**305 8TH AVE NE MINOT, ND 58703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident was completed on September 5, 2024. During the report investigation the facility was found noncompliant with regulatory requirements.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility reported incident, review of facility policy, and staff interviews, the facility failed to ensure residents remained free from abuse from 1 of 1 sampled resident (Resident #1) with verbal, physical, and sexual behaviors towards other residents. Failure to assess, care plan, and operationalize a plan/process resulted in fear, anxiety, pain, and an unsafe environment for all residents residing in the memory care unit. Findings include:	F 600	Resident number ones care plan has been updated on 9/23/24 to address behaviors and to provide one on one as needed. Resident number one has been seen by the same psychiatric provider on August 9, August 23, September 6 and September 20 and medication adjustments have been made during the first three visits. Residents residing on the memory care unit all have the potential to be affected	10/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/27/2024

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F 600	Continued From page 1 Review of the facility policy titled "Abuse, Neglect and Exploitation Policy" occurred on 09/05/24. This policy, revised August 2023, stated, ". . . Abuse: the willful infliction of injury, unreasonable confinement, intimidation . . . with resulting physical harm, pain, or mental anguish. . . . It includes verbal abuse, sexual abuse, physical abuse and mental abuse . . . Residents who mistreat, are aggressive towards . . . other residents . . . must have a care plan in place that addresses the behavior(s) in question and those residents that have had aggressive behavior directed at them . . . must be protected from further injury or mental anguish. Documentation must be in place to identify the steps taken to identify the problems, the corrective action taken, and follow-up monitoring. . . . In a situation where there is an aggressive resident or a catastrophic event such as pushing, hitting, throwing objects, etc. the following steps should be taken . . . Re-direct resident and take to a quiet area if possible. . . . Contact resident provider, follow provider's orders, and update family. . . . Social Services to monitor for trends or patterns and update the residents Care Plan as needed. . . ." A facility reported incident, received by the state agency on 08/23/24, stated Resident #1 kicked a female resident in the stomach which cause her to fall. Review of Resident #1's medical record occurred on all days of survey. Diagnoses included anxiety, dementia, mood disturbance, and psychotic disturbance. The quarterly Minimum Data Set (MDS), dated 07/12/24, indicated severe cognitive deficits and behaviors.	F 600	by other residents' behaviors including verbal, physical and sexual abuse. Residents residing on the memory care unit that have experienced aggressive behaviors over the last 30 days were reviewed to verify appropriate interventions were in place and care plans were updated as indicated. All nurses, CNAs and dietary staff who work in the memory care unit were educated on September 26 regarding the need to report all abuse and neglect including resident to resident abuse immediately to the charge nurse and director of nursing or designee. Education was also given to nurses on assessing behaviors on resident number one and female resident including verbal, physical and sexual behaviors and examples of interventions that can be utilized should behaviors persist. Audits will begin on 9/24/24 with random checks by the unit manager or designee to observe memory care residents including resident number one and female resident daily during different times of day for 5 days for 4 weeks for any inappropriate behaviors to determine if interventions are successful in de-escalating residents' behavior. Once compliance has been achieved for 4 weeks, audits will be done with 5 per month for 3 months until compliance is achieved. Following those, audits will then be completed quarterly with 5 observations until compliance is	

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F 600	Continued From page 2 The progress notes identified the following: * 07/02/24 at 7:06 p.m., "Resident [#1] is calling another resident a piece of [explicit word]. He then got into an altercation with another resident." * 07/07/24 at 5:32 p.m., "Resident went down to end of hall and blocked another resident against the wall and was swearing at him. Other [sic] resident was begging him to just leave him alone. A cna [certified nurse aid] got them seperated [sic] . . . He then came up behind the other resident swearing at him and kicked him in the back. Got them seperated [sic] again and he went after him again and kicked his hand. The other resident then punched him [Resident #1] in the chest. . . ." * 07/07/24 at 11:20 p.m., "Resident is growling at another resident and trying to get close to other resident to kick him. Residents kept seperated [sic]." * 07/09/24 at 11:44 p.m., "Resident went up to another resident and grabbed her breasts. Both residents were separated and redirected immediately. . . ." * 07/11/24 at 7:21 p.m., "The resident kicked another resident's wheelchair. He was taken to another room . . ." * 07/14/24 at 4:54 p.m., "Resident moving around dining room callin [sic] other residents pieces of [explicit word]." * 07/18/24 at 12:45 a.m., "Resident was blocking door from another resident, Did not verbal [sic] respond to resident when she was yelling at him. Resident did come with me to a different spot and had an HS [hour of sleep] snack." * 07/20/24 at 7:13 p.m., "Resident kicked the back of another resident's wheelchair. He also	F 600	achieved. All audits will be presented to the QA committee during scheduled meetings. The DON/ADON are responsible for this process.	

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F 600	Continued From page 3 yelled, 'You stupid [explicit word]' to a different resident. He was redirected each time to another area." * 07/22/24 at 5:55 p.m., "Resident yelling and cursing at other residents. . . ." * 07/27/24 at 8:15 p.m., ". . . Female residents afraid of going near resident. . . ." * 07/28/24 at 3:05 a.m., "Resident [#1] grabbed another female resident by her arm. No injuries noted at this time. Resident is immediately redirected away from the other resident." * 07/29/24 at 10:37 p.m., "Resident is trying to pinch resident [sic] breast after supper. Unable to redirect him away from the females. . . ." * 07/30/24 at 2:17 p.m., "Resident was glaring at another resident. He was redirected away from her before anything happened." * 07/30/24 at 4:59 p.m., ". . . He was grabbing female resident [sic] breast [sic] or talking sexual to them. He would not let a female resident go by him so staff had to get the resident by him . . ." * 07/30/24 at 11:20 p.m., "Resident sat at the main door after supper. Cussed at other residents. . . ." * 08/01/24 at 9:32 p.m., "before supper started to get near female residents. . . . Then he proceeded to kick another male resident [sic] wheelchair and call him '[explicit word].' when taking residents to the table for supper [Resident #1] would go and stare at the female resident and call her '[explicit word]' and stare at her . . . [Resident #1] would then try and quickly get near another female resident if staff looked away. . . . Informed [Resident #1] that he needs to stay away from other residents especially the ladies. It is not appropriate for him to touch other residents or call them names. . . . The minute we turned our back he was headed to a table with female	F 600		

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F 600	Continued From page 4 residents. . . ." * 08/02/24 at 11:16 a.m., "Nursing staff called Social Services last evening to report [Resident #1] was having a lot of behaviors. . . . Some changes have been made to his psychotropic medications and he is being monitored closely." * 08/03/24 at 10:54 a.m., "The resident would not let another resident's family leave by blocking the exit door. He also tried to grab one of their breast [sic] as they tried to leave. . . . Staff redirected the resident to another area." * 08/03/24 at 9:49 p.m., "resident kicked at female resident when she was walking past him after supper. . . ." * 08/04/24 at 1:59 p.m., "CNA reported . . . she tried to redirect him [Resident #1] from hitting another resident. She directed him to another room. . . ." * 08/04/24 at 9:30 p.m., "Resident going up to other female resident [sic], stares at them then calls them [explicit word]. Unable to redirect as he goes to another resident and tries to kick them [sic], grab them [sic] or call them [sic] names. Resident assisted to bed." * 08/07/24 at 11:01 a.m., "Resident grabbed a female resident's left breast after breakfast. Female resident yelled at him and walked away and came to the nurses' desk. Resident's breast was red, no bruising. . . ." * 08/07/24 at 6:51 p.m., "Resident was making faces at another resident in the dining room. Other resident told him to stop looking at her and then she threw her apple juice on him. Both residents were separated . . ." * 08/08/24 at 6:53 p.m., "The resident propels his wheelchair fast towards other residents and he changes the look on his face, which scares them. One resident threw food at him. Staff redirected	F 600		

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F 600	Continued From page 5 him to his room . . ." * 08/08/24 at 11:10 p.m., "The nurse was walking up the hallways on the unit, when she observed resident stomping his feet as he was propelling fast in his wheelchair towards a female resident who was quietly sitting in her wheelchair in the hallways [sic]. There was no physical interaction. The female resident appeared frightened and the suggestion was made to go to her room and she complied and was taken to her room. As the nurse was prepared to leave, the resident stated, 'he is creepy.'" * 08/11/24 at 3:48 a.m., "Resident [#1] went up to a female resident and said 'your [sic] a [explicit word].' He was calling . . . residents 'pieces of shit' and saying '[explicit word] you.' Resident very difficult to redirect." * 08/11/24 at 1:50 p.m., "Resident was wandering around the halls most of shift. . . . He was in a confrontation with another resident." * 08/12/24 at 6:59 p.m., "[Physician] here for rounds. Updated her on the residents' behaviors. . . . Called pharmacy requesting medication combination side effects. Carbidopa-levodopa [Parkinson's medication] can cause increased labito [sic] [sexual drive]." * 08/12/24 at 11:14 p.m., "Resident pedaled himself quickly toward another resident at the door. Tried to grab the resident. [Resident #1] moved away from the door, then turned and went right back to the door. Other resident left the dining room. [Resident #1] kicked and attempted to hit at another resident in the dining room. [Resident #1] taken to his room . . . [Family Nurse Practitioner] called. Update given on behaviors. New orders received. Will update family in the morning." * 08/13/24 at 1:35 p.m., "Resident was blocking	F 600		

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F 600	Continued From page 6 the hall not letting other residents go by. . . ." * 08/13/24 at 9:36 p.m., "[Sic] was calling another resident inappropriate names after supper." * 08/18/24 at 6:45 p.m., "Resident propelling towards a resident and grabbed both her breast [sic]. He was taken to his room where [sic] sat peacefully. . . ." * 08/22/24 at 1:00 p.m., "The CNA called out for this nurse at [1:00 p.m.] She said she witnessed the resident propelling quickly down the hall towards another resident. The other resident was moving towards the wall to move out of his way. Everywhere the other resident moved he would block her. Then he kicked her in the stomach. The other resident fell to the ground. This nurse and CNA took him to his room . . ." * 08/25/24 at 9:16 p.m., "After supper resident [#1] was kicking another resident's wheelchair and saying '[explicit word] you.' able to redirect. Then went to another resident and called him an [explicit word]. Told resident if he continued to kick other residents wheelchairs and call people names then he would need to go to bed. . . ." * 08/27/24 at 6:25 a.m., ". . . Resident is very agitated and aggressive towards . . . residents tonight. He pinched another resident on her face, no injuries noted. He ran into the back of another resident's heels, no injuries noted at this time. He is going up to . . . residents growling at them and calling them '[explicit words].' He is trying to kick . . . resident. He is blocking people so they can't get by him. Resident followed this nurse into a female resident's room and refused to leave. . . . Tylenol was given and ice cream for a snack. . . . This nurse called the social worker about his behaviors. [Physician] was notified about resident's behaviors and a one time order for Ativan was given."	F 600		

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F 600	Continued From page 7 * 08/30/24 at 1:18 p.m., "Resident was following female . . . resident around, hard to redirect, resident removed from common area from other residents . . ." * 08/31/24 at 12:38 a.m., "Resident was kicking other resident [sic] wheelchair after supper. Also calling other resident [sic] '[explicit word].' . . ." * 08/31/24 at 2:22 p.m., "Resident propelling his wheelchair fast towards other residents and telling them to move. . . ." * 08/31/24 at 9:18 p.m., "Resident continue to move his wheelchair fast around the dining room. Stops at different residents and calls them '[explicit word]' or says '[explicit word] You.' Also kicked a couple wheelchairs of different residents." * 09/01/24 at 2:03 p.m., "Resident propelled quickly towards other residents. CNA . . . tried to redirect . . ." * 09/04/24 at 6:04 a.m., "Resident is going up to residents and saying '[explicit word] You.' Attempts made to redirect . . ." Resident #1's care plan stated, ". . . At times becomes physically and verbally abusive when he can't communicate his need. . . . If [Resident #1] is upset, allow time for him to calm down, then re-approach. Distract him from behaviors by offering food, beverage or activity. . . . Remove [Resident #1] from area if he is calling other residents names, growling, or if agitated. . . . Assess any changes in . . . behavior and report to . . . Social Services. . . . [Resident #1] receives psychotropic medication . . . Monitor for changes in . . . behaviors and report to MD [medical doctor]/NP [nurse practitioner] as needed. . . ." The current care card also stated, ". . . Observe and report any changes in mental status caused	F 600		

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F 600	Continued From page 8 by situational stressor . . . Provide opportunities for expression of feelings related to situational stressor . . ." The care plan failed to identify the situational stressors affecting Resident #1 and failed to address his sexually abusive behaviors towards the female residents. During an interview on 09/04/24 at 4:50 p.m., a managerial nurse (#2) indicated staff remove Resident #1 from the area whenever he behaves aggressively towards other residents. During an interview of 09/04/24 at 5:15 p.m., an administrative staff member (#1) reported the memory care unit staff failed notify her when Resident #1 grabbed the breasts of female residents. The facility failed to assess and monitor patterns and trends of behaviors in an effort to protect other residents from abuse and minimize Resident #1's physical aggression towards other residents. The facility failed to ensure Resident #1 did not infringe upon the rights of other residents to be free from verbal, mental, physical, and/or sexual abuse.	F 600		
F 744 SS=G	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by:	F 744		10/10/24

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F 744	Continued From page 9 Based on record review, review of facility policy, and staff interviews, the facility failed to provide adequate dementia care and services for 1 of 1 sampled resident (Resident #1) with dementia and verbal, physical, and sexual abusive behaviors. Failure to adequately assess for necessary care and services and implement effective behavior management interventions resulted in a decreased level of psychosocial well-being for Resident #1 and had a negative impact on other residents. Findings include: The facility failed to provide a policy on dementia care. Review of the facility policy titled "Abuse, Neglect and Exploitation Policy" occurred on 09/05/24. This policy, revised August 2023, stated,". . . Residents who mistreat, are aggressive towards . . . other residents . . . must have a care plan in place that addresses the behavior(s) in question . . . In a situation where there is an aggressive resident or a catastrophic event such as pushing, hitting, throwing objects, etc. the following steps should be taken . . . Social Services to monitor for trends or patterns and update the residents Care Plan as needed. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included anxiety, dementia, mood disturbance, and psychotic disturbance. The current physician's orders included: * Two 125 milligram (mg) Depakote Sprinkles capsules daily for mood stabilization started 08/31/23,	F 744	Resident number one□s care plan has been updated on 9/23/24 to address behaviors and to provide one on one as needed. Female resident□s psychiatric diagnoses were discussed and due to her behaviors and diagnoses, a geropsychiatric referral was made. An interdisciplinary meeting with the memory care unit manager, DON, ADON, Occupational Therapy, Director of Social Services, the activity coordinator, the medical director, the FNP and the facilities administrator was held on September 23, 2024. At this meeting, it was discussed to develop a structured timed activity plan to keep memory care residents with dementia and increased behaviors engaged in meaningful activities. Occupational therapy and activity coordinator, with the assistance of the Alzheimer□s Association, will assist with ideas of meaningful activities. Additional structured activities have been started in memory care on 9/25/24. The occupational therapist will start more planned activities on 9/30/2024 to ensure that nursing staff are able to initiate the activity and make sure that residents are engaged. This occupational therapist will go to memory care for a few hours a day during the week of 9/30/2024 to help the nursing staff initiate the activity. The occupational therapist plans to go daily Monday through Friday until the nursing staff can start the activities without assistance.	

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F 744	Continued From page 10 * 20 mg Escitalopram Oxalate daily for major depressive disorder started 08/06/24, * 25 mg Hydroxyzine HCl daily for anxiety started 07/27/24, and * 0.5 mg Risperdal twice daily for agitation started 08/23/24. The current care plan stated, ". . . At times becomes physically and verbally abusive when he can't communicate his need. Exit seeking. Calls other residents and staff vulgar names. Growls at . . . other residents. . . . If [Resident #1] is upset, allow time for him to calm down, then re-approach. Distract him from behaviors by offering food, beverage or activity. He used to like to sort cards, work jigsaw puzzles and play with dominos. . . . Remove [Resident #1] from area if he is calling other residents names, growling, or if agitated. . . . Assess any changes in his mood or behavior and report to nurse and Social Services. . . . [Resident #1] receives psychotropic medication . . . Monitor for changes in mood/behaviors and report to MD [medical doctor]/NP [nurse practitioner] as needed. . . ." The care card also stated, ". . . Observe and report any changes in mental status caused by situational stressor . . . Provide opportunities for expression of feelings related to situational stressor . . ." The care plan failed to identify the situational stressors affecting Resident #1 and failed to address his sexually abusive behaviors towards female residents. The progress notes identified the following: * 07/02/24 at 7:06 p.m., "Resident [#1] is calling another resident a piece of [explicit word]. He	F 744	Residents residing on the memory care unit all have the potential to be affected by other residents behaviors. Residents residing on memory care that have experienced aggressive behaviors over the last 30 days were reviewed to verify appropriate interventions were in place and care plans were updated as indicated. All nurses, CNAs and dietary staff who currently work in the memory care unit were provided education on 9/26/24 to ensure understanding of the need for social services support and care plan revision(s) after a resident experiences aggression or an altercation. The unit manager and/or designee will review progress notes starting 9/24/24 for residents experiencing aggressive behaviors to monitor any follow-up and care plan has been updated as appropriate M-F for (4) weeks. Once compliance has been achieved for 4 weeks, audits will be done with 5 per month for 3 months until compliance is achieved. Following those, audits will then be completed quarterly with 5 observations until compliance is achieved. The nurse managers will be responsible for completion of the audits. The audits will be presented to the QA committee during the scheduled meetings. The DON/ADON are responsible for the process.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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then got into an altercation with another resident."
* 07/07/24 at 5:32 p.m., "Resident went down to end of hall and blocked another resident against the wall and was swearing at him. Other [sic] resident was begging him to just leave him alone. A cna [certified nurse aid] got them seperated [sic] . . . He then came up behind the other resident swearing at him and kicked him in the back. Got them seperated [sic] again and he went after him again and kicked his hand. The other resident then punched him [Resident #1] in the chest. . . ."
* 07/07/24 at 11:20 p.m., "Resident is growling at another resident and trying to get close to other resident to kick him. Residents kept seperated [sic]."
* 07/09/24 at 11:44 p.m., "Resident went up to another resident and grabbed her breasts. Both residents were separated and redirected immediately. . . ."
* 07/11/24 at 7:21 p.m., "The resident kicked another resident's wheelchair. He was taken to another room . . ."
* 07/14/24 at 4:54 p.m., "Resident moving around dining room callin [sic] other residents pieces of [explicit word]."
* 07/18/24 at 12:45 a.m., "Resident was blocking door from another resident, Did not verbal [sic] respond to resident when she was yelling at him. Resident did come with me to a different spot and had an HS [hour of sleep] snack."
* 07/20/24 at 7:13 p.m., "Resident kicked the back of another resident's wheelchair. He also yelled, 'You stupid [explicit word]' to a different resident. He was redirected each time to another area."
* 07/22/24 at 5:55 p.m., "Resident yelling and

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	355074	A. BUILDING _____ B. WING _____	C 09/05/2024

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F 744	Continued From page 12 cursing at other residents. . . ." * 07/27/24 at 8:15 p.m., ". . . Female residents afraid of going near resident. . . ." * 07/28/24 at 3:05 a.m., "Resident [#1] grabbed another female resident by her arm. No injuries noted at this time. Resident is immediately redirected away from the other resident." * 07/29/24 at 10:37 p.m., "Resident is trying to pinch resident [sic] breast after supper. Unable to redirect him away from the females. . . ." * 07/30/24 at 2:17 p.m., "Resident was glaring at another resident. He was redirected away from her before anything happened." * 07/30/24 at 4:59 p.m., ". . . He was grabbing female resident [sic] breast [sic] or talking sexual to them. He would not let a female resident go by him so staff had to get the resident by him . . ." * 07/30/24 at 11:20 p.m., "Resident sat at the main door after supper. Cussed at other residents. . . ." * 08/01/24 at 9:32 p.m., "before supper started to get near female residents. . . . Then he proceeded to kick another male resident [sic] wheelchair and call him '[explicit word].' when taking residents to the table for supper [Resident #1] would go and stare at the female resident and call her '[explicit word]' and stare at her . . . [Resident #1] would then try and quickly get near another female resident if staff looked away. . . . Informed [Resident #1] that he needs to stay away from other residents especially the ladies. It is not appropriate for him to touch other residents or call them names. . . . The minute we turned our back he was headed to a table with female residents. . . ." * 08/02/24 at 11:16 a.m., "Nursing staff called Social Services last evening to report [Resident #1] was having a lot of behaviors. . . . Some	F 744		

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changes have been made to his psychotropic medications and he is being monitored closely."
* 08/03/24 at 10:54 a.m., "The resident would not let another resident's family leave by blocking the exit door. He also tried to grab one of their breast [sic] as they tried to leave. . . . Staff redirected the resident to another area."
* 08/03/24 at 9:49 p.m., "resident kicked at female resident when she was walking past him after supper. . . ."
* 08/04/24 at 1:59 p.m., "CNA reported . . . she tried to redirect him [Resident #1] from hitting another resident. She directed him to another room. . . ."
* 08/04/24 at 9:30 p.m., "Resident going up to other female resident [sic], stares at them then calls them [explicit word]. Unable to redirect as he goes to another resident and tries to kick them [sic], grab them [sic] or call them [sic] names. Resident assisted to bed."
* 08/07/24 at 11:01 a.m., "Resident grabbed a female resident's left breast after breakfast. Female resident yelled at him and walked away and came to the nurses' desk. Resident's breast was red, no bruising. . . ."
* 08/07/24 at 6:51 p.m., "Resident was making faces at another resident in the dining room. Other resident told him to stop looking at her and then she threw her apple juice on him. Both residents were separated . . ."
* 08/08/24 at 6:53 p.m., "The resident propels his wheelchair fast towards other residents and he changes the look on his face, which scares them. One resident threw food at him. Staff redirected him to his room . . ."
* 08/08/24 at 11:10 p.m., "The nurse was walking up the hallways on the unit, when she observed resident stomping his feet as he was propelling

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fast in his wheelchair towards a female resident who was quietly sitting in her wheelchair in the hallways [sic]. There was no physical interaction. The female resident appeared frightened and the suggestion was made to go to her room and she complied and was taken to her room. As the nurse was prepared to leave, the resident stated, 'he is creepy.'"
* 08/11/24 at 3:48 a.m., "Resident [#1] went up to a female resident and said 'your [sic] a [explicit word].' He was calling . . . residents 'pieces of shit' and saying '[explicit word] you.' Resident very difficult to redirect."
* 08/11/24 at 1:50 p.m., "Resident was wandering around the halls most of shift. . . . He was in a confrontation with another resident."
* 08/12/24 at 6:59 p.m., "[Physician] here for rounds. Updated her on the residents' behaviors. . . . Called pharmacy requesting medication combination side effects. Carbidopa-levodopa [Parkinson's medication] can cause increased labito [sic] [sexual drive]."
* 08/12/24 at 11:14 p.m., "Resident pedaled himself quickly toward another resident at the door. Tried to grab the resident. [Resident #1] moved away from the door, then turned and went right back to the door. Other resident left the dining room. [Resident #1] kicked and attempted to hit at another resident in the dining room. [Resident #1] taken to his room . . . [Family Nurse Practitioner] called. Update given on behaviors. New orders received. Will update family in the morning."
* 08/13/24 at 1:35 p.m., "Resident was blocking the hall not letting other residents go by. . . ."
* 08/13/24 at 9:36 p.m., "[Sic] was calling another resident inappropriate names after supper."
* 08/18/24 at 6:45 p.m., "Resident propelling

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F 744	Continued From page 15 towards a resident and grabbed both her breast [sic]. He was taken to his room where [sic] sat peacefully. . . ." * 08/22/24 at 1:00 p.m., "The CNA called out for this nurse at [1:00 p.m.] She said she witnessed the resident propelling quickly down the hall towards another resident. The other resident was moving towards the wall to move out of his way. Everywhere the other resident moved he would block her. Then he kicked her in the stomach. The other resident fell to the ground. This nurse and CNA took him to his room . . ." * 08/25/24 at 9:16 p.m., "After supper resident [#1] was kicking another resident's wheelchair and saying '[explicit word] you.' able to redirect. Then went to another resident and called him an [explicit word]. Told resident if he continued to kick other residents wheelchairs and call people names then he would need to go to bed. . . ." * 08/27/24 at 6:25 a.m., ". . . Resident is very agitated and aggressive towards . . . residents tonight. He pinched another resident on her face, no injuries noted. He ran into the back of another resident's heels, no injuries noted at this time. He is going up to . . . residents growling at them and calling them '[explicit words].' He is trying to kick . . . resident. He is blocking people so they can't get by him. Resident followed this nurse into a female resident's room and refused to leave. . . . Tylenol was given and ice cream for a snack. . . . This nurse called the social worker about his behaviors. [Physician] was notified about resident's behaviors and a one time order for Ativan was given." * 08/30/24 at 1:18 p.m., "Resident was following female . . . resident around, hard to redirect, resident removed from common area from other residents . . ."	F 744		

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F 744	Continued From page 16 * 08/31/24 at 12:38 a.m., "Resident was kicking other resident [sic] wheelchair after supper. Also calling other resident [sic] '[explicit word].' . . ." * 08/31/24 at 2:22 p.m., "Resident propelling his wheelchair fast towards other residents and telling them to move. . . ." * 08/31/24 at 9:18 p.m., "Resident continue to move his wheelchair fast around the dining room. Stops at different residents and calls them '[explicit word]' or says '[explicit word] You.' Also kicked a couple wheelchairs of different residents." * 09/01/24 at 2:03 p.m., "Resident propelled quickly towards other residents. CNA . . . tried to redirect . . ." * 09/04/24 at 6:04 a.m., "Resident is going up to residents and saying '[explicit word] You.' Attempts made to redirect . . ." The "Behavioral Health Clinic Notes" stated the following: * 07/26/24, ". . . one day he was grabbing breasts and arms of female staff . . . He has been telling other residents that they are pieces of [explicit word] . . . Staff noted he had been watching the door . . . it was reported by staff that they have been taking him outside and that he enjoys this. . . . He does say yes to watching the door hoping to go outside. . . ." * 08/09/24, ". . . I did speak with staff who reported . . . one day . . . he was pretty rude in the evening to staff and other residents but that otherwise he has been doing ok. . . . Staff noted that he does still enjoy going outside and that they noticed improvement in his mood when he is able to go outside. . . ." * 08/23/24, ". . . patient [Resident #1] was in his wheelchair in front of the door when I arrived I did	F 744		

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have to ask him to move in order to open the door enough to get in. . . . Received a call from the nurses at the nursing home regarding behavior of [Resident #1]. Cornering staff, sexually inappropriate, mean comments and door watching he did just have a dose of Sinemet 25-100 added which can cause increase in sexual attention, this dose was added as well as adding Seroquel 50 mg in the am. . . ." Documentation failed to show staff reported Resident #1's intimidating and verbally, physically, and sexually abusive behaviors towards other residents on the unit.

During an interview on 09/04/24 at 4:50 p.m., when asked if staff attempted to identify the situational stressors/triggers that lead to Resident #1's aggressive/abusive behaviors towards other residents, a managerial nurse (#2) responded, "No."

During an interview of 09/04/24 at 5:15 p.m., an administrative staff member (#1) acknowledged staff failed to notify her of Resident #1's behaviors towards female residents, such as grabbing their breasts.

The facility failed to assess and monitor patterns and trends of behaviors in an effort to minimize these behaviors, recognize unmet needs, and prevent situations/triggers which may lead to behaviors and verbal, physical, or sexual abuse toward other residents. The facility failed to develop an effective behavior management program, consistently implement purposeful and meaningful activities, such as going outside, in an attempt to manage the behaviors exhibited by Resident #1, evaluate the behavior management

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F 744	Continued From page 18 program on an on-going basis, and modify interventions as needed. The facility failed to ensure Resident #1 did not infringe upon the rights of others while still allowing him to achieve his highest level of well-being. These failures resulted in verbal, physical, and sexual abuse from Resident #1 towards other residents and residents experiencing fear and anxiety related to Resident #1's abusive behaviors.	F 744		