STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065170	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Platte Rehabilitation and Nursing LLC	2200 Edison St Brush, CO 80723

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to ensure two (#5 and #6) of two residents reviewed for abuse out of eight sample residents were kept free from physical abuse. Resident #4 was admitted to the facility on [DATE] with diagnoses which included alcohol abuse and encephalopathy (brain disease that affects brain function). The resident had a mood problem related to being quick tempered, had poor coping skills and could exhibit verbally aggressive outbursts towards others when he disagreed with them. On 10/21/24, certified nurse aide (CNA) #1 witnessed Resident #4, who was coming inside from the smoking area, purposefully run his wheelchair into Resident #5, who was in the hallway in her wheelchair waiting to go outside to the smoking area. Resident #5 sustained redness to the left lower leg above the ankle and an abrasion to her right forearm where the top layer of skin had come off, in addition to right shoulder and leg pain. Resident #5, who had a diagnosis of anxiety disorder, reported she had increased anxiety and felt more isolated since the incident with Resident #4 because she would stay in her room when Resident #4 was in the hallway due to the anxiety she felt when she was around him. Due to the facility's failures to protect Resident #5 from physical abuse from Resident #4 on 10/21/24, Resident #5 suffered psychosocial harm following the incident. Furthermore, the facility did not initiate additional interventions for Resident #4 following the 10/21/24 incident with Resident #5 to prevent the abuse from occurring again. On 11/21/24 Resident #4 stood up from his wheelchair and grabbed Resident #6 by the shirt collar and pushed Resident #6. Resident #6 pushed Resident #4 away and Resident #4 stumbled backwards and hit his head but did not sustain any injuries. Due to the facility's failures to implement effective behavior interventions and monitoring for Resident #4, the resident was involved in a second resident to resident altercation with Resident #6 one month after the incident with Resident #5. Findings include: (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	I. Facility policy and procedure The Abuse policy, revised 6/11/24, was provided by the regional director of quality and compliance (RDQC) on 1/6/25 at 11:59 a.m. It read in pertinent part, Every resident has the right to be free from all forms of abuse: verbal, sexual, physical, mental, neglect, corporal punishment and involuntary seclusion. This facility does not condone resident abuse and shall take every precaution to prevent resident abuse. Resident abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment of a resident resulting in physical harm or pain, mental anguish or deprivation of goods or services that are necessary to attain or maintain physical, mental or psychosocial well-being. Residents with aggressive or abusive behaviors shall have their care plans written and revised as needed to include approaches to reduce or eliminate the risk for abuse. The facility will ensure that all residents are protected from physical and psychosocial harm during and after abuse investigations, including but not limited to: examining the alleged victim for any sign of injury, including a physical examination and/or psychosocial assessment as indicated, increasing supervision of the alleged victim and other residents as indicated, providing emotional support and/or counseling to the resident during and after the investigation as needed. II. Incident of physical abuse of Resident #5 by Resident #4 on 10/21/24 A. Facility incident report and investigation The 10/21/24 incident report was provided by the RDQC on 1/7/25 9:14 a.m. The report documented the nurse was informed Resident #4 purposely collided into Resident #5 while both residents were seated in their wheelchairs. Resident #4 continued down the hall to his room and Resident #5 was assessed for injuries. Resident #5 reported her right arm was jarred and the nurse documented a 0.5 centimeter (cm) by 0.5 cm abrasion on her right forearm where the top layer of skin had come off. Resident #5 reported her left lower leg above the ankle hit the wheel of her wheelchair. The nurse documented redness to the skin above the resident's left ankle. According to the incident report, there were no predisposing factors which caused the incident to occur. The abuse investigation report, documented on 10/21/24 at approximately 2:37 p.m., documented CNA #1 witnessed Resident #4 run into Resident #5 who was in the hallway seated in her wheelchair. CNA #1 separated the residents and called the nurse for assistance. Resident #5 was assessed by licensed practical nurse (LPN) #1 and was noted to have physical injuries, including redness to the left lower leg above the ankle and an abrasion to her right forearm where the top layer of skin had come off. Resident #4 said he did not have any pain and refused a skin assessment. Immediate safety measures documented were placing the assailant (Resident #4) on frequent checks. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #5 (the victim) was interviewed and said she was wheeling down the hall towards the smoking area when the supervised smokers, including Resident #4 (the assailant), were coming inside. Resident #5 said she made a comment to Resident #4 that he was driving on the wrong side of the road. She said Resident #4 wheeled right into her with his legs hitting hers and spoke profanity to her. Resident #5 said the impact threw her back in her wheelchair causing right shoulder and leg pain. Resident #4 was interviewed and said he was coming inside from smoking. He said Resident #5 told him he should not be driving on the wrong side of the road. Resident #4 said he told her to stay where she was or he would run into her. Resident #4 said he ran into Resident #5 and left. The incident was substantiated by the facility. B. Resident #4 (assailant) 1. Resident status Resident #4, age 68, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included liver disease, epilepsy, diabetes, alcohol abuse and encephalopathy (brain disease that affects brain function). The 11/13/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #4 used a wheelchair, was independent with eating and transferring self and required set up assistance with showering. The MDS assessment revealed Resident #4 had no behavioral symptoms during the prior seven-day assessment look-back period. 2. Resident interview Resident #4 was interviewed on 1/6/25 at 2:50 p.m. Resident #4 said he got along well with other residents and had not had any altercations. Resident #4 laughed and said no one had made him angry at the facility but he said if anyone did make him angry, he would punch them. 3. Record review Resident #4's behavior care plan, initiated 8/16/23 and revised 11/14/24, documented that he had a mood problem related to being quick tempered, had poor coping skills, pressured others to move out of his way (sometimes verbally) and patted the backs of others wheelchairs in attempts to get them to move out of the way. Interventions included encouraging better coping skills and patience with others when they were moving slowly through the hall (initiated 8/16/24), administering medications as ordered, providing behavior health consultations as needed and observing and recording his mood to determine if problems were related to external causes, (all revised 8/20/24). -The facility failed to update the care plan with new interventions following the 10/21/24 incident with Resident #5. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #4's behavior success care plan, initiated 10/1/24 and revised 10/4/24, addressed the resident's verbally aggressive outbursts towards others when he disagreed with them. Interventions (all initiated 10/1/24) included encouraging self-calming behavior such as breathing exercises, ensuring the safety of the resident and others, establishing boundaries and limits with the resident, providing emotional support regarding new onset disruptive behavior and utilizing diversion techniques. -The care plan did not define any triggers for the aggressive outbursts or ways to ensure the safety of others. -The facility failed to update the care plan with new interventions following the 10/21/24 incident with Resident #5. Resident #4's physical aggression care plan, initiated 12/23/24, documented the resident had actual incidents of physical aggression and the potential to become physically aggressive related to the history of aggression and harm to others, poor impulse control and complications with self-mood regulations. The care plan identified Resident #4's triggers for physical aggression were primarily territorial. The resident disliked it when others hovered around his room or invaded his personal space. Interventions included administering medications as prescribed, assessing and addressing contributing sensory deficits (minimizing noise, dimming the lights, keeping the door closed and giving him space from others), providing physical and verbal cues to alleviate anxiety, assisting with verbalizing the source of agitation, encouraging the resident to seek out a staff member when agitated, conducting a thorough analysis of circumstances that may influence behaviors paying attention to triggers that contributed to the behavior, documenting observed behaviors and attempted interventions in the care plan, avoiding large crowds, recognizing his need for personal space, psychiatric consultation as needed and taking prompt action if the resident became agitated to prevent further escalation. -Resident #4's physical aggression care plan was not initiated until two months after the incident with Resident #5 and one month after the resident's second incident of physical abuse towards another resident (see below). -Resident #4's electronic medical record (EMR) failed to reveal documentation that frequent checks were conducted for Resident #4 after the incident, as was specified as an immediate intervention in the facility's investigation report (see investigation above). An interdisciplinary (IDT) team note, dated 10/23/24 at 1:09 p.m., documented the IDT met to review Resident #4 related to his smoking behavior and his recent resident-to-resident altercation with another resident. The note documented an additional plan of care was being implemented for behavior monitoring. The resident was scheduled to meet with the social services director (SSD) for a biweekly review. The facility would review and update as needed. -Review of Resident #4's care plan revealed his behavior care plan was not updated following the 10/21/24 incident (see care plan above). C. Resident #5 (victim) 1. Resident status (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #5, age less than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included acute infarction of spinal cord (spinal cord stroke causing pain or loss of sensation in the back down to legs), occipital neuralgia (pain or loss of sensation in the back of the head and neck), anxiety disorder, hypertension (high blood pressure) and type 2 diabetes mellitus. The 10/23/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was independent with personal hygiene, dressing and transfers. She did not walk but was independent with mobility using a wheelchair. 2. Resident interview Resident #5 was interviewed on 1/6/25 at 9:06 a.m. She was sitting in her wheelchair in her room with both privacy curtains pulled around her. Resident #5 said she did not feel safe at the facility. She said Resident #4 waited in the hall near the door to the smoking area for long periods of time. Resident #5 said she stayed in her room if Resident #4 was in the hallway. Resident #5 said she did not go outside to smoke when Resident #4 went outside because it made her anxious to be around him. Resident #5 said she believed she had whiplash from the incident when Resident #4 rammed into her wheelchair. She said she had a tight knot in the back of her neck for a while afterwards and had to have physical therapy. Resident #5 said she just wanted to move to another facility. Resident #5 was interviewed again on 1/7/25 at 12:41 p.m. Resident #5 was lying in her bed with the privacy curtains closed on both sides with her television on. Resident #5 said she felt more isolated since the incident with Resident #4 because she stayed in her room more. Resident #5 said whenever she saw Resident #4 in the hall she felt anxious and went back into her room. She said she felt like Resident #4 was always in the hall. She said he came down early and sat by the exit to the smoking area. Resident #5 said she believed Resident #4 tried to intimidate her. Resident #5 said things were good for a couple of weeks after the incident with Resident #4 because the supervised smokers were going out back to smoke and she never saw Resident #4. However, Resident #5 said it only lasted for a couple of weeks because there was no fencing or shelter in the back smoking area so the supervised smokers were no longer smoking there. She said Resident #4 continued to go down her hallway past her room several times a day to get to the smoking area. 3. Record review Review of Resident #5's trauma-informed care plan, initiated 12/23/24 (two months after the 10/21/24 incident with Resident #4), documented Resident #5 was fearful related to an incident that occurred at the facility when another resident exhibited aggressive behavior towards her. Interventions included offering Resident #5 another room on the opposite hall (which she declined), offering to escort her to desired locations in the facility (declined due to personal choice), arranging for services with a mental health provider, encouraging her to share her feelings and concerns with staff, identifying items that lessened the effect of the trauma and monitoring her whereabouts and emotional state. -The facility failed to initiate a trauma care plan to address Resident #5's trauma related to the incident with Resident #4 until two months after the incident on 10/21/24. The 7/23/24 Resident Mood Interview assessment (prior to the incident), revealed Resident #5 scored a zero out of 30, indicating she did not have any symptoms of depression. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #5 indicated she never felt lonely or socially isolated. The 10/23/24 Resident Mood Interview assessment (after the incident), revealed Resident #5 scored a six out of 30, indicating she was experiencing depression. The resident indicated she felt down, depressed or hopeless, had trouble falling or staying asleep or was sleeping too much and felt tired or had little energy more than half of the days during a two week period. Resident #5 indicated she sometimes felt lonely or socially isolated. -Review of Resident #5's EMR revealed there was no documentation to indicate the resident's mood changes had been identified or addressed by the facility following the incident with Resident #4. Cross-reference F742 for failure to provide treatment/services for mental/psychosocial concerns. D. Staff interviews LPN #1 was interviewed on 1/6/25 at 9:56 a.m. LPN #1 said she did not witness the occurrence between Resident #4 and Resident #5 but she knew one of the residents was coming in from smoking and the other was going out. LPN #1 said Resident #5 told her Resident #4 rammed his wheelchair into her knees. LPN #1 said Resident #5 did not have any visible marks (however, the occurrence investigation revealed she had an abrasion on her arm and redness to her knee) but later Resident #5 said she got whiplash. LPN #1 said Resident #4 told her people should get out of his way. LPN #1 said they tried to watch for Resident #5 when she came out into the hall or went to smoke. LPN #1 said if Resident #4 was out in the hallway, Resident #5 went back to her room and did not go out to smoke. LPN #1 said frequent checks meant staff laid eyes on the resident every 15 minutes for 72 hours. LPN #1 said the staff documented these checks on paper. CNA #1 was interviewed on 1/6/25 at 11:33 a.m. CNA #1 said on the day of the incident (10/21/24) she saw Resident #4 close to Resident #5 and asked him what he was doing. She said Resident #4 backed away and wheeled down the hall but she did not see him run into Resident #5. CNA #1 said Resident #5 told her Resident #4 took hold of her wheelchair and rammed her into the wall. She said the residents were face to face in their wheelchairs. CNA #1 said the facility did not do 15-minute frequent checks on Resident #4 after the incident. CNA #1 she was not aware of any interventions in place for Resident #4's aggressive behaviors. She said staff were just told to intervene if the residents got too close to each other. The social service director (SSD) was interviewed on 1/7/25 at 10:30 a.m. The SSD said she did not know if there was a physical aggression behavior care plan for Resident #4 prior to the incident on 10/21/24 or when it may have been resolved. The SSD said the facility was using a different EMR program now and she was not able to access the old care plans. The nursing home administrator (NHA), director of nursing (DON) and the RDQC were interviewed together on 1/7/25 at 11:32 a.m. The DON said frequent checks for Resident #4 were implemented following the incident with Resident #5. The DON said frequent checks meant checking on the resident every 15 minutes for 72 hours. The DON said the staff documented on paper and the documentation was uploaded into the EMR. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-However, there was no documentation provided to indicate frequent checks were completed for Resident #4 following the incident (see record review above). The NHA said Resident #4 had a brain injury and was triggered by other people not using common sense. The NHA said people knocking on his door agitated him if he was sitting right there and could see them. He was protective of his personal belongings. The RDQC said the facility would be implementing further interventions for Resident #4's behavior care plan. 48458 III. Incident of physical abuse of Resident #6 by Resident #4 on 11/21/24 A. Facility investigation The 11/21/24 facility abuse investigation documented the incident occurred on 11/21/24 at 10:01 a.m. The investigation documented Resident #4 stood up from his wheelchair and grabbed Resident #6 by the shirt collar. Resident #6 responded by pushing Resident #4 who then fell and hit his head on the wall. The residents were immediately separated and placed on frequent checks. The investigation documented two facility staff members witnessed the resident-to-resident altercation. It documented Resident #6 was an at-risk adult. The police, residents' families, the ombudsman and the physician were notified of the resident-to-resident altercation. The investigation revealed there was no evidence of injury to Resident #6. The investigation documented the NHA interviewed Resident #6 following the incident. The investigation documented Resident #6 said he was walking down the hall with a maintenance staff member when Resident #4 said stop acting tough in front of me. Resident #6 said Resident #4 then stood up and grabbed Resident #6's shirt and pushed Resident #6 and then Resident #6 pushed Resident #4 away. Resident #6 said Resident #4 stumbled backwards and hit his head. Resident #6 said he was not fearful of Resident #4 after the incident. The investigation documented Resident #4 was interviewed by the NHA on 11/21/24 at approximately 1:00 p. m. Resident #4 said Resident #6 was outside of Resident #4's room acting like a tough guy. Resident #4 said he told Resident #6 he would slap him around a little bit and then Resident #4 said he stood up and lost his balance and hit his head on a door frame. The investigation documented the following interviews with witnesses to the incident: -An interview with housekeeper (HK) #1 on 11/21/24 at 1:05 p.m. by the NHA. The interview documented HK #1 said Resident #4 stood up and pushed Resident #6 in the chest and then Resident #6 responded by pushing Resident #4 back. -An undated interview with CNA #4, who was also a member of the maintenance staff, was conducted by the NHA. The interview documented CNA #4 was walking down the hallway with Resident #6 when Resident #4 began yelling at Resident #6. Resident #6 approached Resident #4 to listen to Resident #4 and then Resident #4 stood up and grabbed Resident #6 by the shirt collar. Resident #6 pushed Resident #4 and Resident #4 stumbled back and hit his head. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The investigation documented Resident #6 was placed on frequent checks, follow-up with mental health services and monitoring for psychosocial abnormalities for the following 72 hours. The care plan for Resident #6 was updated to redirect Resident #6 from wandering in front of rooms or doorways of those who had the potential to be upset by the increased presence. The investigation documented increased supervision and medication change were actions taken for Resident #4 to help prevent a recurrence. The investigation documented Resident #4 had been involved in previous altercations within the past 12 months. The investigation concluded the abuse was substantiated. B. Resident #4 (assailant) 1. Record review A nursing progress note, dated 11/21/24 at 12:55 p.m., documented the nurse heard Resident #4 raising his voice and telling someone don't be stupid in front of my door. When the nurse got up to walk out to hallway to see what was going on, Resident #4 stood up and grabbed Resident #6 by the front of his shirt and Resident #6 shoved him away and Resident #4 struck his head on the doorway and fell to his right side. The SSD immediately intervened and attempted to redirect Resident #6 away from Resident #4 as Resident #4 was attempting to get up and go back at Resident #6. -Review of Resident #4's behavior care plans revealed the care plans were not updated following the incident on 11/21/24 with Resident #6. -Review of Resident #4's comprehensive care plan revealed a care plan focus for physical aggression was not initiated until 12/23/24, one month after the incident with Resident #6 and two months after a previous incident on 10/21/24 with Resident #5 (see above). C. Resident #6 (victim) 1. Resident status Resident #6, age less than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included drug induced dyskinesia (uncontrolled involuntary muscle movement), dysphagia (difficulty swallowing) and dementia. The 11/27/24 MDS assessment revealed the resident had a severe cognitive impairment with a BIMS score of five out of 15. The resident ate and walked independently and he required set-up assistance with showering. The MDS assessment did not reveal any behaviors displayed by the resident toward others. 2. Resident observation and interview (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The SSD was interviewed on 1/6/25 at 11:26 a.m. The SSD said she had just spoken with Resident #6 prior to the incident with Resident #4 on 11/21/24. The SSD said she was in the hallway during the incident. he said she heard a loud male voice, turned around and saw Resident #4 shove Resident #6. She said Resident #6 shoved back and Resident #4 lost his balance and fell into the door. She said it appeared Resident #6 was being defensive when he pushed back at Resident #4. The SSD said since the incident, she had directed other residents to not pace in front of Resident #4's doorway. She said Resident #4 had some medication changes after the 11/21/24 incident. The SSD said she updated care plans related to residents' behaviors. The SSD said Resident #4 was the aggressor during the 11/21/24 incident and was also the aggressor during a previous incident on 10/21/24 (see above). The SSD said the IDT met after the incident on 10/21/24. The SSD said she did not see an addition to Resident #4's care plan for behavior monitoring after it was referenced in the IDT progress note on 10/23/24. The SSD said she could not find any notes about an IDT meeting after the 11/21/24 incident. The SSD said she did not see evidence that Resident #4's care plan was updated for behaviors to include his physically aggressive behavior until 12/23/24, four weeks after the 11/21/24 incident. The SSD said Resident #4 had prior physical aggression incidents more than a year ago. The SSD said she thought the care plan related to aggressive behaviors had been resolved since there had not been further incidents until recently. The SSD said Resident #4's triggers for his behaviors were added on 12/23/24. LPN #1 was interviewed on 1/6/25 at 2:00 p.m. LPN #1 said Resident #4 liked to have his way and was very particular about many things. LPN #1 said she was unaware Resident #4 and Resident #6 had an altercation on 11/21/24. CNA #4 was interviewed on 1/6/25 at 2:15 p.m. CNA #4 said he witnessed the altercation between Resident #4 and Resident #6 on 11/21/24. CNA #4 said he was talking with Resident #6 in the hallway outside of Resident #4's room. CNA #4 said Resident #4 became annoyed and stood up from his wheelchair. CNA #4 said Resident #4 grabbed Resident #6's shirt and then Resident #6 pushed him back. CNA #4 said Resident #4 had yelled at other residents before. CNA #2 was interviewed on 1/6/25 at 3:15 p.m. CNA #2 said she was not aware of any resident-to-resident altercations involving Resident #4 and she was not aware of any triggers that would make him upset. The SSD, the NHA and the RDQC were interviewed together on 1/6/25 at 3:21 p.m. The RDQC said she was trying to determine if Resident #4's care plan information had been lost due to technical issues. The SSD and the NHA said there should have been more information added to Resident #4's care plan related to his behaviors after the 10/21/24 altercation with Resident #5. The RDQC said a medication review for Resident #4 was requested on 11/21/24, as there was concern a medication change might have contributed to his behavior issues. The NHA said residents' behavior care plan should be updated within a week of a resident-to-resident incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065170	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Actual harm Residents Affected - Few	-However, the care plan for Resident #4's physically aggressive behavior was not initiated until 12/23/24 (see above). CNA #3 was interviewed on 1/7/25 at 10:34 a.m. CNA #3 said Resident #4 was triggered for behaviors if other residents made comments to him. CNA #3 said she was aware of recent altercations between Resident #4 and other residents. She said Resident #4 was told to watch what he said to other residents, but she said she was not aware of any other behavioral interventions initiated for Resident #4. She said one of the residents was told to be aware of the scheduled times for supervised smoker breaks (as Resident #4 was a smoker) to avoid Resident #4.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on observations, record review and interviews, the facility failed to ensure resident assessments were provided by qualified persons for three (#8, #3 and #5) of eight residents out of eight sample residents. Specifically, the facility failed to: -Ensure Resident #8 and Resident #3, who experienced unwitnessed falls, were assessed by a registered nurse (RN) before they were assisted from the floor; and, -Ensure Resident #5, who was the victim of resident-to-resident physical abuse, was assessed by a RN following the resident-to-resident altercation. Findings include: I. Failed to have a RN assess Resident #8 and Resident #3 after unwitnessed falls, prior to assisting the residents from the floor A. Facility policy and procedure The Falls - Clinical Protocol policy, revised 10/2012, was provided by the regional director of quality and compliance (RDQC) on 1/6/25 at 11:59 a.m. The policy revealed as part of the initial assessment, nursing staff would identify individuals with a history of falls and risk factors for subsequent falling. Staff would ask the resident or resident's representative about a history of falling. While many falls were isolated individual incidents, a significant proportion occurred among a few residents. Those individuals might have a treatable medical disorder or functional disturbance as the underlying cause. The staff would document risk factors for falling in the resident's record and address the resident's fall risk factors with appropriate interventions in the resident's plan of care. The staff would evaluate and document falls that occurred on an incident report form, for example, when/where they happened, and any observations of the events. Staff should categorize falls as unwitnessed, witnessed, or assisted. For an individual who had fallen, the interdisciplinary team (IDT) would complete an evaluation to identify the root cause and recommend appropriate new interventions to address risk factors of falling. Causes referred to factors that were associated with or that directly resulted in a fall, for example, a balance problem caused by an old or recent stroke. Multiple factors in varying degrees might contribute to a falling problem. If the cause of a fall was unclear, if the fall might have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continued to fall despite attempted interventions, it might be appropriate to ask the attending physician to review the situation and help identify contributing causes. (continued on next page)

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	065170	A. Building B. Wing	01/07/2025

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing staff should initiate post-fall assessments after a fall occurred. Staff should complete an assessment to look for new injuries, changes in range of motion, complaints of pain or other adverse clinical changes related to the fall. For unwitnessed falls or falls wherein the resident hit their head, staff should complete neurological and vital sign checks according to the facility's neurological assessment flowsheet. Staff should initiate alert charting on each nursing shift for 72 hours or longer as indicated, wherein each nurse evaluates for adverse changes related to the fall and the efficacy of current fall interventions. -However, the policy did not specify that a RN should do an assessment of the resident before the resident was moved from off the floor for unwitnessed falls. B. Resident #8 1. Resident status Resident #8, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included displaced intertrochanteric fracture of the left femur, subsequent encounter for a closed fracture with routine healing, fracture of the right femur, fracture of the head/neck of the right femur, anxiety and chronic diastolic (congestive) heart failure. The 12/27/24 minimum data set (MDS) assessment revealed Resident #8 had a moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident used a walker and/or a wheelchair. The resident had impairment on one side of the lower extremities (hip, knee, ankle or foot). The resident required substantial/maximal staff assistance for sit to stand (the ability to come to a standing position from a sitting position for a chair, wheelchair or on the side of the bed. 2. Record review The fall risk assessment dated [DATE] at 2:02 p.m., revealed a score of 16, which indicated the resident was a high fall risk Resident #8's care plan for being at risk for falls due to a history of falls, a fall with a fracture, cognition impaired safety awareness, and medication side effects was initiated on 4/3/24 and revised on 1/2/25. Interventions included to ensure the resident's call light was within reach, encourage the resident to use the call light for assistance as needed, ensure the resident's high/low bed was in the lowest position while in bed, ensure the resident was wearing appropriate footwear when ambulating and the resident had been provided a walkie talkie for use in the dining room to contact staff (this was the location the resident spent most of her day and a call light was not available in this area). Staff were to review information on past falls and attempt to determine the cause of the falls, document the possible root causes, alter/remove any potential causes, if possible and educate the resident/family/caregivers/ and the interdisciplinary team as to the causes. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An incident report, dated 12/20/24 at 8:20 p.m., for an unwitnessed fall, was written by licensed practical nurse (LPN) #3 .The report revealed a call light went off in Resident #8's room. A certified nurse aide (CNA) went down to see what the resident needed and found the resident on the floor. The CNA went to go get a nurse. A nurse asked the resident how she ended up on the floor. The resident said everything slipped. The nurse asked a second time how the resident ended up on the floor and the resident asked if she had broken her back. A RN was called from the other side of the facility to do an assessment. LPN #3 and the CNA got Resident #8 from off the floor and into her chair and the resident had no complaints. After LPN #3 and the CNA had assisted Resident #8 back into her chair, the RN walked into the room. The resident started to say it hurts and she was not going to therapy the next day. Resident #8 had a skin tear to the left elbow and the RN was unable to determine the left hip trochanter (hip) condition. The resident was sent to the emergency department to be evaluated. The county hospital near the facility admitted Resident #8 on 12/20/24 at 8:24 p.m., with a chief complaint of falling out of a wheelchair to the ground and a complaint of left hip pain. The resident apparently had a low mechanism fall out of a wheelchair and had acute pain in the left hip and femur regions. The diagnosis was a left hip fracture and the resident would be transferred to another hospital with a higher level of care. The resident was discharged to the second hospital on 12/21/24 at 12:54 a.m. A situation, background, assessment, recommendation (SBAR) note, dated 12/20/24 at 8:56 p.m., revealed the resident had a change in condition related to a fall. The nursing observations, evaluation and recommendations revealed the resident fell with no injury and was sent to the emergency department because the resident started complaining of pain. A nurse note, dated 12/20/24 at 11:58 p.m., revealed the nurse spoke with the hospital and the resident broke her hip and was being transferred to another hospital for treatment. The second hospital admitted the resident on 12/21/24 at 2:13 a.m. The chief complaint was left hip pain from a fall. Resident #8 was transferred to the second hospital from the previous hospital secondary to a left intertrochanteric hip fracture. The resident said she was helping her roommate in the bathroom when she fell on her left side. The resident said she was unable to get up from off the floor due to sharp pain that was constant, which was at least an 8 or 9 out of 10 on a 1-10 pain scale. The musculoskeletal assessment revealed good muscle mass, tone, strength, normal range of motion, except for the left hip, which had pain on ranges of motion. An IDT event review, dated 12/23/24 at 10:28 a.m., revealed Resident #8 had a fall on 12/20/24 due to weakness and poor gait. The resident was sent to the emergency department for an evaluation and treatment. A skilled charting note, dated 12/24/24 at 2:24 p.m., revealed Resident #8 returned from hospital. The resident was confused at times, which appeared to be related to post surgical effects. The resident was able to make her needs known. A nurse note, dated 12/2024 at 8:52 p.m. and written by a LPN, revealed Resident #8 fell on to the floor on her left side, had a skin tear on her left elbow and was at the emergency department getting x-rays done to make sure nothing was broken. (continued on next page)

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	065170	A. Building B. Wing	01/07/2025

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of Resident #8's electronic medical record (EMR) did not reveal that a RN assessed the resident after the unwitnessed fall on 12/20/24 at 8:20 p.m., prior to the resident being assisted by staff from off the floor to a chair. The resident sustained a left hip fracture from the fall. 3. Staff interviews LPN #1 was interviewed on 1/7/25 at 10:10 a.m. LPN #1 said a RN should perform an assessment on a resident for an unwitnessed fall, before the resident was moved from off the floor. She said the assessment was out of the scope of practice of a LPN. LPN #2 was interviewed on 1/7/25 at 11:06 a.m. LPN #2 said a RN must assess a resident who had an unwitnessed fall before the resident was moved from off the floor. She said the complete resident assessment was not in the scope of practice of an LPN. RN #1 was interviewed on 1/7/25 at 11:27 a.m. RN #1 said a RN should do an assessment of a resident that had an unwitnessed fall before the resident was moved from off the floor. She said the complete resident assessment was not in the scope of practice of an LPN. The nursing home administrator (NHA), the director of nursing (DON), the assistant director of nursing (ADON) and the RDQC were interviewed on 1/7/24 at 1:04 p.m. The NHA, the DON, the ADON and the RDQC said Resident #8 had an unwitnessed fall on 12/20/24 at 8:20 p.m. and was sent to the emergency department for evaluation and treatment. The NHA, the DON, the ADON and the RDQC said the resident received a diagnosis of a left hip fracture. The NHA, the DON, the ADON and the RDQC said LPN #3 and a CNA moved Resident #8 off the floor, before a RN did an assessment of the resident. The NHA, the DON, the ADON and the RDQC said a RN should do an assessment of a resident with an unwitnessed fall, prior to the resident being moved from off the floor. The DON said it was not in the LPN's scope of practice to conduct an assessment of a resident after an unwitnessed fall. She said LPN #3, who moved the resident off the floor, received an in-service on falls on 12/23/24. C. Resident #3 1. Resident status Resident #3, age greater than 65, was admitted on [DATE] and discharged home on 11/13 24. According to the November 2024, CPO, diagnoses included stable burst fracture of T9-T10 (thoracic) vertebra, subsequent encounter for fracture with routine healing, mechanical complication of internal fixation device of vertebrae, protein-calorie malnutrition and pneumonia. The 11/13/24 MDS assessment revealed Resident #3 was cognitively intact with a BIMS score of 15 out of 15. The resident used a manual wheelchair. The resident had no impairments in either the upper or the lower extremities. The resident required substantial/maximal staff assistance for sit to stand (the ability to come to a standing position from a sitting position for a chair, wheelchair or on the side of the bed. (continued on next page)

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	065170	A. Building B. Wing	01/07/2025

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review The baseline admission care plan, dated 11/10/24, revealed the resident was at risk for falls. The resident did not have any falls within the last two to six months prior to admission to the facility. The interventions included anticipating/meeting the resident's needs, keeping frequently used items within reach, educating/encouraging the resident to wear appropriate footwear, such as non-skid socks or shoes when ambulating, educating the resident/family/caregiver regarding safety reminders and what to do if a fall occurred, following the facility policy if a fall occurred, orienting the resident to the call light, keeping the resident's call light within reach, encouraging the resident to use the call light and referring the resident to therapy for evaluation/treatment as indicated to address the resident's fall risk. A care plan for the resident being at risk for fall related to an actual fall, impaired mobility and recent surgery was initiated on 11/12/24. Interventions included for staff to anticipate and meet the resident's needs, keep frequently used items within reach, keep the resident's call light within reach and encourage the resident to use it for assistance as needed, educate and encourage the resident to wear appropriate footwear, such as non-skid socks or shoes, when ambulating/mobilizing, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs and follow facility fall protocol if a fall occurred and offer the resident a bedside commode. The incident report, dated 11/11/24 at 10:48 p.m. and written by LPN #3 for an unwitnessed fall, revealed LPN #3 went down to Resident #3's room because her call light went off and the CNA was working in another room. LPN #3 opened the door and the resident was on the floor. LPN #3 asked Resident #3 if anything hurt. The resident said no, but she hit her elbow. LPN #3 looked at the resident's elbow and there was no bleeding, however there was a small bruise. LPN #3 and a CNA helped the resident from the floor and back into bed. The nurse observed a skin tear on the resident's right knee. The skin tear was washed and a one centimeter (cm) by one cm bandage was placed on the skin tear. A RN came and assessed Resident #3 after the resident was assisted from the floor by LPN #3 and the CNA. The fall occurred when Resident #3 went to the bathroom and slipped on the floor. The resident wore socks with sticky pads on the bottom of the socks. The resident said that she went to the bathroom after pressing her call light and no staff came. The resident was oriented to person, place, situation and time. A weekly skin check assessment, dated 11/11/24 at 11:04 p.m., revealed Resident #3 had a skin tear to the right knee, a bruise to the right elbow and symptoms of a wound to the lower back area measuring approximately one foot long. (continued on next page)

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	065170	A. Building B. Wing	01/07/2025

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse note, dated 11/11/24 at 10:30 p.m., revealed this nurse (LPN #3) was notified of Resident #3's fall at 10:25 p.m. LPN #3 went into the resident's room to assess the resident. The resident was alert/orientated times four and appeared to be at baseline in mental status. The resident said she did not want to wait for assistance and got up to go to the restroom on her own. The resident said she had to grab onto the sink to keep from falling onto the floor. The resident said she landed on the right side of her body. Observations revealed old and new bruising to the right elbow. A bandaid was observed to the resident's right lower leg. The resident said she had a small cut from a fall and a nurse had placed a bandaid over the area. The resident complained of neck pain and lower back pain that was normal due to spinal fashion. The resident had no other apparent injuries observed. A nurse note, dated 11/11/24 at 11:01 p.m., revealed Resident #3 fell on to the floor. The resident had a skin tear to right leg and a bruise to right elbow. The DON, a RN and the physician were notified. The IDT event review note, dated 11/12/24 at 9:51 a.m., revealed Resident #3 had an unwitnessed fall on 11/11/24 related to poor safety awareness. The facility treated the skin tear and started neurological assessments. An intervention put in place was an in-room commode. There were no new physician orders. -Review of Resident #3's EMR did not reveal that a RN assessed the resident after the unwitnessed fall on 11/11/24 at 10:25 p.m., prior to the resident being assisted by staff from off the floor. 3. Staff interviews The NHA, the DON, the ADON and the RDQC were interviewed on 1/7/24 at 1:25 p.m. The NHA, the DON, the ADON and the RDQC said Resident #3 had an unwitnessed fall on 11/11/24 at 10:25 p.m. The NHA, the DON, the ADON and the RDQC said LPN #3 and a CNA moved the resident off the floor before a RN assessed the resident. The DON said a RN should have completed an assessment before Resident #3 was moved off the floor. The DON said the resident was not sent to the hospital after the fall. 50853 II. Failed to ensure a RN assessed Resident #5 following a resident-to-resident altercation A. Resident #5 1. Resident status Resident #5, age less than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included acute infarction of the spinal cord (spinal cord stroke causing pain or loss of sensation in the back down to legs), occipital neuralgia (pain or loss of sensation in the back of the head and neck), anxiety disorder, hypertension (high blood pressure) and type 2 diabetes mellitus. The 10/23/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was independent with personal hygiene, dressing and transfers. She did not walk but was independent with mobility using a wheelchair. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident interview Resident #5 was interviewed on 1/6/25 at 9:06 a.m. Resident #5 said another resident rammed into her wheelchair in the hallway in October 2024. Resident #5 said she believed she had whiplash from the incident when she was jolted back in her wheelchair. She said she had a tight knot in the back of her neck for a while afterwards and had to have physical therapy to relieve the tightness. 3. Record review The 10/21/24 incident report was provided by the RDQC on 1/7/25 9:14 a.m. The report documented LPN #1 was informed another resident purposely collided into Resident #5 while both residents were seated in their wheelchairs. Resident #5 reported her right arm was jarred and LPN #1 documented a 0.5 centimeter (cm) by 0.5 cm abrasion on her right forearm where the top layer of skin had come off. Resident #5 reported her left lower leg above the ankle hit the wheel of her wheelchair. LPN #1 documented redness to the skin above the resident's left ankle. The abuse investigation report, dated 10/21/24 at approximately 2:37 p.m., documented another resident ran into Resident #5 who was in the hallway seated in her wheelchair. CNA #1 separated the residents and called LPN #1 for assistance. Resident #5 was assessed by LPN #1 and did have physical injuries, including redness to the left lower leg above the ankle and an abrasion to her right forearm where the top layer of skin had come off. The abuse investigation included an interview with Resident #5. She said another resident wheeled right into her with his legs hitting hers. Resident #5 said the impact threw her back in her wheelchair causing right shoulder and leg pain. Cross-reference F600 for failure to protect residents from abuse. -There was no documentation in Resident #5's EMR to indicate a RN conducted an assessment of the resident following the resident-to-resident altercation. 4. Staff interviews LPN #1 was interviewed on 1/6/25 at 9:56 a.m. LPN #1 said she did not witness the resident-to-resident altercation but Resident #5 told her another resident rammed his wheelchair into her knees. LPN #1 said Resident #5 did not have any visible marks (however, the occurrence investigation revealed she had an abrasion on her arm and redness to her knee), but she said Resident #5 later said she got whiplash. LPN #1 said she was the only nurse who assessed Resident #5 after the incident. LPN #1 said there was not a RN supervisor in the building at the time of the incident and she did not call a RN to assess the resident because the resident did not fall. The DON and the RDCQ were interviewed together on 1/7/25 at 11:32 a.m. The DON said after a resident fell or there was an incident with potential injury, the LPN on duty should call a RN to assess the resident. The DON said this was the procedure not just for falls, but for any potential injury. The DON said a LPN could make observations of obvious injuries, provide first aid and do vital signs but then should contact a RN to advise over the phone or come in and do an in-person assessment of the resident. The DON said if there was not a RN in the building, the LPN should call the RN on-call. The DON said a RN should have been contacted to assess Resident #5's injuries after the resident-to-resident altercation. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based upon observations, record review and interviews, the facility failed to ensure that two (#4 and #5) of two residents out of eight sample residents, received the appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Resident #4 was admitted to the facility on [DATE] with diagnoses of alcohol abuse and encephalopathy (brain disease that affects brain function). The resident had a mood problem related to being quick tempered, had poor coping skills and could exhibit verbally aggressive outbursts towards others when he disagreed with them. The facility failed to implement effective interventions for Resident #4 and appropriately address Resident #4's abuse behaviors towards other residents. The facility failed to protect residents from continued verbal and mental abuse from Resident #4. Interviews and observations revealed Resident #4's behaviors resulted in Resident #5's increased anxiety and social isolation. The staff failed to thoroughly assess Resident #5 for changes in behavior after Resident #4 purposefully ran his wheelchair into Resident #5 on 10/21/24, which caused a skin tear on Resident #5's right forearm, shoulder pain, anxiety and self isolation. Due to the facility's failures to address Resident #4's behaviors, Resident #5 suffered physical abuse from Resident #4, which resulted in psychosocial harm for Resident #5. Findings include: I. Facility policy and procedure The Social Services policy, dated 12/19/16, was provided by the regional director of quality and compliance (RDQC) on 1/7/25 at 1:49 p.m. It read in pertinent part, Our facility provides medically related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental or psychosocial well-being. The director of social services is a qualified social worker and is responsible for executing the social services for the residents of the facility, including but not limited to consultation with allied professional health personnel regarding provisions for the social and emotional needs of the resident and family. Factors that impact a resident's psychosocial functioning may include behavioral problems (anxiety, loneliness, depressed mood, anger, fear), poor interaction and social skills. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065170	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0742 Level of Harm - Actual harm Residents Affected - Few	The social services department is responsible for identifying individual social and emotional needs, assisting is providing corrective action for resident's needs by developing and maintaining individualized social service care plans, maintaining regular and follow-up progress notes indicating the resident's response to the plan, making referrals to social service agencies as appropriate and maintaining appropriate documentation of referrals. II. Incidents of physical abuse by Resident #4 on 10/21/24 and 11/21/24 The 10/21/24 incident report was provided by the RDQC on 1/7/25 at 9:14 a.m. The report documented the nurse was informed Resident #4 purposely collided into Resident #5 while both residents were seated in their wheelchairs. Resident #4 continued down the hall to his room and Resident #5 was assessed for injuries. Resident #5 reported her right arm was jarred and the nurse documented a 0.5 centimeter (cm) by 0.5 cm abrasion on her right forearm where the top layer of skin had come off. Resident #5 reported her left lower leg above the ankle hit the wheel of her wheelchair. The nurse documented redness to the skin above the resident's left ankle. According to the incident report, there were no predisposing factors which caused the incident to occur. Resident #5 (the victim) was interviewed and she said she was wheeling down the hall towards the smoking area when the supervised smokers, including Resident #4 (the assailant), were coming inside. Resident #5 said she made a comment to Resident #4 that he was driving on the wrong side of the road. She said Resident #4 wheeled right into her with his legs hitting hers and spoke profanity to her. Resident #5 said the impact threw her back in her wheelchair causing right shoulder and leg pain. Resident #4 was interviewed and said he was coming inside from smoking. He said Resident #5 told him he should not be driving on the wrong side of the road. Resident #4 said he told her to stay where she was or he would run into her. Resident #4 said he ran into Resident #5 and left. The incident was substantiated by the facility. -However, the facility failed to implement person-centered interventions to address Resident #4's behaviors to prevent an additional altercation with Resident #6 on 11/21/24. -The facility failed to thoroughly assess Resident #5 for changes in mood and behavior, and provide interventions to help Resident #5's increased social isolation, anxiety and fear of Resident #4. The 11/21/24 facility investigation documented the incident occurred on 11/21/24 at 10:01 a.m. The investigation documented Resident #4 stood up from his wheelchair and grabbed Resident #6 by the shirt collar. Resident #6 responded by pushing Resident #4 who then fell and hit his head on the wall. The residents were immediately separated and placed on frequent checks. The investigation documented Resident #4 was interviewed by the nursing home administrator (NHA) on 11/21/24 at approximately 1:00 p.m. Resident #4 said Resident #6 was outside of Resident #4's room acting like a tough guy. Resident #4 said he told Resident #6 he would slap him around a little bit and then Resident #4 said he stood up, lost his balance and hit his head on a door frame. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	The investigation documented Resident #4 had been involved in previous altercations within the past 12 months. The investigation concluded the abuse was substantiated. III. Resident #4 A. Resident status Resident #4, age 68, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included liver disease, epilepsy (seizure disorder), diabetes, alcohol abuse and encephalopathy. The 11/13/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #4 used a wheelchair, was independent with eating and transferring self and required set up assistance with showering. B. Resident interview Resident #4 was interviewed on 1/6/24 at 2:50 p.m. Resident #4 said he got along well with other residents and had not had any altercations. Resident #4 laughed and said no one had made him angry at the facility, but he said if anyone did make him angry, he would punch them. C. Record review Resident #4's behavior care plan, initiated 8/16/23 and revised 11/14/24. The care plan documented that he had a mood problem related to being quick tempered, had poor coping skills, pressured others to move out of his way (sometimes verbally) and patted the backs of other's wheelchairs in attempts to get them to move out of the way. Interventions included encouraging better coping skills and patience with others when they were moving slowly through the hall (initiated 8/16/24), administering medications as ordered, providing behavior health consultations as needed and observing and recording his mood to determine if problems were related to external causes, (all revised 8/20/24). -The facility failed to update the care plan with new interventions related to the two physical abuse altercations with other residents on 10/21/24 and 11/21/24. Resident #4's behavior success care plan , initiated 10/1/24 and revised 10/4/24., addressed the resident's verbally aggressive outbursts towards others when he disagreed with them. Interventions (all initiated 10/1/24) included encouraging self-calming behavior such as breathing exercises, ensuring the safety of the resident and others, establishing boundaries and limits with the resident, providing emotional support regarding new onset disruptive behavior and utilizing diversion techniques. -The care plan did not define any triggers for the aggressive outbursts or ways to ensure the safety of other residents. -There were no new interventions for the behavior success plan after the 10/21/24 and 11/21/24 physical abuse altercations. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Resident #4's physical aggression care plan, initiated 12/23/24, documented the resident had actual incidents of physical aggression and the potential to become physically aggressive related to the history of aggression and harm to others, poor impulse control and complications with self-mood regulations. Interventions (all initiated on 12/23/24) included administering medications as prescribed, assessing and addressing contributing sensory deficits (minimizing noise, dimming the lights, keeping the door closed and giving him space from others), providing physical and verbal cues to alleviate anxiety, assisting with verbalizing the source of agitation, encouraging the resident to seek out a staff member when agitated, conducting a thorough analysis of circumstances that may influence behaviors paying attention to triggers that contributed to the behavior, documenting observed behavior and attempted interventions in the care plan, avoiding large crowds, recognizing his need for personal space, psychiatric consultation as needed and taking prompt action if the resident became agitated to prevent further escalation. -Resident #4's physical aggression care plan was not initiated until two months after the incident with Resident #5 and one month after the resident's second incident of physical abuse towards another resident on 11/21/24. D. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 1/6/25 at 11:33 a.m. CNA #1 said she was not aware of any interventions in place for Resident #4's physically aggressive behavior. CNA #1 said staff were just told to intervene if Resident #4 got too close to Resident #5. CNA #3 was interviewed on 1/7/25 at 10:34 a.m. CNA #3 said Resident #4's behavior could be triggered by a situation, for example when a CNA asked if he wanted a shower. CNA #3 said other residents usually did not trigger him unless they made a comment first. CNA #3 said they reminded him of the scheduled times for supervised smoker breaks. She said she was not aware of any other behavior interventions that were initiated for Resident #4. The social services director (SSD) was interviewed on 1/7/25 at 10:30 a.m. The SSD said she did not know if there was a physical aggression behavior care plan for Resident #4 prior to the incident on 10/21/24 or when it may have been resolved. The SSD said the facility was using a different electronic medical record (EMR) now and she was not able to access the old care plans. The NHA and the RDQC were interviewed together on 1/7/25 at 11:32 a.m. The NHA said Resident #4 had a brain injury and was triggered by other people not using common sense. The NHA said people knocking on Resident #4's door agitated him if he was sitting right there and could see them. The NHA said Resident #4 was protective of his personal belongings. The NHA said the facility should have identified triggers and added more interventions to Resident #4's care plan after the first physical altercation. The RDQC said the facility would review and update Resident #4's care plan with interventions to prevent further altercations. IV. Resident #5 A. Resident status (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Resident #5, age less than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included acute infarction of spinal cord (spinal cord stroke causing pain or loss of sensation in the back down to legs), occipital neuralgia (pain or loss of sensation in the back of the head and neck), anxiety disorder, hypertension (high blood pressure) and type 2 diabetes mellitus. The 10/23/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was independent with personal hygiene, dressing and transfers. She did not walk but was independent with mobility using a wheelchair. B. Resident observation and interview Resident #5 was interviewed on 1/6/25 at 9:06 a.m. Resident #5 was sitting in her wheelchair in her room with both privacy curtains pulled around her. Resident #5 said she did not feel safe at the facility. Resident #5 said she stayed in her room if Resident #4 was in the hallway. Resident #5 said she did not go outside to smoke when Resident #4 went out because it made her anxious to be around him. Resident #5 said she just wanted to move to another facility. Resident #5 was interviewed again on 1/7/25 at 12:41 p.m. Resident #5 was lying in her bed with the privacy curtains closed on both sides with her television on. Resident #5 said she felt more isolated since the incident with Resident #4 because she stayed in her room more. Resident #5 said whenever she saw Resident #4 in the hall she felt anxious and went back into her room. She said she felt like Resident #4 was always in the hall. She said he came down early (before the supervised smoking times) and sat by the exit to the smoking area. She believed Resident #4 tried to intimidate her. Resident #5 said things were good for a couple of weeks after the incident because the supervised smokers were going out back to smoke and she never saw Resident #4. Resident #5 said it only lasted for a couple of weeks because there was no fencing or shelter in the back smoking area so the supervised smokers resumed using the prior smoking area at the end of her hallway. She said Resident #4 continued to go down her hallway past her room several times a day to get to the smoking area. C. Additional resident interview Resident #7 was interviewed on 1/7/25 at 11:30 a.m. Resident #7 said she was not afraid of Resident #4 because she just stayed to herself and ignored him. Resident #7 said some residents were afraid of Resident #4, especially Resident #5. D. Record review The 10/21/24 abuse investigation report documented Resident #5 was the victim of physical abuse by Resident #4. According to the report, after the incident, Resident #5 was hyper-focused on the situation and her injuries. Resident #5 was educated to choose alternate smoking times after the supervised smokers (including Resident #4) were finished and back inside the building. -The abuse investigation follow-up did not address Resident #5's psychosocial well-being, including her fear of Resident #4 or her anxiety related to the incident. Cross-reference F600 for failure to protect residents from abuse. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	The comprehensive care plan addressed psychosocial areas of mood related to her admission and current situation (initiated 10/1/24) and challenges adjusting to her admission (initiated 10/1/24). -The mood care plan was updated on 1/6/25 (during survey) to add Resident #5 was involved in a physical altercation with another resident related to physical aggression towards her. -The care plan revision documented the mood care plan was initiated on 10/21/24, however it was not part of the comprehensive care plan reviewed on 1/6/25 at 9:35 a.m. A risk for depression care plan, initiated 12/22/24, related to her recent decline in health, change in living situation, and financial situation. Interventions included observing for signs or symptoms of depression and contacting the provider if the depression screen was positive. -However, the care plan was initiated two months after the mood interview/depression assessment indicated Resident #5 had increased signs of depression and there was no documentation the provider was notified (see Resident Mood Interview assessments below). The trauma informed care plan, revised 12/23/24, revealed the resident had fearfulness from an event that occurred at the facility when another resident exhibited aggressive behavior towards her. Interventions (all initiated 12/23/24) included offering her another room on the opposite hall (which she declined), offering to escort her to desired locations in the facility (declined due to personal choice), arranging for services with a mental health provider, encouraging her to share her feelings and concerns with staff, identifying items that lessen the effect of the trauma and monitoring her whereabouts and emotional state. -The trauma informed care plan was initiated over two months after the traumatic incident with Resident #4 occurred. The 12/23/24 trauma interview revealed Resident #5 had experienced trauma related to being a victim of physical aggression. The interview documented Resident #5 experienced anxiety, feeling of detachment and fearfulness related to the incident. Resident #5 indicated counseling would help her to deal with the trauma. The 7/23/24 Resident Mood Interview assessment (prior to the incident), revealed Resident #5 scored a zero on the mood interview, indicating she did not have any symptoms of depression. Resident #5 answered the question regarding social isolation as she never felt lonely or socially isolated. The 10/23/24 Resident Mood Interview assessment (after the incident), revealed Resident #5 scored a six on the mood interview, indicating she felt down, depressed or hopeless more than half of the time, had trouble falling or staying asleep or was sleeping too much more than half of the time, and felt tired or had little energy more than half of the time over the past two weeks. Resident #5 answered the question regarding social isolation as she sometimes felt lonely or socially isolated. -There was no social service progress note regarding these mood changes for Resident #5. -There were no changes to the plan of care related to these changes. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-There was no documentation that the physician or behavioral health services were notified of these changes. E. Staff interviews The activity director (AD) was interviewed on 1/6/25 at 4:35 p.m. The AD said Resident #5 liked to come to social activities, especially if there was food. The AD said Resident #5 was coming out of her room less often for the past month and had been sleeping in later in the mornings. The SSD was interviewed on 1/7/25 at 10:30 a.m. The SSD said she typically made a progress note if there was a change on a residents' MDS assessment. The SSD said she did not know why she did not make a progress note for Resident #5. The SSD said she should have made a quarterly progress note for Resident #5 in October 2024. The SSD verified there was not a social service progress note for Resident #5 in October 2024 after she completed the resident's mood interview assessment. The SSD said she sent an email to behavior health services requesting a visit for Resident #5 but did not document this in the medical record. The SSD said Resident #5 was experiencing stress about her finances and wanting to move to another facility. The SSD said a trauma care plan was added to Resident #5's plan of care on 12/23/24 because that was when the resident expressed she was still having fear from the incident with Resident #4. The SSD said they offered Resident #5 an alternate location for her puzzles and a room change but she declined. The SSD said she had sent several referrals to other facilities and Resident #5 had been accepted at a couple of them in another town, but Resident #5 was not interested in moving to those facilities. -Documentation of the behavioral health services referral and visit were requested at the time of survey but not received from the facility by the end of the survey on 1/7/25. The NHA was interviewed on 1/7/25 at 11:32 a.m. The NHA said the social services staff should have, at a minimum, a quarterly progress note for each resident, and more if there were resident changes. The NHA said if there was a change in a resident's mood or on the MDS assessment, there should be a social services note addressing the change.