

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/28/2024
NAME OF PROVIDER OR SUPPLIER Wyatt Manor Nursing and Rehab Ctr, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4659 Highway 505 Jonesboro, LA 71251	

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	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118</p> <p>Based on record reviews, observations and interviews, the facility failed to protect the resident's right to be free from physical abuse by another resident for 1 (#1) of 3 (#1, #2, and #3) sampled residents. The facility failed to protect resident #1 from physical abuse by resident #2.</p> <p>The deficient practice resulted in an actual harm for resident #1 on 10/05/2024 at 6:37 p.m. when resident #1 sustained injuries to the right and left side of his face from resident #2. Resident #1 was sitting outside when he was hit by resident #2 with an object across the left side of his face. Resident #1 stood up, backed away, raised his hands and attempted to walk away from resident #2. At this time, resident #2 hit resident #1 on the right side of the face. The sheriff's department was notified and came to the facility to start an investigation. Resident #1 was sent to a local hospital for evaluation and resident #2 was sent to a hospital for evaluation and treatment.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. The completion date was 10/07/2024.</p> <p>Findings:</p> <p>Review of the facility's Abuse/Neglect Policy Revision #12 - dated 12/11/2018 revealed the facility will not condone any form of resident abuse or neglect. Each resident residing in this facility has the right to be free from verbal, sexual, mental and physical abuse, including corporal punishment and involuntary seclusion, and use of photographs or recordings in any manner that would demean or humiliate a resident(s). Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies, serving the resident, family members or legal guardians, friends or other individuals. Each resident also has the right to be free from mistreatment, neglect and misappropriation of property.</p> <p>Resident #1</p> <p>Review of the medical record for resident #1 revealed an admitted [DATE] with diagnoses of type 2 diabetes mellitus, syncope and collapse, altered mental status, schizoaffective disorder depressive type, mood disorder, dementia, and unspecified psychosis.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #1 had a Brief Interview for Mental Status (BIMS) of 9 indicating the resident had moderate cognitive impairment for daily decision making. Further review of the MDS revealed the resident required supervision with one person physical assistance with bed mobility and transfers. Resident #1 did not exhibit any behaviors towards others, hallucinations, or delusions.</p> <p>Review of the physician's progress noted dated 10/01/2024 revealed the resident had schizoaffective disorder depressive type. Further review of the progress note revealed there was no reports of increased behaviors.</p> <p>Review of the hospital notes dated 10/05/2024 revealed resident #1 was diagnosed with an abrasion of the skin, and multiple skin tears. Review of the Computed Tomography (CT) of the maxillofacial report dated 10/05/2024 revealed no evidence of acute fractures.</p> <p>Review of the xray of the facial bones dated 10/11/2024 revealed no obvious orbital or zygomatic fractures were identified. Review of the xray of the mandible dated 10/11/2024 revealed no obvious acute displaced fracture or dislocation.</p> <p>On 10/21/2024 at 1:00 p.m., an interview with resident #1 revealed he was sitting outside in a chair by himself and resident #2 came up to him and hit him with something in the face two times. Resident #1 denied having an argument or a conversation with resident #2 prior to the incident. Resident #1 revealed he and resident #2 were outside smoking earlier on 10/05/2024 and they said hello to each other. Resident #1 revealed he had not had any altercations with resident #2 before. At this time, an observation of resident #1 revealed he did not have any open areas, bruising or swelling on his face.</p> <p>Resident #2</p> <p>Review of the medical record for resident #2 revealed an admitted [DATE] with diagnoses including alcohol use, major depression severe with psychotic symptoms, anxiety, and major depressive disorder. Resident #2 was discharged to the community on 10/06/2024.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed resident #2 had a BIMS score of 15 which indicated the resident was cognitively intact for daily decision making. Resident #2 did not exhibit any behaviors towards others, hallucinations, or delusions. Resident #2 required supervision with one person physical assist with bed mobility and transfers.</p> <p>Review of the Incident Report dated 10/05/2024 at 7:10 p.m. revealed resident #1 ambulated to the nurses station bleeding from under his right eye and the bridge on the right side of his nose. A tennis ball sized raised area was noted to resident #1's left lower jaw. Resident #1 stated that skinny person hit me and he needs to go to the mental institution. Each resident was placed on 1:1 with staff. Facial areas cleansed and left open to air. No further bleeding.</p> <p>Review of the Incident Report dated 10/05/2024 at 7:42 p.m. revealed resident #1 had reported to nurses station with facial trauma stating that he had been hit outside. This nurse reported to men's patio to conduct investigation where resident #2 was found sitting in a chair and admitted to the assault. Resident #2 stated I hit that m----- f----- with my fist two times and you can call the law I do not give a f---. Resident #2 was placed on 1:1 observation and assessed for injury.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Investigative Report dated 10/05/2024 at approximately 7:00 p.m. revealed, S5Licensed Practical Nurse (LPN) reported to S2Director of Nursing (DON) that there had been a resident to resident incident. S2DON notified S3Assistant Director of Nursing (ADON) and S1Administrator. S3ADON arrived to the facility at approximately 7:15 p.m. Resident #2 was in his room with S7Certified Nursing Assistant (CNA) sitting 1:1. Resident #1 was in the dayroom with a S8CNA sitting upright in a chair awake and alert. S3ADON reviewed the camera footage and at 5:55 p.m. resident #2 and resident #1 were both witnessed by S6CNA sitting near one another on the men's patio during a supervised smoke break. There was no indication that the two may be quarreling. Resident #2 was pleasant and chatting with the staff. Resident #2 was last seen by S6CNA at 6:30 p.m. sitting at a table in the dining room. Camera footage confirms this and shows resident #2 then ambulated to the men's patio where he sat until the incident began at 6:36 p.m. Resident #1 was seen by staff ambulating throughout facility and grounds from 6:00 p.m. - 6:36 p.m. when the incident began. There was no event leading up to the incident. It was seemingly unprovoked. On the men's patio, resident #2 was sitting in a chair, sees resident #1 walk from behind the building and sit down in a chair more than 20 feet away. It does not appear that any words were exchanged at this time. Resident #2 goes inside the building and returned back to the men's patio at 6:37:17 p.m. with a long round object in his right hand and walks directly up to resident #1 who remains seated, and appears to be exchanging words. At 6:37:32 p.m., resident #2 strikes resident #1 with the object across his left face. Resident #1 stands up, backs away, raises hands and attempts to walk away. At 6:37:41 p.m., resident #2 strikes resident #1 again, this time across the right face. Resident #1 continues to try to walk away while resident #2 appears to be shouting at him while holding the object in his right hand in a threatening manner. At 6:38:04 p.m., resident #2 walked back into building to his room. At this time, resident #1 ambulated to a chair on the men's patio and sits down for approximately 2 minutes. Resident #1 then ambulated inside of facility through the back breeze way and ambulated to the nurses station at 6:44 p.m. to self-report incident. Resident #1 complained of pain to the right maxilla and left mandible. There is a superficial laceration over the right maxilla and [NAME] of nose. There is some mild soft tissue swelling to the right maxilla and moderate bruising noted to the right maxilla. There is significant soft tissue swelling noted over the left mandible. Areas were cleansed and patted dry. At 6:57 p.m. S5LPN located resident #2 on the men's patio to begin an investigation. Resident #2 was immediately placed on 1:1 supervision. The physician was notified of the incident. New orders were obtained to send resident #1 to the emergency room for evaluation and treatment and the local Sherriff's department was notified of the incident by S3ADON.</p> <p>Review of the nurses notes dated 10/05/2024 at approximately 6:45 p.m. revealed resident #1 was standing in front of the nurses station. The nurse looked up and saw resident, noted facial bleeding and a tennis ball sized raised area to left cheek, facial area cleansed per nursing home protocol and then noted area under his right eye that measured approximately 3 and a half centimeters and right side bridge of nose that measured approximately 3 centimeters, resident states pain is a 5 on the pain scale of 1 to 10.</p> <p>Review of the nurses notes dated 10/05/2024 at 8:05 p.m. revealed resident #2 stated that peer (referring to resident #1) was walking around with clinched fists stating I am gonna kill someone and he said I walked up to him (referring to resident #1) and hit him in the face with my fist two times.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/21/2024 at 11:45 a.m., review of the video recording with S1Administrator revealed resident #2 was seen sitting outside on 10/05/2024 at 6:36 p.m. with two other residents on the patio. Resident #1 walked from the side of the building, resident #2 saw resident #1 and he walked inside the building and came back outside to the patio at 6:37 p.m. with a long round object. At 6:37 p.m., resident #2 walked to the area in which resident #1 was sitting and resident #2 hit resident #1 on the left side of the face with the long round object. Resident #1 stood up and tried to walk away. On 10/05/2024 at 6:37 p.m., resident #2 struck resident #1 across the right side of the face. Further review of the video recording revealed at 6:38 p.m. resident #2 walked inside and resident #1 sat in a chair on the back patio. At 6:44 p.m., resident #1 went inside the building to the nurses station.</p> <p>On 10/22/2024 at 3:16 p.m., interview with S5LPN revealed she didn't know anything about an altercation between resident #1 and resident #2 on 10/05/2024 until resident #1 came to the nurses' station and informed her that the skinny guy hit him. S5LPN revealed she found out that resident #2 was the person that hit resident #1. She found resident #2 on the patio and he told her that he hit resident #1. S5LPN revealed resident #2 was immediately placed on 1:1 observation. The Administrative staff and physician were notified. The ambulance was notified to transport resident #1 to the emergency department. S5LPN revealed the Sheriff's department was notified and they came and escorted resident #2 out of the building to the emergency department for evaluation.</p> <p>On 10/28/2024 at 10:15 a.m., interview with S2DON confirmed resident #2 hit resident #1 two times with a long object causing facial injuries. The Sherriff's department transported resident #2 to the emergency room for evaluation and treatment. Resident #1 was transported by ambulance to the emergency department for evaluation and treatment.</p> <p>During the survey, in-service records and Quality Assurance (QA) monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility.</p> <p>The facility implemented the following actions with a completion date of 10/07/2024.</p> <ol style="list-style-type: none"> 1. Resident #1 was placed one on one with a nurse at the nurses' station. 2. Resident #2 was placed one on one with a CNA in his room, no other roommates were in the room at this time. 3. The facility searched for any objects that could be used as a weapon inside the facility and facility outside grounds. (Floor fan rod and fan removed from resident #2's room) 4. Baseline of safety checks conducted by S3Assistant Director of Nursing (ADON) with all residents in the facility. 5. On 10/05/2024, S2DON and S3ADON interviewed all interviewable residents to ensure they felt safe in the facility. 6. On 10/05/2024, S3ADON assessed all non interviewable residents for evidence of injury or trauma. 7. Monitor initiated on 10/05/2024 for monitoring for any object that can be used as a weapon. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>8. Monitor initiated on 10/05/2024 to review a random sample of residents to ensure they feel safe in the facility.</p> <p>9. Monitor initiated on 10/05/2024 to observe for agitation in a random sample of residents.</p> <p>10. Monitor initiated on 10/05/2024 to review a random sample of nurses' notes on a random sample of residents for documentation of agitation.</p> <p>11. On 10/06/2024 resident #2 was discharged from the hospital and was sent home with his family.</p> <p>12. All staff were inserviced on 10/07/2024 by S3ADON discussing recognizing early intervention of the potentially aggressive residents.</p> <p>13. On 10/07/2024, S3ADON talked to resident #1 whom indicated he no longer feels fearful.</p> <p>Review of the Quality Assurance Performance Improvement (QAPI) records revealed the following:</p> <p>The facility will monitor and interview a random sample of residents to ensure they feel safe in the facility. This monitor will also assess a random sample of non interviewable residents to ensure no evidence of injury or trauma. The monitor will be completed by S2DON or designee at least 3 times a week for 4 weeks, then every month.</p> <p>A monitor was created to observe for agitation in a random sample of residents. The monitor will be completed by S2DON or designee at least 3 times a week for 4 weeks, then every month.</p> <p>A monitor was created to review a random sample of nurses' notes on a random sample of residents for documentation of agitation, arguing and fighting. The monitor will be completed by S2DON or designee at least 3 times a week for 4 weeks, then every month.</p> <p>A monitor was created for each resident's room to be checked for any objects that could be used as a weapon. The monitor will be completed by S2DON or designee one time a week for 4 weeks, then monthly.</p>		