| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265258 | A. Building<br>B. Wing | 07/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belleview Valley Nursing Home | 23144 Highway 32<br>Belleview, MO 63623 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32751<br><br>Based on observation, record review and interview, the facility failed to ensure one resident (Resident #2) was free from physical abuse, and 11 other vulnerable residents at an increased likelihood for abuse to occur when facility staff placed residents with a history of physical and verbal altercations and unstable, aggressive behaviors towards other residents, on the secured unit which housed 12 residents with dementia, receiving hospice care, or requiring total care from staff. The aggressive residents were placed on the secured unit for 24 hours to 5 days until the administrator felt they were no longer a risk to residents outside the locked unit. Resident #1 was placed on the secured unit after returning from a hospital evaluation due to physical aggression. Resident #1 got in an altercation with Resident #2, a resident on the secured unit for safety and dementia care. Resident #1 pushed Resident #2 into the toilet. Resident #2 sustained bruising to his/her face. The census was 88.<br><br>On 07/09/24 at 4:00 P.M., the Administrator was notified of the immediate jeopardy (IJ) which began on 06/23/24. The IJ was removed on 07/09/24, as confirmed by surveyor onsite verification.<br><br>Record review of the facility undated Abuse policy showed:<br><br>- The facility will ensure that each resident is free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat a resident's medical symptoms;<br><br>- The facility will ensure the resident is free from physical or chemical restraints imposed for purpose of discipline or convenience and that are not required to treat the resident's medical symptoms.<br><br>The facility did not provide a policy regarding the criteria for placement on the secured unit.<br><br>1. Record review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 05/28/24 showed:<br><br>- Admission to facility on 09/10/22;<br><br>(continued on next page) |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265258 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/18/2024 |
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| NAME OF PROVIDER OR SUPPLIER Belleview Valley Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 23144 Highway 32 Belleview, MO 63623 | |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - Diagnoses of Schizophrenia (symptoms can include delusions, hallucinations, disorganized speech, trouble with thinking and lack of motivation), bipolar (a condition causing uncontrolled mood swings), depression, and Mild Intellectual Disability (significant impairment and adaptive functioning);<br><br>- Cognition intact;<br><br>- Requires supervision of one staff with activities of daily living (ADLs);<br><br>- Receives antipsychotic (medication that alter brain chemistry to help reduce psychotic symptoms like hallucinations, delusions and disordered thinking), depression, and antidepressant medications seven days a week on a routine basis;<br><br>- Guardian in place.<br><br>Review of Resident #1's care plan, originally developed on 06/02/22 and updated on 03/01/24, showed:<br><br>- The resident has the potential to be physically aggressive (outbursts, impatient, agitated at others and a history of verbal and physical altercations) related to anger. History of harm to other and poor impulse control;<br><br>- The resident has the potential to be verbally aggressive (yelling, screaming) related to ineffective coping skills, mental/emotional illness, poor impulse control, outbursts at others when not getting what asked for right away due to forgetfulness and repetition;<br><br>- The resident has a communication problem related to language barrier, unspecified intellectual disabilities, and short-term memory loss;<br><br>- No new interventions since 06/02/22;<br><br>- No mention of assessing for the appropriateness of placement on the secured unit.<br><br>- Record review of Resident #1's emergency room record dated 6/23/2024 showed:<br><br>- The resident was sent to the emergency room for aggression with other residents;<br><br>- The resident returned to the facility the same date with a diagnosis of medically cleared to return.<br><br>Record review of the Resident #1's emergency room record dated 7/4/2024 showed:<br><br>- The resident was sent to the emergency room for aggressive behavior with a resident on the secured unit;<br><br>- The resident told the hospital he/she had been in a physical altercation with a resident and had exposed him/herself to the facility staff and said suck my dick;<br><br>- The resident displayed poor ability to handle stressors;<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - The resident was discharged back to the facility as chronic schizophrenia with aggressive response.<br><br>During an interview on 07/09/24, at 12:15 P.M., Resident #1 said he/she had been placed on the unit 06/23/24 through 07/04/24 because of previous aggressive behaviors with other residents. He/she said when a resident is aggressive, they are sent out to the emergency room and when they come back are placed on the secured unit. He/she said this is to keep residents on the regular hall safe until the resident can calm down. Resident #1 said he/she does not remember hitting Resident #2 on 07/04/24. The resident said he/she probably did hurt Resident #2, but does not remember.<br><br>2. Review of Resident #2's medical record showed:<br><br>- admitted [DATE];<br><br>- Diagnoses included alcohol induced persistant dementia, dementia with severe behavioral disturbances<br><br>Record review of Resident #2's quarterly MDS, dated [DATE] showed:<br><br>- Severe cognitive impairment;<br><br>- Requires supervision of one to two staff with ADLs;<br><br>- Receives antipsychotic, depression, and antidepressant medications seven days a week on a routine basis;<br><br>- Guardian in place.<br><br>Review of Resident #2's care plan, updated 02/04/24, showed the resident cannot communicate, wanders and has the potential to be physically aggressive (hit, kick, push others) related to dementia. Interventions included to anticipate needs and monitor/document/report as needed any sign or symptom of resident posing a threat to him/herself or others.<br><br>Review of Resident #2's Skin Evaluation note, dated 07/05/24, showed noted bruising to the resident's face from a previous altercation with another resident.<br><br>Observation on 07/09/24 at 5:15 P.M., showed the resident wandering on the secured unit hallway. The resident was confused and unable to communicate. The resident wandered into other resident's rooms and had to be redirected by staff.<br><br>Review of the facility's self-report of resident to resident abuse, dated and received in the regional office on 07/04/24 showed:<br><br>- A written statement by Housekeeping Staff (HS) A, dated 07/04/24 at 10:30 A.M. HS A heard a commotion in the bathroom between rooms [ROOM NUMBERS] on the secured unit. HS A immediately went and found staff, Certified Nurse Aid (CNA) A;<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - A written statement by CNA A, dated 07/04/24 at 10:30 A.M., showed HS A reported to CNA A of hearing loud banging in the bathroom between rooms [ROOM NUMBERS]. CNA A and HS A immediately went to the room and found Resident #1 had Resident #2 shut in the bathroom saying Stay the fuck out of my room. CNA A attempted to explain to Resident #1 that Resident #2 had dementia and was very confused, but Resident #1 did not seem to care and continued to be very angry about the situation;<br><br>- The administrator and investigator concluded Resident #1 pushed/shoved Resident #2 into his/her bathroom onto the toilet when Resident #2 went into his room by accident. There were no witnesses for the incident, however, HS A did hear and report this immediately. No injuries noted for Resident #1. Resident #2 noted to have faded bruising to face after the altercation;<br><br>- Final interventions included:<br><br>- Separated both residents<br><br>- Resident #1 sent out for an evaluation<br><br>- Resident #1 moved to B-Hall (non-secured unit)<br><br>- Resident #1 placed on 15 min face checks for 24-Hours following re-admission from evaluation<br><br>- Both residents assessed by nursing for injuries<br><br>- Residents' doctor and responsible parties made aware of incident.<br><br>Observation on 07/09/24 at 5:15 P.M., showed the resident wandering on the secured unit hallway. The resident was confused and unable to communicate. The resident wandered into other resident's rooms and had to be redirected by staff.<br><br>During an interview on 07/03/24 at 5:15 P.M., Licensed Practical Nurse (LPN) A said Resident #2 wanders the hallway on the secured unit. He/she does have to be redirected when he/she enters other resident rooms.<br><br>During an interview on 08/07/24 at 9:00 A.M., CNA A said on 07/04/24 HS A called out to him/her due to a commotion and noise in the adjoining bathroom between rooms [ROOM NUMBERS]. CNA A went to the room to find Resident #1 holding the bathroom door shut, trapping Resident #2 in while yelling stay the fuck out of my room. CNA A attempted to redirect Resident #1, but the resident remained angry. Resident #1 was able to be removed and the residents were separated. Resident #2 appeared to have red marks on his/her wrist. CNA A said it appeared Resident #1 had grabbed and held Resident #2's wrist and forced Resident #2 into the bathroom and held the door shut. CNA A said Resident #2 wanders all the time. CNA A said it does not seem safe to place the aggressive residents on the secured unit. The staff do 15 minute checks on the secured unit.<br><br>3. Review of the resident room roster, provided by the facility, showed a total of 15 residents on the secured unit. The roster showed Residents #1, #3, #4, and #5 on the unit for temporary behavior monitoring. Resident #2 and 11 additional residents lived on the secured unit on a full time basis. Review of the records for those 11 residents showed the following:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - All 11 residents had moderate to severe cognitive impairment;<br><br>- All 11 residents needed the secured unit for increased supervision;<br><br>- Three of the 11 residents wandered and had to be redirected;<br><br>- Two of the 11 residents received hospice care for terminal illness.<br><br>Observations and interviews showed:<br><br>- On 07/09/24 from 11:30 A.M., through 6:30 P.M., Resident #3 resided on the secured unit. During an interview on 07/09/24 at 11:30 A.M., Resident #3 said he/she will be on the secured unit until Friday of this week due to being in an altercation with other residents on the unsecured hall. Resident #3 said the residents who live on the secured unit all the time are really confused or really sick. Resident #3's medical record showed no documentation or an assessment showing why the resident was placed on the secured/locked unit and no care plan for placement on the secured unit.<br><br>- On 07/09/24, Resident #4 resided on the secured unit. During an interview on 07/09/24 at 11:20 A.M., Resident #4 said he/she was placed on the secured unit as punishment for hitting another resident. The resident said he/she was not asked or given a choice of moving on the unit or not. Resident #4 said the residents who live full time on the secured unit are very confused and can't do much for themselves. The resident's record showed no documentation or an assessment showing why the resident was placed on the secured/locked unit and no care plan for placement on the secured unit;<br><br>- On 07/09/24, Resident #5 resided on the secured unit. During an interview on 07/09/24 at 11:45 A.M., Resident #5 said he/she was placed on the secured unit as punishment for hitting another resident. The resident's record showed no documentation or an assessment showing why the resident was placed on the secured/locked unit and no care plan for placement on the secured unit.<br><br>4. During an interview on 07/09/24 at 2:15 P.M., LPN A said every resident who is the aggressor in an altercation is placed on the secured unit for a minimum of 24 hours with 15-minute checks by staff on the unit. This is done under the direction of the Administrator, and he/she is the only staff who can decide if the resident is removed from the unit after 24 hours. There is no criteria that he/she is aware of that is used for placement on the secured/locked unit. The normal placement of residents on that unit are hospice residents, residents who need increased supervision due to wandering, confusion and/or medically increased need for assistance with ADLs. The residents who reside on the secured unit full time are the most vulnerable.<br><br>During an interview on 07/09/24 at 3:00 P.M., the Administrator said residents who are the aggressors in a situation or incident are automatically placed on the secured unit. Residents are not given a choice. The facility does not have the capability to provide one on one care to keep residents separated and or safe from one another after an altercation. The Administrator said he had not thought of the safety of the other vulnerable residents residing on the secured unit due to aggressors are medically cleared before being placed on the unit. There is no criteria for placement and/or when removed from unit, it is at his discretion. The administrator said he/she does not a background in psychiatric care and has not received any special training.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 07/09/2024 at 3:45 P.M., the Director of Nursing said he/she has concerns related to aggressive residents being placed on the secured unit with other residents who are incapable of protecting themselves, although it is the Administrator's direction to do so after an altercation. The Administrator told him/her, moving the residents to their secured unit is an intervention for bad behavior and not intended to be punishment.<br><br>During an interview on 7/11/2024 at 5:20 P.M., the facility Psychiartrist said he was not aware that all residents who are aggressive were being placed on the secured unit after going to the emergency room . He believes this is not a good practice, but believes the Administrator is attempting to keep residents on the regular hall safe. He stated placing a resident on one one one is a better practice. When asked, he agreed taking a resident with a psychiatric diagnosis and forcing them to a locked unit and secluding them without a choice could promote aggressive behaviors. He stated he believes he can work with the facility to try to find a safer method to keeping the aggressive residents from harming others.<br><br>NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.<br><br>At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s).<br><br>Complaint # MO238516 |

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| F 0603<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31057<br><br>Based on observation, interview and record review, the facility failed to ensure three residents (Residents #3, #4, and #5) of 10 sampled residents were free from involuntary seclusion. The facility failed to have a policy or system in place to identify clinical criteria for placing a resident in a secured/locked area. The facility failed to ensure placement on the unit was not for staff convenience or discipline. The facility to document clinical criteria in the resident's record for placement on the secured unit and ensure the resident's physician and members of the interdisciplinary team were involved in the assessment. The facility census was 88.<br><br>1. Record review of the facility undated Abuse policy showed:<br><br>- The facility will ensure that each resident is free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat a resident's medical symptoms;<br><br>- The facility will ensure the resident is free from physical or chemical restraints imposed for purpose of discipline or convenience and that are not required to treat the resident's medical symptoms.<br><br>The facility did not provide a policy on the criteria for admission to the secured unit.<br><br>2. Record review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 06/28/24 showed:<br><br>- Admission to facility on 12/14/23;<br><br>- Diagnoses of schizophrenia (symptoms can include delusions, hallucinations, disorganized speech, trouble with thinking and lack of motivation), bipolar (a condition causing uncontrolled mood swings), and depression;<br><br>- Cognition intact;<br><br>- No hallucinations or delusions;<br><br>- Physical and verbal behavioral symptoms 1-3 days a week;<br><br>- Requires supervision of one staff with activities of daily living (ADLs);<br><br>- Receives antipsychotic (medication that alter brain chemistry to help reduce psychotic symptoms like hallucinations, delusions and disordered thinking), depression, and antidepressant medications seven days a week on a routine basis;<br><br>- Guardian in place.<br><br>(continued on next page) |

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| F 0603<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observations on 07/09/24 showed from 11:30 A.M., through 6:30 P.M., the resident resided on the secured unit.<br><br>During an interview on 07/09/24 at 11:30 A.M., Resident #3 said he/she will be on the secured unit until Friday of this week due to being in an altercation with other residents. The resident said he/she was not asked if he/she wanted to be placed on the secured unit and was unsure if his/her guardian was aware of the placement. Resident #3 said the facility always puts him/her on the unit after altercations if he/she is the one doing the hitting.<br><br>Review of #3's resident medical record showed no documentation for:<br><br>- An assessment to be placed on the secured unit;<br><br>- The resident/guardian involvement in the decision for placement on the secured unit;<br><br>- No documentation on the resident's care plan for interventions for placement on the secured unit or criteria to be placed on the secured unit.<br><br>3. Review of Resident #4's quarterly MDS, dated [DATE], showed:<br><br>- Admission to facility on 12/23/21;<br><br>- Diagnoses of schizophrenia, anxiety, and post-traumatic stress disorder (PTSD) (a disorder that develops in some people who have experienced a shocking, scary, or dangerous event);<br><br>- Cognition intact;<br><br>- No hallucinations or delusions;<br><br>- No physical, verbal, and or other behavioral symptoms;<br><br>- Requires supervision of one staff with ADLs;<br><br>- Receives antipsychotic, depression, and antidepressant medications seven days a week on a routine basis;<br><br>- Guardian in place.<br><br>Review of Resident #4's medical record showed no documentation for:<br><br>- An assessment to be placed on the secured unit;<br><br>- The resident/guardian involvement in the decision for placement on the secured unit;<br><br>- No documentation on the resident care plan for interventions for placement on the secured unit or criteria to be placed on the secured unit.<br><br>(continued on next page) |

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| F 0603<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/09/24 at 11:20 A.M., Resident #4 said he/she was placed on the secured unit as punishment for hitting another resident. The resident said he/she was not asked or given a choice of moving on the unit or not.<br><br>4. Review of Resident #5's quarterly MDS, dated [DATE], showed:<br><br>- Admission to facility on 01/13/23;<br><br>- Diagnoses of schizophrenia, anxiety, and seizure disorder;<br><br>- Cognition intact;<br><br>- No hallucinations or delusions;<br><br>- No physical, verbal, and or other behavioral symptoms;<br><br>- Requires supervision of one staff with ADLs;<br><br>- Receives antipsychotic, depression, and antidepressant medications seven days a week on a routine basis;<br><br>- Guardian in place.<br><br>Review of Resident #5's medical record showed no documentation for:<br><br>- Criteria to be placed on the secured unit;<br><br>- The resident/guardian involvement in the decision for placement on the secured unit;<br><br>- No documentation on the resident care plan for interventions for placement on the secured unit or criteria to be placed on the secured unit.<br><br>During an interview on 07/09/24 at 11:45 A.M., Resident #5 said he/she was placed on the secured unit as punishment for hitting another resident.<br><br>During an interview on 7/18/24 at 9:15 A.M., Resident #5's guardian said he/she was aware of the facility placing the resident on the locked unit, but was under the understanding this was the only option the facility had to use. He/she would like to see other interventions used before locking the resident up.<br><br>5. During an interview on 07/09/24, Licensed Practical Nurse (LPN) A said every resident who is the aggressor in an altercation, is placed on the secured unit for a minimum of 24 hours with 15-minute checks by staff on the unit. This is done under the direction of the Administrator, and he/she is the only staff who can decide if the resident is removed from the unit after 24 hours. There is no criteria that he/she is aware of that is used for placement on the secured unit. The normal placement of residents on that unit are hospice residents, residents who are in need of increased supervision due to wandering, confusion and/or medically increased need in assistance with ADLs. The residents who live on the secured unit full time are those most vulnerable in the facility's population.<br><br>(continued on next page) |

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| F 0603<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/09/24 at 3:00 P.M., the Administrator said residents who are the aggressors in an altercation are automatically placed on the secured unit, residents are not given a choice. The facility does not have the capability to provide one on one care to keep residents separated and or safe from one another after an altercation. The Administrator said he had not thought of the safety of the more vulnerable residents residing on the unit due to aggressors are medically cleared before being placed on the unit. There is no criteria for placement and/or when removed from unit, it is at his discretion. The administrator said he/she does not a background in psychiatric care and has not received any special training.<br><br>During an interview on 07/09/24 at 3:45 P.M., the Director of Nursing (DON) said she has concerns related to aggressive residents being placed on the secured unit with residents who are incapable of protecting themselves. The DON said she had not been at the facility very long, but understood putting residents on the unit after an altercation was an intervention for bad behavior and not intended to be punishment.<br><br>During an interview on 07/09/24 at 4:00 P.M., Resident #10 said when any residents get into fights, the one who hits first gets placed in the hole referring to the secured unit for punishment.<br><br>During an interview on 7/11/24 at 5:20 P.M., Psychiatrist A said he/she was not aware that all residents who act as the aggressor in an altercation were being placed on the secured unit after going to the emergency room . He/She said that is not a good practice, but believed the Administrator is attempting to keep residents on the regular hall safe. He/She agreed that placing a resident on one one one is a better practice. He/She said placing a resident with a psychiatric diagnosis on a locked unit and secluding them without a choice could promote the aggressive behavior. He/She will work with the facility to try to find a safer method to keeping the aggressive residents from harming others.<br><br>MO238516, MO238659, MO238661 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265258 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/18/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Belleview Valley Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE: 23144 Highway 32 Belleview, MO 63623 | |

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

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46555<br><br>Based on interview and record review, the facility failed to provide an appropriate facility-initiated discharge notice, failed to provide an appropriate discharge plan prior to providing the discharge notice, failed to reassess a resident's status after being discharged from an acute care hospital, and refused to allow the resident (Resident #1) to return to the facility out of three sampled residents. The facility census was 88.<br><br>The facility did not provide a policy regarding transfers and discharges.<br><br>1. Review of Resident #1's Pre-Admission Screening/Resident Review (PASRR) Level II Evaluation, dated 08/10/22, showed:<br><br>- The resident's needs could be met in a nursing facility;<br><br>- The resident did not need specialized services beyond those typically provided by a nursing facility;<br><br>- The support services to be provided by the nursing facility were a safe structured environment, developing effective coping skills to proper handle issues with anger, physical aggression and poor impulse control, medication therapy, and a personal support network;<br><br>- Diagnoses include schizoaffective disorder (a mental health condition where people experience psychosis as well as mood symptoms), bipolar mood disorder (a mental disorder with periods of elevated moods and depression), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), autistic disorder (a serious developmental disorder that impairs the ability to communicate and interact), developmental disorder of scholastic skills (a condition of significant discrepancy between an individuals perceived level of intellect and their ability to acquire new language and other cognitive skills);<br><br>- Had a legal guardian;<br><br>- History of aggression and suicidal/homicidal ideation.<br><br>Review of the resident's medical record showed:<br><br>- admitted on [DATE];<br><br>- Diagnoses of bipolar disorder,schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), epilepsy, autistic disorder, developmental disorder of scholastic skills;<br><br>- Had a legal guardian (a court appointed person who had the authority to make decisions for a person);<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - The resident was alert, oriented, and cognitive abilities were moderately impaired;<br><br>- On 06/18/24 at 7:41 P.M., the resident made his/her way out the dining room door of the unit to the courtyard. He/She went to the smoking courtyard of the open halls and started tearing boards from the fence. A nurse stepped between him/her and the fence to impede his/her destruction. The nurse had his/her back turned toward the resident and he/she struck the nurse with his/her first in the back. Another staff member was able to redirect the resident back into the facility;<br><br>- On 06/21/24 at 7:23 P.M., the charge nurse received a call from the hospital the resident would be discharged on back to the facility 06/24/24. The contact information for the Administrator was provided to the hospital and informed hospital staff to contact the Administrator on the morning of 06/24/24, prior to discharge back to the facility;<br><br>- The resident's Order Summary, dated 06/18/24, showed it was a necessary discharge from the facility for the resident's welfare and the facility being unable to meet the resident's safety needs. The resident's behavioral status endangered the health and safety of him/herself and others in the facility. The facility was unable to prevent the resident from destroying the fencing, using a fire extinguisher, and using broken fencing to attack staff and him/herself. Other facility residents were endangered by the resident's violent behaviors. Another facility would be better able to Intervene and keep the resident safe;<br><br>- No documentation from the physician regarding the specific needs or services the current facility cannot meet;<br><br>- No documentation from the physician of the efforts the facility had attempted in meeting those needs;<br><br>- No documentation from the physician of the specific services the receiving facility would provide that the current facility could not;<br><br>- No documentation of a discharge plan prior to providing the discharge notice to the resident and/or the resident's legal guardian;<br><br>- No documentation of the facility's reassessment of the resident's status after being discharged from the hospital;<br><br>- No documentation of a written facility initiated discharge notice provided to the resident and/or legal representative upon discharge to the hospital on 06/19/24.<br><br>Review of the resident's discharge Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by the facility staff), dated 06/19/24, showed:<br><br>- discharged to a short-term hospital;<br><br>- Unplanned discharge;<br><br>- Return to the facility not anticipated.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's Notice of Discharge for Emergency Situation - Safety of Individuals Endangered, dated 06/24/24, showed:<br><br>- The notice was addressed to the resident and the resident's legal guardian;<br><br>- The notice was faxed and mailed to the resident at the hospital, and emailed and mailed to the resident's legal guardian on 06/24/24;<br><br>- This letter is a notice of discharge. After careful evaluation and in consultation with your attending physician, the facility concluded that the safety of other individuals in the facility is endangered by your continued residence and the facility can no longer meet your needs. The reason the safety of individuals in the facility is endangered by your continued residence is evidenced by on June 18, 2024, you tore boards from the fence, expressed physical anger towards a nurse that attempted to redirect you from destructing the facility's property and you struck the nurse on the back with your fist. On June 16, 2024, you broke planks off the exterior fence, removed a fire extinguisher, made threats, exited the facility multiple times, refused to return to the facility while standing along a wooded area outside the facility and were sent to the hospital. On June 15, 2024, you made threats to harm another resident, removed a fire extinguisher and threatened to use it to harm another resident, and were transported by officers to the hospital. On June 12, 2024, you made threats to physically harm another resident with a fire extinguisher and were sent to hospital. It is the responsibility of the facility to provide a safe environment for all residents in which to live. The reason the facility can no longer meet your needs is evidenced by the resident inflicting self harm and suicide threats with actions. It is the responsibility of the facility to provide a safe environment for all residents in which to live. The facility can no longer meet your needs as evidenced by your continued leaving of the facility by pushing through the unit gate, breaking down the exterior fence, walking towards the highway and wooded area outside the property, and threats or acts of violence towards other residents and staff;<br><br>- The effective date of the discharge is 06/24/24. The facility deems this discharge to be an emergency. The location discharged to is the acute care hospital;<br><br>- Discharge location was the hospital;<br><br>- No documentation from the physician of the efforts the facility attempted in meeting the resident's needs;<br><br>- No documentation from the physician of the specific services the receiving facility would provide that the current facility could not;<br><br>- No documentation of a discharge plan prior to providing the discharge notice to the resident and/or the resident's legal guardian.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/02/24 at 9:40 A.M., the Administrator said the resident had been sent out repeatedly due to behaviors. The resident went to the courtyard and tried to break the boards off the fence. He/She attacked a staff member with a broken board, tried to elope from the facility and attacked others with the fire extinguishers. The resident was sent out to the hospital and when the facility was contacted by the hospital for the resident to be sent back to the facility on [DATE], he contacted an attorney to issue an emergency discharge on 06/24/24. He realized they could not prevent the resident from trying to hurt himself/herself and others and from trying to escape outside. The resident really needed to be in a lock down unit. The resident was not allowed to returned to the facility. The resident was still at the hospital as far he knew.<br><br>During an interview on 07/02/24 at 11:45 A.M., the Social Services Director said he/she had sent out numerous referrals for the resident, but had not had anyone accept him/her.<br><br>During an interview on 08/09/24 at 8:02 A.M., the resident's legal guardian said the resident was still at the hospital and had been there for over a month. The resident didn't need to be at the hospital, but he/she was still there because the legal guardian and the hospital still couldn't find placement for the resident. The facility did not notify him/her of the resident's discharge to the hospital in a timely manner. Multiple times the facility would let him/her know the resident had been sent out to the hospital a few days after he/she had returned back to the facility. The staff said they were busy and didn't have time to notify him/her. The legal guardian did receive the resident's emergency discharge notice from the facility by email on 06/24/24. The legal guardian wanted the resident to go back to the facility from the hospital since he/she had no where else to go.<br><br>Complaint #MO238081 and #MO238356 |