STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265423	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westview Nursing Home	301 West Dunlop Street Center, MO 63436

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of individual needs for one resident (Resident #1), in a review of sampled four residents. The facility failed to address the resident's communication barrier, provide effective communication tools, and ensure all staff were aware of the communication tools necessary to determine the resident's needs. The facility census was 60. Review of the facility's policy for communication with persons with limited English proficiency (LEP), last reviewed on 6/30/23, showed the following: -Purpose of the policy was to ensure that all residents receive care in a language that they understand; -Facility would take reasonable steps to ensure that persons with LEP had meaningful access and an equal opportunity to receive skilled nursing care and participate in activities and programs; -The policy of the facility was to ensure meaningful communication with LEP residents involving their medical conditions and treatment; -The policy also provided for communication of information contained in vital documents, including but not limited to, admission agreements, consents, and (do not resuscitate) DNR forms; -Language assistance would be provided through use of competent bilingual staff, staff interpreters, contracts, or formal arrangements with local organizations provided interpretation or translation services, or technology and telephonic interpretation services; -Identifying LEP residents and their language: -The facility would promptly identify the language and communication needs of the LEP resident. If necessary, staff would use a language identification card (or I speak cards available on-line at www.lep.gov) to determine the language. During the admission process, the facility shall ensure that it identified any resident who is a LEP person; -If the facility had a LEP resident, staff will at may have direct contact with LEP resident would be trained in effective communication techniques, including the effective use of an interpreter; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Obtaining a qualified interpreter: -The administrator was responsible for keeping a list of any name, language, phone number of any bilingual staff and for contacting the appropriate bilingual staff member to interpret, if an interpreter was needed, if an employee who spoke the needed language is available and was qualified to interpret; - In the alternative, the administrator, in consultation with the Regional Director and in house counsel, would ensure that arrangements were made for in-person or telephonic interpretation through a contract with qualified interpreters; -Providing written translations: -When translation of documents was needed, the facility would submit documents to be translated by a qualified medical translation service; -The administrator, in consultation with Regional Director and in-house counsel would ensure that arrangements and contracts were made all needed translations; -Monitoring language needs: -On an ongoing basis, facility would assess changes in demographics or other needs that may require reevaluation of this policy and its procedures. In addition, facility would regularly assess the efficiency of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, and feedback from residents. 1. Review of Resident #1's level one (I) Preadmission Screening and Resident Review (PASARR), a screening process for individuals prior to admission into a nursing facility to determine if they have a serious mental illness and/or intellectual disability/developmental disability, dated 12/11/20, showed the following: -Recent medical incidents included a Grade II left temporal (highly associated with memory skills. Left temporal lesions result in impaired memory for verbal material) meningioma (meningioma is a tumor that grows from the membranes that surround the brain and spinal cord, called the meninges) status post craniotomy (is the surgical removal of part of the bone from the skull to expose the brain) with residual effects including altered mental status; -His/Her primary language was Spanish; -He/She was oriented to person and place; -His/Her memory was fair; -Diagnoses included aphasia following cerebral infarction (stroke). Review of the resident's face sheet showed the following: -He/She was admitted to the facility on [DATE]; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was his/her own responsible party. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 1/8/24, showed the following: -The resident admitted to the facility on [DATE]; -Cognition was not documented; -He/She had no speech; -He/She was understood; -He/She understood others; -He/She was not of Hispanic Latino/a, or Spanish origin; -He/She spoke English; -He/She did not want an interpreter to communicate with physicians and/or healthcare staff. Review of the resident's care plan, dated 1/3/24, showed the following: -He/She had a communication problem related to aphasia and language barrier; -He/She would be able to make basic needs known by sign language daily; -He/She would maintain current level of communication function by how, with what assistance i.e., making sounds, using appropriate gestures, responding to yes/no questions appropriately, using communication board, and writing messages; -Be conscious of the resident's position when in groups, activities, and dining room to promote proper communication with others; -Allow him/her time to respond, repeat as necessary, do not rush him/her; -Request clarification from him/her to ensure understanding; -Face him/her when speaking, make eye contact, and turn off TV/radio to reduce environmental noise; -Ask yes/no questions if appropriate; -Use simple, brief, and consistent words/cues; -He/She was able to understand English, but responded using sign language; -He/She had impaired coping; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ensure him/her to verbalize feelings regarding fear and/or anxiety; -He/She had a diagnosis of aphasia related to stroke; -Allow resident time to process and understand what was being said to him/her and allow time to answer; -Give him/her alternate communication options; pen and paper and/or communication board. (The resident's care plan did not address the resident spoke Spanish and /or the need for an interpreter or interpreter devices to assist the resident in communicating with staff/residents.) Review of the resident's hospital medical records, dated 3/9/24, showed the following: -The resident presented from the nursing home where he/she reportedly got into a physical altercation with another resident, striking him/her. The resident had been having progressively worsening issues with aggression according to the nursing home staff. The resident spoke very little English; therefore, translation services were utilized; -He/She was a non-English speaking and had the additional impediment of previous stroke causing significant aphasia. Attempted to converse with the resident using a translator and were unable to get any kind of significant information from him/her; -It was difficult to decide if he/she understands and cannot respond secondary to his/her dysphasia (he/she was able to respond to some things verbally) or a language barrier; -He/She had a history of a stroke and had trouble with communicating, but was able to understand. -Psychiatric consult note: the resident was a poor historian due to not able to speak English, stroke history, and intellectual disability. He/She used gestures, signs, and talked gibberish. During an interview on 3/12/24 at 10:30 A.M., the Administrator said the following: -The resident had a communication barrier. She thought he/she spoke Spanish and had his/her own sign language to communicate; -The resident could understand English, but had difficulty making himself/herself understood; -The resident becomes frustrated when he/she was unable to understand; -There was an incident last weekend when he/she became upset when staff did not understand him/her, and he/she threw his/her plate and coffee on the floor; -There was one nurse on night shift (Registered Nurse D) who could speak some Spanish, but she thought that was the only staff who could converse in Spanish with the resident; -Staff obtained a picture book approximately one week ago to assist staff/resident communication, but the resident threw it in the trash; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The book was now kept in the Social Service Director's (SSD's) office; -The resident was roommates with Resident #2 , but Resident #2 could not communicate well with the resident. During an interview on 3/12/24 at 11:10 A.M., Certified Nurse Assistant (CNA) A said the following: -The resident had his/her own way to communicate which could usually be understood; -The resident spoke minimal English; -He/She communicated with the resident by asking yes/no questions; -One nurse, who worked night shift, could converse with the resident in Spanish and the resident still wouldn't respond sometimes. Observation of on 3/12/24 at 1:00 P.M. showed the resident lay in his/her bed calmly listening to music on his/her phone. There was no communication board and/or ring with pictures located in his/her room. During interview with the resident on 3/12/24 at 1:00 P.M., it was difficult to communicate due to the communication barrier. When asked if he/she had ring of pictures for communication, the resident used hand gestures around his/her eyes, and responded yeah yeah yeah when asked if he/she needed glasses to see. During an interview on 3/12/24 at 4:00 P.M., Certified Medication Technician (CMT) B said the following: -The resident spoke Spanish; -The resident spoke minimal English; -The resident communicated by using his/her hands; -The resident became frustrated because others didn't know what he/she was trying to communicate; -He/She was not aware of any special communication tools, including picture ring or communication book, to aide in communication with the resident. During an interview on 3/12/24 at 4:01 P.M., the maintenance director said the following: -The resident's language was Spanish; -He/She spoke some Spanish and tried to converse with the resident, but the resident would not converse back; -The resident used his/her own sign language to communicate his/her wants/needs; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was not aware of any special book or translation techniques used to assist with communicating with the resident, but wished the facility had something like that because it would help a lot. During an interview on 3/12/24 at 4:15 P.M., the care plan coordinator said the following: -The resident's primary language was Spanish; -The resident had aphasia; -The resident could understand English, but could not communicate it back very well; -The resident communicated by pointing and using hand gestures; -He/She had only been at the facility since February, and had not had a chance to review the resident's care plan. The resident's primary language should be addressed on the care plan along with any special tools needed for staff/resident communication; -He/She was not aware of any special communication tools being used at this time. During an interview on 3/13/24 at 1:00 P.M., Licensed Practical Nurse (LPN) C said the following: -The resident had a language barrier. The resident did not have a problem understanding, but had difficulty communicating to others what he/she wanted; -The resident used his/her own gestures and staff had to learn what those gestures meant. It would be hard for someone who was not familiar with the resident to communicate as they may not know what the resident was trying to communicate; -He/She was not aware of any communication tools used, including a picture ring or communication book, but that would help if they were available. During an interview on 3/14/24 AT 7:40 A.M., Registered Nurse (RN) D said the following: -The resident had aphasia and spoke Spanish which caused difficulty understanding and being understood; -He/She spoke some Spanish and could communicate some with the resident, but the resident only spoke single words not full sentences; -The resident mostly used his/her own sign language to communicate; -The resident's communication barrier caused difficulty between the resident and most of the staff; -He/She was not sure if there were staff on other shifts who could communicate with the resident in Spanish; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was unaware of any communication tools used to aid staff with communicating with the resident; -The resident was easily irritated which could be caused from staff and/or other peers not understanding him/her. During an interview on 3/13/24 at 10:00 A.M., the SSD said the following: -The resident's primary language was Spanish, but the resident could understand English; -She purchased a flip picture book for staff to use to communicate with the resident, but the resident threw it in the trash. She took the book to her office for staff to obtain when needed. Staff would not have access to her office unless she was there or call her to let them in to obtain the book. Staff were aware of resident's communication barrier and the key ring with the pictures; -She was not aware of any staff who spoke Spanish; -She was not aware the resident spoke Spanish when he/she was accepted as a resident; -She was not involved with the admission/acceptance process. The facility's Admission Coordinator obtained all information prior to acceptance of the resident; -She had not reached out to any interpreters to assist, but it would be a good idea. She was still in the learning phase of her position; -She had not investigated any translation applications that could be used on cell phones. The transportation driver told her about an app that he/she used to translate, but nothing was used facility-wide; During an interview on 3/14/24 at 11:00 A.M., the Dietary Manager said the following: -The resident seemed frustrated a lot and she was not sure if the resident's actions were due to inability to understand, to be understood, or a behavior; -The resident became frustrated when trying to communicate and would use the gesture to forget it when he/she could not communicate what he/she wanted/needed; -Staff were learning to communicate with the resident via the resident's own sign language, but it was difficult at times; -The resident had cards with pictures that the SSD gave him/her to use to communicate, but the resident said he/she needed glasses and could not see it, and threw the book in the trash; -She wished staff could do more to understand the resident to help him/her quicker. During an interview on 3/14/24 at 11:24 A.M., the Admission Coordinator said the following: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He was told the resident could speak some English. He was not aware of the need for any special communication tools to communicate with the resident; -He reviewed the resident's information the hospital provided and did not see any indication that the facility could not meet the resident's needs. He forwarded the referral to the facility's interdisciplinary team (IDT) for review. During an interview on 3/14/24 at 12:15 P.M., the resident's physician said the following: -Staff had not reached out to him for guidance for better communication with the resident; -The resident had a history of a head injury and spoke Spanish. It was unclear how much the resident understood; -He expected the facility to have some means to communicate with the resident such as an English to Spanish app for a phone to understand his/her needs or how would they know what he/she wanted and/or needed. During an interview on 3/14/24 at 2:10 P.M., Nurse Aide (NA) F said the following: -The resident spoke Spanish, but could understand English; -The resident spoke minimal English; -The resident had a hard time communicating, but would eventually get out what he/she was trying to say; -The resident used hand gestures to communicate. A lot of the staff took it as the resident was being aggressive when he/she talked with his hands, but he/she was not. During an interview on /26/24 at 3:25 P.M., the Director of Nursing said the following: -She expected staff, who provided care for the resident, be familiar of his/her communication deficits and/or barrier, and have knowledge of the tools needed to assist with communication; -The resident's communication was quite different. The resident made up his/her own sign language which made it difficult for staff to understand him/her and for him/her to understand the staff; -The SSD provided a ring with pictures to assist with resident communication; -Staff were made aware of this ring of pictures, but the facility had several new staff which might not be aware; -Communication tools should be documented on the resident's care plan; -Staff should have access to the communication tool and it should not be stored where the staff were unable to access it.

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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** 32530 Based on interview and record review, the facility failed to develop and implement behavioral health interventions to ensure the physical and psychosocial well-being of two residents (Resident #1 and #2), in a review of four sampled residents. Staff identified Resident #1, who had diagnoses of anxiety and depression, had a language/communication barrier and became agitated when unable to communicate effectively and was not aggressive unless provoked. The facility failed to identify meaningful interventions to address the root cause of the resident's behaviors, and the facility did not ensure an effective means for the resident to communicate his/her needs which resulted in increased agitation. On 2/24/24, the resident became agitated when unable to have a second slice of pizza. Staff administered a medication (that was not ordered to treat the resident's anxiety) to treat the resident's agitation. Staff failed to identify the root cause of the resident's behavior and develop interventions to address the root cause. On 3/9/24, the resident was involved in a physical altercation after Resident #2 (roommate) would not move from the doorway as Resident #1 entered the room. Resident #2 pushed Resident #1 which resulted in Resident #1 hitting Resident #2 multiple times in the head and upper body. During evaluation at the hospital on 3/9/24, Resident #1 reported Resident #2 had exposed himself/herself and performed self-sexual activities in front on him/her and attempted multiple times to touch him/her and his/her possessions afterwards. This made Resident #1 very upset. Resident #1 felt uncomfortable around Resident #2 and as a result became agitated. Resident #1 was placed on an antipsychotic medication for agitation and sleep. Prior to the incident on 3/9/24, staff identified Resident #2 took Resident #1's belongings, which upset Resident #1, however, no interventions were implemented to prevent further incidents. Staff identified Resident #2 instigated incidents and provoked other residents. The facility failed to identify meaningful interventions to address the resident's behaviors directed towards other residents. Staff discussed imposing interventions with the resident's increased behaviors, including setting limits on activities the resident enjoyed. The facility census was 60. Review of the facility policy, Initial Psychosocial History, last reviewed/revised on 1/19/22, showed the following: -Purpose of the policy was to ensure that a comprehensive social history was completed on all residents. The social history was imperative to provide key information to develop an individualized plan of care that addressed the resident's physical, mental, and psychosocial well-being; - The social services director (SSD) would complete the initial psychosocial history on all residents within 72 hours of admission, excluding weekends and holidays; -The facility would recognize that each person was unique and were entitled to basic rights. The SSD would adopt a holistic perspective by recognizing that each resident had individualized needs that interplay to a positive wellbeing which included social, psychological, physical, and spiritual; (continued on next page)

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F 0742
 	
Level of Harm - Actual harm
 	
Residents Affected - Few
	-The initial psychosocial history form included identifying information, family and relationships, occupational and educational history, marital history, activities of daily living skills and preferences, psychosocial assessment, socialization and support systems, legal history, admission to facility, medical and psychiatric history, special considerations, and discharge planning;
	
	-The SSD, to ensure a holistic approach, would also review and include pertinent information in the initial psychosocial history from the PASARR (if applicable), nursing assessment, history and physical, resident interview, and family/guardian interview;
	
	-Once the initial psychosocial history was completed, the SSD would meet with the administrator and/or the director of nursing (DON) to communicate findings, discuss plan of care needs and ensure all immediate care needs were met;
	
	-Each weekday morning, the SSD would bring completed initial psychosocial history forms or a list of completed in the electronic medical record (EMR) to the morning meeting and review with the interdisciplinary team (IDT) to address development of the individualized plan of care.
	
	Review of the facility's policy, Behavioral Emergency, dated 1/5/23, showed the following:
	
	-Purpose of the policy was to provide safe treatment and humane care to the resident in a behavioral crisis, to ensure that the resident was not being coerced, punished, and disciplined for staff convenience;
	
	-The guardian would be notified and imposed limitations may be placed on the resident, including hospitalization or other special directives;
	
	-Documentation of behavior emergencies would include evaluation of the resident's behavior, including consideration for precipitating events or environmental triggers, and other related factors in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible, not identifying or attempting to identify the root causes of the behavior and not revising the plan of care with measurable goals and interventions to address the care and treatment for a resident with behavioral and/or mental/psychosocial symptoms;
	
	The licensed nurse would document the behavioral emergency in the medical record by utilizing the BIRPEEEE documentation guidelines
	
	a) B = Behavior; define the behavior;
	
	b) I = intervention; document interventions, note behavior emergency policy and document interventions from the behavioral emergency policy;
	
	c) R = Reaction/Response; document reaction and response of resident after interventions;
	
	d) P = Plan; continue current plan of care, continue observation/monitoring of resident;
	
	e) E = Evaluation;
	
	f) E = Evaluation;
	
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F 0742 Level of Harm - Actual harm Residents Affected - Few	g) E = Evaluation; h) E = Evaluation. 1. Review of Resident #1's level one Preadmission Screening and Resident Review (PASARR), a screening process for individuals prior to admission into a nursing facility to determine if they have a serious mental illness and/or intellectual disability/developmental disability, dated 12/11/20, showed the following: -Recent medical incidents included a Grade II left temporal (highly associated with memory skills. Left temporal lesions result in impaired memory for verbal material) meningioma (meningioma is a tumor that grows from the membranes that surround the brain and spinal cord, called the meninges) status post craniotomy (is the surgical removal of part of the bone from the skull to expose the brain) with residual effects including altered mental status; -His/Her primary language was Spanish; -He/She was oriented to person and place; -His/Her memory was fair; -Diagnoses included anxiety disorder, depressive disorder, malignant (cancerous) neoplasm of the cerebral meninges, and aphasia following cerebral infarction (stroke); -Medication regimen included duloxetine (antidepressant medication) and trazodone (anti-anxiety medication); -He/She showed no signs of mental illness; -He/She had not received intensive psychiatric treatment in the previous two years. Review of the resident's hospital records, dated 12/20/23, showed the resident's medical history included peripheral artery disease (the narrowing or blockage of the vessels that carry blood from the heart to the legs), stroke, resection of meningioma, altered mental status, aphasia (loss of ability to understand or express speech, caused by brain damage), and encephalomalacia (is a localized softening of the substance of the brain, due to bleeding or inflammation); Review of the resident's face sheet showed the following: -He/She was admitted to the facility on [DATE]; -He/She was his/her own responsible party. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 1/8/24, showed the following: -The resident was admitted to the facility on [DATE]; (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-Cognition was not documented; -He/She had no speech; -He/She was understood; -He/She understood others; -No psychosis or behaviors affecting others. Review of the resident's care plan, dated 1/3/24, showed the following: -He/She had a communication problem related to aphasia and language barrier; -He/She would be able to make basic needs known by sign language daily; -He/She would maintain current level of communication function by how, with what assistance i.e., making sounds, using appropriate gestures, responding to yes/no questions appropriately, using communication board, and writing messages; -Allow him/her time to respond, repeat as necessary, do not rush him/her; -Request clarification from him/her to ensure understanding; -Ask yes/no questions if appropriate; -Use simple, brief, and consistent words/cues; -He/She was able to understand English, but responded using sign language; -He/She had a diagnosis of aphasia related to stroke; -Allow resident time to process and understand what was being said to him/her and allow time to answer; -Give him/her alternate communication options; pen and paper and/or communication board; -He/She had impaired coping; -Ensure him/her to verbalize feelings regarding fear and/or anxiety. (The care plan did not identify any other coping skills for the resident.) (Review of the resident's care plan showed no documentation regarding behaviors or agitation directed towards others.) Review of the resident's medication administration record (MAR), dated 1/1/24 to 1/31/24, showed no documented behaviors for this time frame. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westview Nursing Home	301 West Dunlop Street Center, MO 63436

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's physician's orders, dated February 2024, showed the following: -Monitor for behaviors every shift; -Hydroxyzine (antihistamine medication used also to treat anxiety) 25 milligrams (mg), give one tablet every six hours as needed (PRN) for itching; -Duloxetine (an antidepressant medication) 60 mg, give one capsule daily for depression. Review of the resident's nursing progress note, dated 2/24/24 at 1:25 P.M., showed the resident was very upset at lunch due to not being able to have a second slice of pizza. He/She become very angry and started yelling and threw his/her plate at the wall. The nurse attempted to calm him/her down, but other staff came and started to talk to him/her also. The resident became angrier and swiped drinks off the table onto the floor. Staff assisted him/her to leave the dining room to calm down. The resident become physically aggressive with staff and sat on the floor in the doorway. The nurse convinced the resident to go to his/her room and calm down. The resident sat on his/her bed and apologized. A PRN dose of hydroxyzine was administered, and the resident later fell asleep. No other behaviors were noted. Review of the resident's MAR, dated February 2024, showed the following: -Hydroxyzine 25 mg tablet; one tablet every six hours as needed for itching; -Staff administered hydroxyzine 25 mg on 2/24/24 at 1:25 P.M. (Staff administered hydroxyzine for the resident's behaviors and not for itching as indicated in the resident's physician's orders.) -Monitor for behaviors every shift; -There were no behaviors documented from 2/1/24 to 2/29/24. Review of the resident's medical record showed no documentation staff attempted to identify the root cause of the resident's behavior on 2/24/24 or developed interventions to address the root cause for the resident's behavior. Review of the resident's progress notes, dated 3/9/24 at 7:44 A.M., showed at approximately 6:20 A.M., a code green (code used to alert staff for behavioral event and need for intervention) was called for a resident-to-resident altercation. Staff reported they saw the resident punching Resident #2 because he/she was mad over a phone charger. The resident tossed his/her coffee filled cup on the floor. He/She was sent to the hospital for further management and care. Review of the resident's hospital medical records, dated 3/9/24, showed the following: -admitted to the emergency room with chief complaint of moderate aggression; -He/She presented to the emergency department complaining of aggression with a one-day onset. He/She presented from the nursing home where he/she reportedly got into a physical altercation with another resident, striking him/her. The resident had been having progressively worsening issues with aggression according to the nursing home staff; (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-Exam showed no gross motor deficits, no neurological deficits, and he/she was alert and oriented to person, place, and time; -He/She was calm and cooperative; -He/She was a non-English speaking and had the additional impediment of previous stroke causing significant aphasia. Attempted to converse with the resident using a translator and were unable to get any kind of significant information from him/her besides the fact that someone was messing with his/her phone charger; -Social services assessment showed he/she reported that he/she had been in an argument with his/her roommate over a phone charger that he/she believed the roommate took from him/her. He/She hit his/her roommate. He/She had a history of a stroke and had trouble with communicating, but was able to understand. The facility reported that he/she was getting upset more often and this was the first time that he/she had hit anyone. The facility reported that he/she had gotten upset because they ran out of pizza and he/she threw his/her plate across the room and started picking arguments with other residents. The facility reported no mental health history and he/she was not on medications for mental health; -Psychiatric consult note: the resident was a poor historian due to not able to speak English, stroke history, and intellectual disability. He/She used gestures, signs, and talked gibberish. He/She denied previous psych history. He/She said his/her roommate exposed himself/herself in front of him/her and attempted to touch him/her multiple times. He/She felt uncomfortable around him/her and as a result became agitated. Recommendation included to start Seroquel (antipsychotic medication) 25 mg every bedtime for agitation and sleep; -It had eventually come out that the roommate was performing self-sexual activities in front of him/her and then trying to grab his/her possessions afterwards. This made the resident very upset; -Telepsychiatry recommended initiation of Seroquel 25 mg at bedtime which was added to the resident's discharge orders; -Discharge instructions included to take Seroquel 25 mg one tablet daily at bedtime, and to continue all other medications as directed by the originating prescriber. Review of the resident's nursing progress note, dated 3/9/24 at 11:00 A.M., showed that upon his/her return from the hospital, he/she was moved to the behavioral unit and placed on 15-minute safety checks. Education was provided to the resident on facility policies and peer-to-peer contact, as well as appropriate behavior and coping mechanisms. Review of the resident's care plan showed no documentation staff updated the resident's care plan with coping mechanisms and/or interventions to address aggressive behaviors after the altercation with Resident #2 on 3/9/24. Review of the facility's investigation, dated 3/11/24, showed the following: (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-On 3/9/24, the Director of Nursing (DON) and the Administrator were notified of a resident-to-resident altercation between the resident and Resident #2. It was stated that the altercation started in the bedroom of the two residents; -Staff on duty witnessed the resident (Resident #1) trying to enter the room, but was unable to due to Resident #2 sitting in his/her wheelchair in front of the doorway. The resident attempted to go around Resident #2 and accidentally stepped on Resident #2's foot; -Resident #2 become visibly upset, yelling, cursing, and pushed the resident causing him/her to fall onto the bed; -The resident got up and started to hit Resident #2 multiple times in the head and upper body; -When Resident #2 was asked what had happened, he/she stated that he/she pushed the resident for stepping on his/her foot and the resident hit him/her; -The resident was sent to the hospital for evaluation and treatment; -Care plan interventions included residents were separated in different locations of the building for safety, psychological evaluation, and treatment, placed on 15-minute safety checks, and education was provided to the resident on facility policies and peer to peer contact, as well as appropriate behavior and coping mechanisms. Review of a resident contract signed by the resident, dated 3/11/24, showed that he/she agreed to not have any verbal or physical altercations with fell ow residents. Failure to abide by this contract would lead to limitations being placed for him/herself or being discharged to another facility. Review of the resident's MAR, dated 3/1/24 to 3/31/24, showed the following: -Seroquel 25 mg; one tablet at bedtime related to anxiety disorder was started on 3/11/24 (order was obtained from the hospital on 3/9/24); -Staff documented Seroquel 25 mg; one tablet at bedtime was administered on 3/11/24. During an interview on 3/12/24 at 10:30 A.M., the Administrator said the following: -The resident had never had physical behaviors since he/she was admitted ; -The resident could understand English, but had difficulty making himself/herself understood; -The resident becomes frustrated when he/she is unable to understand, but had never been aggressive; -There was an incident last weekend when he/she became upset when staff did not understand him/her, and he/she threw his/her plate and coffee on the floor; (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-The resident was roommates with Resident #2 , but Resident #2 could not communicate well with Resident #1. The resident attempted to maneuver around Resident #2 who was blocking the doorway to their room. The resident ended up on Resident #2's foot. Resident #2 become upset and pushed the resident, and he/she fell on the bed. The resident then got up and struck Resident #2. The resident was sent to the hospital and returned with new order for Seroquel; -The resident was moved in with Resident #2 approximately a week ago because they both had problems with their previous roommates; -Earlier in the week, prior to the altercation, the resident said Resident #2 had touched his/her personal belongings and he/she did not like Resident #2 touching his/her personal belongings. Review of the resident's medical record showed there was no evidence to show staff implemented interventions to address Resident #2 touching Resident #1's personal belongings prior to the altercation on 3/9/24. During an interview on 3/12/24 at 11:10 A.M., Certified Nurse Assistant (CNA) A said the following: -On 3/9/24, he/she came out of another room when he/she saw the resident step on Resident #2's foot as he/she tried to maneuver around Resident #2 who was blocking the doorway. Resident #2 shoved the resident on the bed and the resident jumped up and struck Resident #2.; -He/She was unaware of any previous issues between the two residents; -The resident was not usually aggressive. Observation of on 3/12/24 at 1:00 P.M. showed the resident lay in his/her bed calmly listening to music on his/her phone. He/She appeared happy as evidenced with smile on his/her face. During interview with the resident on 3/12/24 at 1:00 P.M., showed it was difficult to communicate due to the communication barrier. He/She pointed to his/her scar on his/her head to show where he/she had previous surgery. He/She picked up his body spray and sat it back down and responded yeah yeah yeah when asked if someone had taken his/her body spray. He/She responded yeah yeah yeah when asked if it was his/her previous roommate (Resident #2). During an interview on 3/12/24 at 4:00 P.M., Certified Medication Technician (CMT) B said the following: -The resident spoke minimal English and communicated by using his/her hands; -The resident became frustrated because others didn't know what he/she was trying to communicate; -He/She had not seen the resident be physically aggressive. During an interview on 3/12/24 at 4:01 P.M., the Maintenance Director said the resident was mellow until provoked, then he/she would become agitated. During an interview on 3/12/24 at 4:15 P.M., the Care Plan Coordinator said the following: (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-The resident only became physically aggressive if he/she was provoked; -He/She had never seen the resident lash out for no reason; -The resident was normally quiet and kept to himself/herself in his/her room. During an interview on 3/13/24 at 1:00 P.M., Licensed Practical Nurse (LPN) C said the following: -On 2/24/24, the resident was sitting at the dining room table with a peer who had received more pizza. The resident was told there was no more when he/she had asked for more. The resident became frustrated, staff tried to redirect and calm him/her down, but only made him/her more agitated; -He/She administered hydroxyzine because it could also be used for anxiety; -The resident had a language barrier. The resident did not have a problem understanding, but had difficulty communicating to others what he/she wanted; -The resident was usually nice and tried to keep to himself/herself; -He/She noticed a behavior one time and that was because another resident had instigated the issue; -The resident attempted to get out of the room, but his/her roommate Resident #2 was blocking the doorway. The resident accidentally stepped on Resident #2's toes which caused Resident #2 to become angry and he/she pushed the resident on the bed. The resident got up and struck Resident #2; -Resident #1 went to the hospital and was evaluated by psych; -The hospital reported to him/her that the resident said Resident #2 had performed self-sexual behaviors in front of Resident #1 and then Resident #2 wiped his/her hands on Resident #1, all of which he/she reported to management staff; -Resident #1 did not communicate Resident #2's inappropriate sexual behavior to the facility staff; -Resident #2 was known to be an instigator and cause problems; -Resident #1 and Resident #2 should not have been roommates because of Resident #2's history with other roommates and/he she reported that to management staff, but the resident's remained in the same room; -Resident #2 would accuse Resident #1 of taking his/her stuff, when it was Resident #1's stuff that Resident #2 had originally taken. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/14/24 at 2:30 P.M., the administrator said she was unaware that Resident #2 had performed self-sexual behaviors in front of Resident #1 and then Resident #2 wiped his/her hands on Resident #1. She felt like Resident #1 would have told staff if that had occurred. She was aware Resident #1 did not like Resident #2 touching his/her belonging and would make Resident #1 upset when Resident #2 touched his/her things. She spoke with Resident #2 and explained that he/she could not bother other resident's belongings and Resident #2 said he/she would not do it again. During an interview on 3/14/24 AT 7:40 A.M., Registered Nurse (RN) D said the following: -The resident had aphasia and spoke Spanish which caused difficulty understanding and being understood; -The resident's communication barrier caused difficulty between the resident and most of the staff; -The resident was easily irritated which could be caused from staff and/or other peers not understanding him/her; -The facility did not know much about the resident's history due to the communication barrier. -The resident was involved in an altercation with a peer and was sent to the hospital for physical aggression. He returned from the hospital with a new order for Seroquel to calm him/her down and aid with sleep. During an interview on 3/13/24 at 10:00 A.M., the Social Services Director said the following: -The resident's primary language was Spanish, but he/she could understand English; -There was an incident between the resident and the Dietary Manager approximately one month ago. The resident wanted more coffee and he/she started yelling. Not sure if the communication barrier caused the resident's increased agitation, but it could have played a role in it; -The root cause of the resident's behaviors was his/her communication skills; -Overall, she had not seen the resident be aggressive. The resident was normally smiling and appeared happy/cheerful; -The facility was working on being able to meet the resident's psycho-social needs. The resident tried to tell his/her story, but she could not understand him/her. -The resident was admitted directly from a hospital after his/her former facility refused to let him/her return. She did not know any other details regarding the resident. During an interview on 3/14/24 at 11:00 A.M., the Dietary Manager said the following: -The resident had an episode in the dining room when he/she wanted something and wanted it immediately; (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-The resident seemed frustrated a lot and she was not sure if the resident's actions were due to inability to understand, to be understood, or a behavior; -The resident became frustrated when trying to communicate and would use the gesture to forget it when he/she could not communicate what he/she wanted/needed. During an interview on 3/14/24 at 12:15 P.M., the resident's physician said the following: -The facility did not provide him/her with any of the resident's medical history; -He would expect the facility to reach out to the previous facility and obtain the resident's history and/or background before accepting the resident so they could have better knowledge about the resident's needs; -The resident had a history of a head injury and spoke Spanish. It was unclear how much the resident understood; -The resident was usually calm when he saw the resident; -The resident was in an altercation recently with a peer and was sent to the emergency room . The resident saw tele psych and was recommended that he/she start on Seroquel. It was reported that the resident appeared agitated on a frequent basis. He did not feel that the resident needed the medication due to the degree of provocation. The Seroquel was continued to prevent further incidents of aggression. During an interview on 3/26/24 at 3:25 P.M., the Director of Nursing said the following: -The resident's communication was quite different. The resident made up his/her own sign language which made it difficult for staff to understand him/her and for him/her to understand the staff; -Staff should have contacted the physician for an order to administer the hydroxyzine for increased anxiety/agitation and not take it upon themselves to administer without contacting the physician first. The physician may have recommended some other intervention. During interview on 4/10/24 at 2:13 P.M., the Administrator said the following: -The resident was started on Seroquel on 3/11/24 after the incident with Resident #2; -The resident's diagnosis for Seroquel use was anxiety; -The root cause of the resident's behavior on 3/9/24 was that Resident #2 provoked him/her by shoving him/her; -The root cause of previous incidents involving the resident and behaviors was due to his/her communication barrier. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	2. Review of Resident #2's Preadmission Assessment and Resident Screening (PASARR), a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability. , dated 9/6/22, showed the following: -His/Her diagnoses included major depressive disorder, recurrent severe psych features, adjustment disorder (is an emotional or behavioral reaction to a stressful event or change in a person's life) with depressed mood, alcohol-induced mood disorder, stimulant abuse with stimulant-induced mood disorder, antisocial personality disorder, opioid use, meth dependence, alcohol intoxication abuse, and cannabis use; -His/Her estimated intellectual function level was average; -He/She had a history of a closed traumatic brain injury (TBI) with loss of consciousness (an injury to the brain from external mechanical force), post-traumatic stress disorder (PTSD, is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event) secondary to TBI; -History of withdrawn, depressed, suspicious and paranoid, anxiety, abnormal thought process. Oriented to person, place and situation but not time, impaired procedural, and situational memory. Required guardianship and had a history of incarceration; -Multiple previous psychiatric treatments, including incarceration, hospitalization s, and outpatient; -Aggressive/assaultive behaviors included fire setting, yelling, and cursing when frustrated; -Required physical assistance with toileting, personal hygiene, bathing, and dressing/undressing; -Use of wheelchair, unassisted; -He/She was open and honest with others and would curse when he/she got frustrated; -He/She felt worthless; -He/She had thoughts about hurting and/or killing himself/herself in the past when he/she was not seeing his/her children. He/She thought he/she would be better off dead; -He/She had thoughts about hurting or killing someone only when people threatened him/her; -Assessment and implementation of behavioral support plan included monitoring of behavioral symptoms and provision of behavioral support; -Medication therapy and monitoring services included psychiatric follow up to prescribe and manage medications; -Provide for individual personal space; -Establish consistent routines; (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-Provide schedule of daily tasks/activities; -Provide instructions at the individual's level of understanding; -Assess and plan for the level of supervision required to prevent harm to self or others; -Safety plan to address potential risk to self or others, -Plan should identify clear steps that would be taken to support the individual during a crisis, specify who to contact for assistance, how staff should work together with individual during the crisis, as well as identify when the physician, emergency medical services, and/or law enforcement should be contacted; -Personal support should include to assess and plan for meaningful socialization and recreational activities to diminish tendencies toward isolation, withdrawal, etc. Review of the resident's face sheet showed he/she was admitted to the facility on [DATE]. Review of the residents quarterly MDS, dated [DATE], showed the following: -Staff did not complete the areas to assess the resident's cognitive pattern or mood; -The resident had no behaviors in the previous seven days. Review of the resident's care plan, last revised on 1/9/24, showed the following: -He/She had a behavior problem related to his/her disease process, resisting care, and having altercations with peers; -Administer medications as ordered, anticipate, and meet the resident's needs; -Caregivers to provide opportunity for positive interaction and interaction. Stop and talk with him/her when passing by; -If reasonable, discuss the resident's behavior and explain/reinforce why behavior was inappropriate and/or unacceptable to the resident; -He/She had decreased activity involvement related to immobility and physical limitations; -Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. (Review showed no documented interventions to meet his/her psychosocial needs, no documentation to address meaningful socialization and recreational activities to diminish tendencies toward isolation, withdrawal, etc., and to provide for individual personal space as indicated on the resident's PASARR, and no documentation to address how staff were to respond when the resident had behaviors directed towards others.) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530 Based on observation, interview, and record review, the facility failed to ensure one resident (Residents #1), in a review of four sampled residents, was free from unnecessary psychotropic medications. The facility administered a medication ordered for itching to the resident following an incident of agitation which staff identified was a response to the resident's communication barrier. The facility failed to ensure an appropriate indication for use of a newly ordered antipsychotic medication implemented following an incident where the resident responded with physical aggression after another resident pushed him/her onto the bed. The facility census was 60. Review of the facility's Psychotropic and Antipsychotic PRN (as needed)) Medication Orders Guideline, dated 11/28/17, showed the following: -While there may be isolated situations where pharmacological intervention was required first, these situations do not negate the obligation of the facility to develop and implement non-pharmacological interventions; -Psychiatric disorders or expressions and/or indications of distress, as with all symptoms, it was important to seek the underlying cause of the distress. Some examples of potential causes included delirium, pain, psychiatric or neurological illness, environmental or psychological stressors, dementia, or substance intoxication or withdrawal. Non-pharmacological approaches, unless clinically contraindicated must be implemented to address expressions or indications of distress. However, medications may be effective when the underlying cause of a resident's distress has been determined, non-pharmacological approaches to care were ineffective or expressions of distress had worsened. Medications may be unnecessary and are likely to cause harm when given without a clinical indication, at too high of a dose, for too long after the resident's distress had been resolved, or if the medications were not monitored for efficacy, risks, benefits, and revised as necessary; -Regarding PRN medications, it was important that the medical record included documentation related to the attending physician's or other prescriber's evaluation of the resident and indications, specific circumstances for use, and the desired frequency of administration for each medication; -As part of the evaluation, gathering and analyzing information helps define clinical indications and provide baseline data for subsequent monitoring of psychotropic medication use; -When psychopharmacological medications were used as an emergency measure, adjunctive approaches such as individualized, non-pharmacological approaches and techniques must be implemented. Review of the facility policy, Medication Administration and Monitoring, last reviewed/revised on 9/20/23, showed the following: -Purpose of the policy was to ensure a process was in place for proper administration of medications, techniques of administering medications, effective monitoring of residents for adverse consequences associated with side effects to medications; (continued on next page)

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	265423	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westview Nursing Home	301 West Dunlop Street Center, MO 63436

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Medications were to be administered per physician's orders. 1. Review of Resident #1's level one (I) Preadmission Screening and Resident Review (PASARR), a screening process for individuals prior to admission into a nursing facility to determine if they have a serious mental illness and/or intellectual disability/developmental disability, dated 12/11/20, showed the following: -Recent medical incidents included a Grade II left temporal (highly associated with memory skills. Left temporal lesions result in impaired memory for verbal material) meningioma (meningioma is a tumor that grows from the membranes that surround the brain and spinal cord, called the meninges) status post craniotomy (is the surgical removal of part of the bone from the skull to expose the brain) with residual effects including altered mental status; -His/Her primary language was Spanish; -He/She was oriented to person and place; -His/Her memory was fair; -Diagnoses included anxiety disorder, depressive disorder, malignant (cancerous) neoplasm of the cerebral meninges, and aphasia following cerebral infarction (stroke); -He/She showed no signs of mental illness; -He/She had not received intensive psychiatric treatment in the previous two years. Review of the resident's hospital records, dated 12/20/23, showed the following: -Chief complaint for admission was homeless; -Medical history included stroke, altered mental status, aphasia (loss of ability to understand or express speech, caused by brain damage), and encephalomalacia (is a localized softening of the substance of the brain, due to bleeding or inflammation). Review of the resident's face sheet showed the following: -He/She admitted to the facility on [DATE]; -He/She was his/her own responsible party. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 1/8/24, showed the following: -The resident was admitted to the facility on [DATE]; -Cognition was not documented; -He/She had no speech; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was understood; -He/She understood others; -No psychosis or behaviors affecting others. Review of the resident's care plan, dated 1/3/24, showed the following: -He/She had a communication problem related to aphasia and language barrier; -He/She would maintain current level of communication function by how, with what assistance i.e., making sounds, using appropriate gestures, responding to yes/no questions appropriately, using communication board, and writing messages; -Allow him/her time to respond, repeat as necessary, do not rush him/her; -Request clarification from him/her to ensure understanding; -Ask yes/no questions if appropriate; -Use simple, brief, and consistent words/cues; -He/She was able to understand English, but responded using sign language; -He/She had a diagnosis of aphasia related to stroke; -Allow resident time to process and understand what was being said to him/her and allow time to answer; -Give him/her alternate communication options; pen and paper and/or communication board; -He/She had impaired coping; -He/She was encouraged to verbalize feelings regarding fear and/or anxiety. (No other coping skills were identified in the resident's care plan.) Review of the resident's medication administration record (MAR), dated 1/1/24 to 1/31/24, showed no documented behaviors for this time frame. Review of the resident's physician's orders, dated February 2024, showed the following: -Monitor for behaviors every shift; -Hydroxyzine((an antihistamine) 25 mg, give one tablet every six hours PRN for itching. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's nursing progress note, dated 2/24/24 at 1:25 P.M., showed the resident was very upset at lunch due to not being able to have a second slice of pizza. He/She become very angry and started yelling and threw his/her plate at the wall. The nurse attempted to calm him/her down, but other staff came and started to talk to him/her also. The resident became angrier and swiped drinks off the table onto the floor. Staff assisted him/her to leave the dining room to calm down. The resident become physically aggressive with staff and sat on the floor in the doorway. The nurse convinced the resident to go to his/her room and calm down. The resident sat on his/her bed and apologized. Staff administered a PRN (as needed) dose of hydroxyzine and the resident later fell asleep. No other behaviors were noted. Review of the resident's MAR, dated February 2024, showed the following: -Hydroxyzine 25 mg tablet; one tablet every six hours as needed for itching; -Staff administered hydroxyzine 25 mg on 2/24/24 at 1:25 P.M. (Staff administered hydroxyzine for the resident's behaviors and not for itching as indicated in the resident's physician's orders.); -Monitor for behaviors every shift; -There were no behaviors documented from 2/1/24 to 2/29/24. Review of the resident's progress notes, dated 3/9/24 at 7:44 A.M., showed at approximately 6:20 A.M., a code green (code used to alert staff for behavioral event and need for intervention) was called for a resident-to-resident altercation. Staff reported they saw the resident punching Resident #2 because he/she was mad over a phone charger. The resident tossed his/her coffee filled cup on the floor. He/She was sent to the hospital for further management and care. Review of the resident's hospital medical records, dated 3/9/24, showed the following: -admitted to the emergency room with chief complaint of moderate aggression; -He/She presented to the emergency department complaining of aggression with a one-day onset. He/She presented from the nursing home where he/she reportedly got into a physical altercation with another resident, striking him/her. The resident had been having progressively worsening issues with aggression according to the nursing home staff; -Exam showed no gross motor deficits, no neurological deficits, and he/she was alert and oriented to person, place, and time; -He/She was calm and cooperative; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Social services assessment showed he/she reported that he/she had been in an argument with his/her roommate over a phone charger that he/she believed the roommate took from him/her. He/She hit his/her roommate. He/She had a history of a stroke and had trouble with communicating, but was able to understand. The facility reported that he/she was getting upset more often and this was the first time that he/she had hit anyone. The facility reported that he/she had gotten upset because they ran out of pizza and he/she threw his/her plate across the room and started picking arguments with other residents. He/She was on hydroxyzine which was ordered from his/her primary physician. The facility reported no mental health history and he/she was not on medications for mental health; -Psychiatric consult note: the resident was a poor historian due to not able to speak English, stroke history, and intellectual disability. He/She used gestures, signs, and talked gibberish. He/She denied previous psych history. He/She said his/her roommate exposed himself/herself in front of him/her and attempted to touch him/her multiple times. He/She felt uncomfortable around him/her and as a result became agitated. Recommendation included to start Seroquel (antipsychotic medication) 25 mg every bedtime for agitation and sleep; -It had eventually come out that the roommate was performing self-sexual activities in front of him/her and then trying to grab his/her possessions afterwards. This made the resident very upset; -Telepsychiatry recommended initiation of Seroquel 25 mg at bedtime which was added to the resident's discharge orders; -Discharge instructions included to take Seroquel 25 mg one tablet daily at bedtime, and to continue all other medications as directed by the originating prescriber. Review of the facility's investigation, dated 3/11/24, showed the following: -On 3/9/24, the Director of Nursing (DON) and the Administrator were notified of a resident-to-resident altercation between the resident and Resident #2. The altercation started in the bedroom of the two residents; -Staff on duty witnessed the resident (Resident #1) trying to enter the room, but was unable to due to Resident #2 sitting in his/her wheelchair in front of the doorway. The resident attempted to go around Resident #2 and accidentally stepped on Resident #2's foot; -Resident #2 become visibly upset, yelling, cursing, ,and pushed the resident causing him/her to fall onto the bed; -The resident got up and started to hit Resident #2 multiple times in the head and upper body; -When Resident #2 was asked what had happened, he/she said he/she pushed the resident for stepping on his/her foot and the resident hit him/her; -The resident was sent to the hospital for evaluation and treatment. Review of the resident's MAR, dated 3/1/24 to 3/31/24, showed the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Seroquel 25 mg; one tablet at bedtime related to anxiety disorder was started on 3/11/24 (order was obtained from the hospital on 3/9/24); -Staff documented Seroquel 25 mg; one tablet at bedtime was administered on 3/11/24. During an interview on 3/12/24 at 10:30 A.M., the Administrator said the following: -The resident had never had physical behaviors since he/she was admitted ; -The resident was roommates with Resident #2 , but Resident #2 could not communicate well with Resident #1. The resident attempted to maneuver around Resident #2 who was blocking the doorway to their room. The resident ended up on Resident #2's foot. Resident #2 become upset and pushed the resident, and he/she fell on the bed. The resident then got up and struck Resident #2; -The resident was sent to the hospital and returned with new order for Seroquel. During an interview on 3/12/24 at 11:10 A.M., Certified Nurse Assistant (CNA) A said the following: -On 3/9/24, he/she came out of another room when he/she saw the resident step on Resident #2's foot as he/she tried to maneuver around Resident #2 who was blocking the doorway. Resident #2 shoved the resident on the bed and the resident jumped up and struck Resident #2.; -He/She was unaware of any previous issues between the two residents; -The resident was not usually aggressive. Observation of on 3/12/24 at 1:00 P.M. showed the resident lay in his/her bed calmly listening to music on his/her phone. He/She appeared happy as evidenced with smile on his/her face. During an interview on 3/12/24 at 4:15 P.M., the care plan coordinator said the following: -The resident only became physically aggressive if he/she was provoked; -He/She had never seen the resident lash out for no reason; -The resident was normally quiet and kept to himself/herself in his/her room. During an interview on 3/13/24 at 1:00 P.M., Licensed Practical Nurse (LPN) C said the following: -On 2/24/24, the resident was sitting at the dining room table with a peer who had received more pizza. The resident was told there was no more when he/she had asked for more. The resident became frustrated, staff tried to redirect and calm him/her down, but only made him/her more agitated; -He/She administered hydroxyzine because it could also be used for anxiety; -He/She did not recall contacting the physician and just gave the medication in the moment because he/she felt it was appropriate to use in that situation; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was usually nice and tried to keep to himself/herself; -He/She noticed a behavior one time and that was because another resident had instigated the issue; -The resident attempted to get out of the room, but his/her roommate Resident #2 was blocking the doorway. The resident accidentally stepped on Resident #2's toes which caused Resident #2 to become angry and he/she pushed the resident on the bed. The resident got up and struck Resident #2; -The resident went to the hospital and was evaluated by psych. During an interview on 3/14/24 AT 7:40 A.M., Registered Nurse (RN) D said the following: -The resident's communication barrier caused difficulty between the resident and most of the staff; -The resident was easily irritated which could be caused from staff and/or other peers not understanding him/her; -The resident had an order for hydroxyzine to be administered for itching. He/She would have to contact the physician and obtain an order to give it for any other indication such as for increased behaviors; -The resident was involved in an altercation with a peer and was sent to the hospital for physical aggression. He returned from the hospital with a new order for Seroquel to calm him/her down and aid with sleep. During an interview on 3/14/24 at 12:15 P.M., the resident's physician said the following: -He expected staff to contact him for further direction if a medication such as hydroxyzine could be used for agitation/anxiety if it was indicated on the orders for itching; -The resident was in an altercation recently with a peer and was sent to the emergency room . The resident saw tele psych and was recommended that he/she start on Seroquel. It was reported that the resident appeared agitated on a frequent basis. He did not feel that the resident needed the medication due to the degree of provocation. The Seroquel was continued to prevent further incidents of aggression. During an interview on /26/24 at 3:25 P.M., the Director of Nursing said she would not expect staff to administer hydroxyzine for increased anxiety/agitation if was indicated for itching on the resident's physician's orders. Staff should have contacted the physician for an order to administer for increased anxiety/agitation and not take it upon themselves to administer without contacting the physician first. The physician may have recommended some other intervention. During interview on 4/10/24 at 2:13 P.M., the Administrator said the following: -The resident was started on Seroquel on 3/11/24 after the incident with Resident #2; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's diagnosis for Seroquel use was anxiety; -Hospital psych evaluated the resident for the use of Seroquel; the facility did not assess the need for the medication and if the diagnosis was appropriate for use; -The root cause of the resident's behavior on 3/9/24 was that Resident #2 provoked him/her by shoving him/her; -The root cause of previous incidents involving the resident and behaviors was due to his/her communication barrier.