STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265526	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chariton Park Health Care Center	902 Manor Drive Salisbury, MO 65281

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 47246 Based on observation, interview, and record review, the facility failed to protect one resident (Resident #1), in a sample of seven residents, from physical abuse by another resident, (Resident #3), who had a history of aggressive behaviors. Staff failed to separate the residents and sufficiently monitor Resident #3 after he/she had initially verbally assaulted Resident #1. Resident #3 was able to return to the dining area and physically assault Resident #1. Resident #1 received scratches and had a large clump of hair pulled from his/her scalp. The facility census was 117. Review of the facility policy, Resident's Rights, dated (revised) 07/05/23, showed the facility must protect and promote rights of each resident, including freedom from verbal, sexual, mental and physical abuse, corporal punishment and involuntary seclusion. Review of the facility policy, Abuse and Neglect, dated (revised 06/12/24), showed the following: -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations; -The facility will take steps to prevent mistreatment while the investigation is underway; -Residents who allegedly mistreat another resident will be removed from contact with the resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his or her safety, as well as the safety of other residents and employees in the facility. 1. Review of Resident #1's face sheet, undated, showed he/she had a legal guardian. Review of the resident's care plan, dated 08/07/24, showed no issues with behavioral symptoms, verbal or physical, directed at others. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 08/09/24, showed the following: -Cognitively intact; (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	-Diagnoses included hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held contrary to reality); -No behavioral symptoms, verbal or physical, directed at others; -Use of antipsychotics (a medication to help reduce psychotic symptoms like hallucinations, delusions, and disordered thinking), antianxiety, and antidepressant medications. During an interview on 09/04/24 at 11:40 A.M., the resident said the following: -A couple of days ago, he/she was frustrated that Resident #3 was in the hallway outside his/her room, and on the facility resident phone for a long period of time, when he/she (Resident #1) had expected a call from his/her family; -He/She asked Resident #3 to get off the phone and Resident #3 became angry, started yelling at him/her, threw the phone down and then called him/her (Resident #1) a bad name; -The activity director was in the dining room and told Resident #3 to go to his/her room to calm down and he/she did, but he/she did not stay there; -He/She walked into the dining room and Resident #3 came up to him/her and threw his/her shoulder into him/her (Resident #1), scratched his/her neck and pulled a clump of his/her hair out; -The activity director and another staff person responded to the incident and shielded him/her with her arms, while another staff pulled Resident #3 off him/her; -The activity director took him/her to her office for the afternoon and Resident #3 stayed on the unit; -He/She was upset and afraid after Resident #3 attacked him/her; -He/She and Resident #3 were still on the same unit but avoided each other now. Observation on 09/04/24 at 11:45 A.M. showed the following: -Resident #1 had a mildly red, linear scratch on the back of his/her neck, measuring approximately six inches in length and less than two millimeters in width; -The resident had a clump of brown hair wrapped up in a paper towel in his/her pocket that measured about the size of a half-dollar; -The resident had a small area of baldness along the left side of the scalp, and it measured about two inches in width by two inches in length. During an interview on 09/11/24 at 11:30 A.M., the resident's legal guardian said Resident #1 did not have a history of verbal or physical aggression towards other residents. 2. Review of Resident #3's face sheet, undated, showed he/she had a legal guardian. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's electronic medical record showed a Pre-Admission Screening and Resident Review Level Two (PASARR II), dated 08/30/23, showed the following: -The resident was discharged from a previous skilled nursing facility due to aggression and the facility filed charges and a restraining order against him/her; -The resident was unable to live in a less-restrictive environment at this time for his/her safety and the safety of others, he/she required 24-hour supervision; -Diagnoses included major depressive disorder, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), generalized anxiety disorder, and post-traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event); -The resident's legal guardian said the resident had a history of aggressive behaviors when he/she was frustrated or when he/she felt his/her needs were not being met; -Behaviors to be addressed in the nursing facility plan of care included attention seeking behaviors, irritability, anxiety, outbursts, and per hospital records, history of aggressive behavior when the resident is frustrated or when he/she felt his/her needs were not being met. Review of the resident's baseline care plan, dated 08/12/24, showed no documentation regarding behaviors, interventions or PASARR II recommendations related to the resident's behaviors. Review of the resident's admission MDS, completed by the facility staff and dated 08/25/24, showed the following: -Cognitively intact; -Diagnoses included hallucinations and delusions; -No behavioral symptoms; -Use of antipsychotic, antianxiety and antidepressant medications. During an interview on 09/04/24 at 1:10 P.M., the resident said the following: -A couple of days ago, he/she was on the phone in the hallway when Resident #1 accused him/her of being on the phone for too long and it made him/her (Resident #3) mad; -He/She had problems in the past of acting out when he/she was mad; -He/She might have cussed at Resident #1, he/she was not sure; -The facility staff told him/her to go to his/her room and he/she did for maybe 15 minutes and then he/she went to the dining room; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Resident #1 hit him/her first on the chest when he/she went to the dining room, so he/she pulled Resident #1's hair; -A staff person pulled him/her off Resident #1 and told him/her (Resident #3) to go to his/her room; -Staff put him/her on 1:1 monitoring (one staff monitored the resident exclusively) and stayed with him/her for a little bit; he/she was not sure how long; -He/She was still on the same unit as Resident #1 and he/she just stayed away from Resident #1 now. During an interview on 09/04/24 at 2:15 P.M., the activity director said the following: -On 09/02/24, around 9:30 A.M., she was in the dining room when Resident #3 began yelling and cussing at Resident #1 because Resident #1 complained Resident #3 had been on the resident phone for too long; -She and another staff member told Resident #3 to calm down because Resident #3 was yelling and cussing at Resident #1, and she (the activity director) told Resident #3 to go to his/her room; -Resident #3 started yelling and cussing at her (the activity director) and another staff member, while Resident #3 walked to his/her room; -She thought the situation was resolved because Resident #3 went to his/her room, staff did not follow Resident #3 to his/her room and did not stay with him/her; -Resident #3 returned to the dining area in a few minutes and used his/her shoulder to shove Resident #1 and then started to pull Resident #1's hair; -She called a code green (indicating additional staff were needed due to a resident was a threat to himself/herself or to others) when Resident #3 was physically aggressive towards Resident #1; -She and Licensed Practical Nurse (LPN) A separated the residents; she put her arms around Resident #1 because Resident #3 was still pulling at Resident #1's hair; -LPN A pulled Resident #3 off Resident #1; -She took Resident #1 to her office and off the unit for the afternoon so Resident #1 could calm down; -Resident #1 was initially teary and told her he/she was in shock, but then Resident #1 said he/she was calmer and he/she went back to the unit later in the afternoon; -Resident #3 remained on the unit; she (the activity director) was not sure if staff stayed with Resident #3 after the incident occurred; -She was aware of Resident #3's history of aggression. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/18/24 at 8:40 A.M., LPN A said the following: -On 09/02/24, Resident #3 was on the phone in the dining room (of the 400-500-600 unit) when Resident #1 started complaining because he/she wanted to use the phone; -He/She did not remember what the residents said to each other, but he/she knew the residents were in an argument by the tone of their voices; -He/She told the residents to separate, and the activity director took Resident #1 off the unit and LPN A told Resident #3 to go to his/her room; -He/She could not remember if any other staff went with Resident #3 to his/her room; -Resident #1 returned to the unit with the activity director, he/she could not remember how long Resident #1 was gone; -Resident #3 came out of his/her room and was not calmed down yet, LPN A could not remember how he/she knew Resident #3 was not calm; -Resident #3 went up to Resident #1 and pushed him/her and then pulled his/her hair; -LPN A and another staff member got in between Resident #1 and Resident #3 to separate them, but he/she could not remember which staff helped him/her separate the residents; -He/She could not remember if a code green was called; -Resident #1 was taken off the unit by the activity director again and LPN A thought Resident #3 was taken to his/her room by a certified nurse assistant (CNA), he/she could not remember; -He/She did not think Resident #1 and Resident #3 had any physical injuries but he/she could not remember if he/she did a physical assessment of the residents; -If he/she had done a physical assessment of the residents, he/she would have documented the assessment in the electronic medical record (EMR); -He/She could not remember if he/she documented the events that occurred between Resident #1 and Resident #3 in the EMR; -He/She could not remember if he/she reported the events that occurred between Resident #1 and Resident #3 to administration; -He/She was not sure if the verbal exchange between Resident #1 and Resident #3 was abuse since he/she did not actually hear what was said; -He/She said physical altercations between residents would be considered resident-to-resident abuse. During an interview on 09/11/24 at 2:15 P.M., the resident's legal guardian said the following: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The resident had a long history of aggression that could be unprovoked; -The facility should have been aware of the resident's past behaviors of aggression and poor coping skills; -It was important for the facility to include in the resident's care plan, his/her history of aggressive behavior when frustrated. During an interview on 09/04/24 at 3:45 P.M., the director of nurses (DON) said the following: -She was not aware of the verbal or physical altercation that occurred between Resident #1 and Resident #3 on 09/02/24; -She was aware of Resident #3's history of aggression and poor coping skills, but was not aware if Resident #3 had any behaviors at the prior facility before the resident's arrival in the last couple of weeks; -She would have expected staff to separate the residents and provide protection for Resident #1 when Resident #3 began to verbally assault him/her; -If staff had provided a 1:1 with Resident #3 when he/she was verbally aggressive, it may have prevented the physical assault of Resident #1; -The residents involved should have been separated while an investigation of the incident took place. During an interview on 09/04/24 at 5:30 P.M., the administrator said the following: -She was aware that there was a verbal altercation between Resident #1 and another resident on 09/02/24; -She thought Resident #1 left the unit with the activity director after the verbal altercation with Resident #3; -She was not aware that Resident #3 physically attacked Resident #1; -She was aware that Resident #3 had a history of aggression; it was in his/her PASARR II; -If staff had provided a 1:1 with Resident #3 when he/she was verbally aggressive with Resident #1, it may have prevented the physical assault of Resident #1 by Resident #3; -The residents involved should have been separated while an investigation of the incident took place. #MO00241466

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47246 Based on interview and record review, the facility failed to report an allegation of resident-to-resident abuse involving two residents (Resident #1 and Resident #3), in a sample of seven residents, to the state agency (SA) as required. The facility census was 117. Review of the facility policy, Abuse and Neglect, dated (revised 06/12/24), showed the following: -It is the policy of the facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources or misappropriation of resident property are reported immediately to the administrator of the facility and to other appropriate agencies in accordance with current state and federal regulation within prescribed time frames; -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology; -Procedure for response and reporting allegations of abuse/neglect/exploitation: -The licensed nurse will notify the administrator or designee, attending physician, resident's family/legal representative, and medical director; -The administrator or designee will refer to the State Operations Manual (SOM) for reporting and utilize the Abuse/Neglect Reporting Decision Tree to assess the particular incident. Should the incident be a reportable event, notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than two hours after discovery or forming a suspicion; -Follow-up with appropriate agencies, during business hours, to confirm the report was received; -Within five working days of the incident, report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified; -VI. Notifications: -Additionally, the following may need to be notified depending on the circumstances and according to state law; the local/state ombudsman, state adult protective services, resident's physician, facility medical director; -The policy did not address if/when the facility was to notify law enforcement. 1. Review of Resident #1's face sheet, undated, showed he/she had a legal guardian. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 08/09/24, showed the the resident was cognitively intact and the resident had no behavior symptoms. Review of the resident's nursing progress notes, dated 09/02/24, showed no documentation any verbal or physical altercation between Resident #1 and Resident #3 on that date. During an interview on 09/04/24 at 11:40 A.M., the resident said the following: -A couple of days ago, he/she was frustrated that Resident #3 was in the hallway outside his/her room, and on the facility resident phone for a long period of time, when he/she (Resident #1) expected a call from his/her family; -He/She asked Resident #3 to get off the phone and Resident #3 became angry, started yelling at him/her, threw the phone down and then called him/her a bad name; -The activity director was in the dining room and told Resident #3 to go to his/her room to calm down and he/she did, but he/she did not stay there; -He/She walked into the dining room and Resident #3 came up to him/her and threw his/her shoulder into him/her (Resident #1), scratched his/her neck, and pulled a clump of his/her hair out; -The activity director and another staff person responded to the incident, and the activity director shielded him/her with her arms, while another staff pulled Resident #3 off him/her (Resident #1); -The activity director took him/her to her office for the afternoon and Resident #3 stayed on the unit; -He/She was upset and afraid after Resident #3 attacked him/her; -He/She and #3 were still on the same unit but avoided each other now. Observation on 09/04/24 at 11:45 A.M. showed the following: -The resident had a mildly red, linear scratch on the back of his/her neck, measuring approximately six inches in length and less than two millimeters in width; -The resident had a clump of brown hair wrapped up in a paper towel in his/her pocket that measured about the size of a half-dollar; -The resident had a small area of baldness along the left side of the scalp, and it measured about two inches in width by two inches in length. During an interview on 09/11/24 at 11:30 A.M., the resident's legal guardian said she was not made aware of the verbal or physical altercation between the resident and another resident on 09/02/24, or that Resident #1 had reported he/she felt scared and anxious and had reported physical injuries. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record showed no documentation that the facility had followed their policy and notified the resident's legal guardian, physician or medical director of the incident. During an interview on 09/04/24 at 2:15 P.M., the activity director said the following: -On 09/02/24, around 9:30 A.M., she was in the dining room when Resident #3 began yelling and cussing at Resident #1 because Resident #1 complained Resident #3 had been on the resident phone for too long; -She and another staff member told Resident #3 to calm down because Resident #3 was yelling and cussing at Resident #1, and she (the activity director) told Resident #3 to go to his/her room; -Resident #3 started yelling and cussing at her and another staff member while Resident #3 walked to his/her room; -She thought the situation was resolved because Resident #3 went to his/her room; staff did not follow Resident #3 to his/her room and did not stay with him/her; -Resident #3 returned to the dining area in a few minutes and used his/her shoulder to shove Resident #1 and then started to pull Resident #3's hair; -She called a code green (indicating additional staff are needed due to a resident is a threat to himself/herself or to others) when Resident #3 became physically aggressive towards Resident #1; -She and LPN A tried to separate the residents; she put her arms around Resident #1 because Resident #3 was still pulling at Resident #1's hair; -LPN A tried to pull Resident #3 off Resident #1; -The administrator was in the building and came to the unit when the code green was called; -She took Resident #1 to her office and off the unit for the afternoon so Resident #1 could calm down; -Resident #1 was initially teary and told her he/she was in shock, but then Resident #1 said he/she was calmer and he/she went back to the unit later in the afternoon; -Resident #3 remained on the unit; she was not sure if staff stayed with Resident #3 after the incident occurred; -The administrator had her and Resident #1 fill out a witness statement, and she probably had LPN A and a couple of other residents fill one out too. During an interview on 09/11/24 at 2:15 P.M., the resident's legal guardian said she was not made aware of the verbal or physical altercation between the resident and another resident on 09/02/24, or that the other resident had reported physical injuries caused by the resident (Resident #3). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record showed no documentation that the facility had followed their policy and notified the resident's legal guardian, physician or medical director of the incident. During an interview on 09/04/24 at 3:05 P.M., LPN A said the following: -He/She worked as the charge nurse on 09/02/24 from 06:00 A.M. to 06:00 P.M.; the hall/unit Resident #1 and Resident #3 resided on; -He/She was not aware of any altercation between Resident #1 and Resident #3 on that day; -He/She was not sure why the activity director said he/she had helped to separate Resident #1 and Resident #3 when a physical altercation took place. During an interview on 09/18/24 at 8:40 A.M., LPN A said the following: -On 09/02/24, Resident #3 was on the phone in the dining room (of the 400-500-600 unit) when Resident #1 started complaining because he/she wanted to use the phone; -He/She did not remember what the residents said to each other, but he/she knew the residents were in an argument by the tone of their voices; -He/She told the residents to separate, and the activity director took Resident #1 off the unit and LPN A told Resident #3 to go to his/her room; -He/She could not remember if any other staff went with Resident #3 to his/her room; -Resident #1 returned to the unit with the activity director, he/she could not remember how long Resident #1 was gone; -Resident #3 came out of his/her room and was not calmed down yet, LPN A could not remember how he/she knew Resident #3 was not calm; -Resident #3 went up to Resident #1 and pushed him/her and then pulled his/her hair; -LPN A and another staff member got in between Resident #1 and Resident #3 to separate them, but he/she could not remember which staff helped him/her separate the residents; -He/She could not remember if a code green was called; -Resident #1 was taken off the unit by the activity director again and LPN A thought Resident #3 was taken to his/her room by a certified nurse assistant (CNA), he/she could not remember; -He/She did not think Resident #1 and Resident #3 had any physical injuries but he/she could not remember if he/she did a physical assessment of the residents; -If he/she had done a physical assessment of the residents, he/she would have documented the assessment in the electronic medical record (EMR); (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She could not remember if he/she documented the events that occurred between Resident #1 and Resident #3 in the EMR; -He/She could not remember if he/she reported the events that occurred between Resident #1 and Resident #3 to administration; -He/She was not sure if the verbal exchange between Resident #1 and Resident #3 was abuse since he/she did not actually hear what was said; -He/She said physical altercations between residents would be considered resident-to-resident abuse; -Verbal and physical altercations between residents should be reported to administration; -A physical altercation and resident-to-resident assault should probably have been reported to the local law enforcement agency, he/she was not sure, but he/she did not report it. During an interview on 09/04/24 at 3:45 P.M. and at 4:30 P.M., the director of nurses (DON) said the following: -She was not aware of the verbal or physical altercation that occurred between Resident #1 and Resident #3 on 09/02/24; -The administrator was in the facility on 09/02/24. She was not sure why the incident was not reported to her (the DON); -She was not aware of any written statements completed by staff or residents related to the incident; -If she had been made aware of this incident, she would have reported it to the state agency in the appropriate time frame and begun an investigation; -LPN A just told her that he/she intervened in the altercation between Resident #1 and Resident #3 on 09/02/24 but did not report it to anyone because he/she was scared. During an interview on 09/04/24 at 5:30 P.M., the administrator said the following: -She was aware that there was a verbal altercation between Resident #1 and another resident on 09/02/24 when a code green was called; -She thought Resident #1 left the unit with the activity director after the verbal altercation with Resident #3; -She was not aware that Resident #3 physically attacked Resident #1 until today; -She was not aware of any written statements completed by staff or residents related to the incident; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265526	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chariton Park Health Care Center	902 Manor Drive Salisbury, MO 65281

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She would have reported this incident to the state agency and begun an investigation in the appropriate time frame if she had known about it. #MO00241466

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47246 Based on observation, interview and record review, the facility failed to investigate an allegation of verbal and physical resident to resident abuse involving two residents (Resident #1 and #3) in a sample of seven residents reviewed. The facility census was 117. Review of the facility policy, Abuse and Neglect, dated (revised 06/12/24), showed the following: -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology; -The facility will investigate all allegations and types of incidents as listed above in accordance to the facility procedure for reporting/response; -The administrator or designee will complete an administrative investigation to include personal statements from staff and residents involved in a situation that has any type of accusations of abuse either by staff or resident abuse; -The administrative investigation will consist of any pertinent information describing the situation being investigated, the names of all staff and residents involved, the root cause of the incident, the recommendations from the investigation including the facts that prove or disprove the alleged situation occurred, the plan of correction or action by the administrative staff, all statements attached from residents and staff involved and any training or education that the administration feels need to be provided to staff or residents to ensure education has been provided to prevent future similar situations; -The administrative investigation will also include a review of the resident's record to ensure that the documentation reveals that the legal guardian and/or responsible party was notified (if applicable), the physician was made aware, the resident was fully assessed, interventions and physician's orders were followed, the resident was re-evaluated, and the plan of care was updated to reflect the change in medical or behavioral status. 1. Review of Resident #1's face sheet, undated, showed he/she had a legal guardian. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 08/09/24, showed the resident was cognitively intact and had no behavior symptoms. During an interview on 09/04/24 at 11:40 A.M., the resident said the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A couple of days ago, he/she was frustrated that Resident #3 was in the hallway outside his/her room, and on the facility resident phone for a long period of time, when he/she (Resident #1) expected a call from his/her family; -He/She asked Resident #3 to get off the phone and Resident #3 became angry, started yelling at him/her, threw the phone down and then called him/her (Resident #1) a bad name; -The activity director was in the dining room and told Resident #3 to go to his/her room to calm down and he/she did, but he/she did not stay there; -He/She walked into the dining room and Resident #3 went up to him/her and threw his/her shoulder into him/her (Resident #1), scratched his/her neck, and pulled a clump of his/her hair out; -The activity director and another staff person responded to the incident, and the activity director shielded him/her with her arms, while another staff pulled Resident #3 off him/her (Resident #1); -The activity director took him/her to her office for the afternoon and Resident #3 stayed on the unit; -He/She was upset and afraid after Resident #3 attacked him/her; -He/She and #3 were still on the same unit but avoided each other now. -No one had spoken to him/her about the incident since. Observation on 09/04/24 at 11:45 A.M. showed the following: -Resident #1 had a mildly red, linear scratch on the back of his/her neck, measuring approximately six inches in length and less than two millimeters in width; -The resident had a clump of brown hair wrapped up in a paper towel in his/her pocket that measured about the size of a half-dollar; -The resident had a small area of baldness along the left side of the scalp, and it measured about two inches in width by two inches in length. During an interview on 09/04/24 at 2:15 P.M., the activity director said the following: -On 09/02/24, around 9:30 A.M., she was in the dining room when Resident #3 began yelling and cussing at Resident #1 because Resident #1 complained Resident #3 had been on the resident phone for too long; -She and another staff member told Resident #3 to calm down because Resident #3 was yelling and cussing at Resident #1, and she (the activity director) told Resident #3 to go to his/her room; -Resident #3 started yelling and cussing at her and another staff member while Resident #3 walked to his/her room; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She thought the situation was resolved because Resident #3 went to his/her room; staff did not follow Resident #3 to his/her room and did not stay with him/her; -Resident #3 returned to the dining area in a few minutes and used his/her shoulder to shove Resident #1 and then started to pull Resident #3's hair; -She called a code green (indicating additional staff are needed due to a resident is a threat to himself/herself or to others) when Resident #3 became physically aggressive towards Resident #1; -She and LPN A tried to separate the residents; she put her arms around Resident #1 because Resident #3 was still pulling at Resident #1's hair; -LPN A tried to pull Resident #3 off Resident #1; -The administrator was in the building and came to the unit when the code green was called; -The administrator had her and Resident #1 fill out a witness statement, and she thought the administrator had LPN A and a couple of other residents fill one out too. During an interview on 09/04/24 at 3:05 P.M., LPN A said the following: -He/She worked as the charge nurse on 09/02/24 from 06:00 A.M. to 06:00 P.M. on the unit Resident #1 and Resident #3 reside on; -He/She was not aware of any altercation between Resident #1 and Resident #3 on that day; -He/She was not sure why the activity director said he/she had helped to separate Resident #1 and Resident #3 when a physical altercation took place. During an interview on 09/04/24 at 3:45 P.M. and at 4:30 P.M., the Director of Nurses (DON) said the following: -She was not aware of the verbal or physical altercation that occurred between Resident #1 and Resident #3 on 09/02/24; -The administrator was in the facility on 09/02/24; she was not sure why the incident was not investigated; -She was not aware of any written statements completed by staff or residents related to the incident; -If she had been made aware of this incident, she would have begun an investigation. During an interview on 09/04/24 at 5:30 P.M., the administrator said the following: -She was aware that there was a verbal altercation between Resident #1 and another resident on 09/02/24 when a code green was called; (continued on next page)

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