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	09/12/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46506 Based on interview and record review, the facility failed to provide adequate supervision/oversight following an altercation involving two residents (Resident #1 and #3), in a review of seven sampled residents. While Residents #1 and #3 were on one-on-one supervision following the altercation, staff failed to adequately separate the residents and intervene to ensure the second altercation, involving Resident #1 and #2, did not occur. The facility census was 117. Review of the facility's Behavioral Emergency Policy, last revised 6/26/24, showed the following: -All staff should recognize when the resident has become or can become a danger to themselves or someone else. De-escalation techniques should be utilized as first resort; -Should the resident exhibit extreme behaviors such as resident-to-resident altercations which did not respond to non-violent intervention, the licensed nursing staff and/or nursing administration will assess the resident who is displaying signs of crisis, ensuring that safety of resident and others is the priority. Monitoring of the resident will be initiated, if appropriate. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 9/2/24, showed the following: -Moderately impaired cognition; -Diagnoses included anxiety disorder (group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation) and schizophrenia (chronic mental illness that affects how a person thinks, feels, and behaves); -No behaviors directed toward others. Review of the resident's undated Care Plan showed the following: -The resident's current diagnoses are schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder) and schizophrenia. His/Her symptoms included periods of grossly disorganized thought and behavior and included walking day and night, auditory hallucinations, and bizarre delusional ideation; (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Non-pharmaceutical interventions including one-on-one as needed; -Monitor/record/report to physician as needed for risk for harming others, increased anger, labile mood or agitation, or feelings of being threatened by others or thoughts of harming someone. 2. Review of Resident #3's undated Care Plan showed the following: -The resident had a history of mental illness. He/She experienced frequent manic episodes with multiple psychiatric admissions and bizarre combative behavior. His/Her psychosis sufficiently severe to create marked impairment in social and occupational functioning. He/She lacked any insight into limitations, mental illness and coping; -Staff will redirect the resident when negative behaviors are observed; -Walks the unit with music/earbuds rapping loudly and preferred genre often potentially offensive to others due to foul language and violent nature. The resident frequently needs redirection to lower volume as well as his/her own voice, so as not to disturb others. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -He/She experienced disorganized thinking that fluctuated, hallucinations, delusions, and verbal behaviors directed towards others; -Diagnoses included schizoaffective disorder, bipolar type (a mental illness with episodes of extreme highs and sometimes severe lows), anxiety disorder, and personality disorder (mental health condition that involves long-lasting, disruptive patterns of thinking, behavior, mood and relating to others). 3. Review of Resident #2's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -He/She had hallucinations and delusions; -He/She did not have any behaviors directed towards others. Review of the resident's undated care plan showed the following: -The resident had a psychosocial wellbeing problem related to anxiety (feeling of fear, dread, or uneasiness), schizoaffective disorder, bipolar (mental illness that causes extreme shifts in mood, energy, and activity levels), personality disorder (mental health condition that involves long-lasting, disruptive patterns of thinking, behavior, mood and relating to others), obsessive compulsive disorder (chronic mental condition that causes people to have unwanted, intrusive thoughts and repetitive behaviors), and antisocial disorder (mental health condition that causes harmful behaviors without remorse); (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When conflict arose, the staff were to remove the resident to a calm safe environment and low to vent/share feelings. -Behavioral symptoms per PASRR Level 2 included: suspicious of others. -If the staff saw the resident exhibiting any behaviors listed in this section, refer to coping skills and redirect immediately; -Coping skills included walking, listening to music, and drawing/writing. -The resident's safety plan showed he/she felt his/her warning sign was anger. 4. Review of the facility's investigation report, dated 9/6/24, showed the following: -Resident #3 yelled to Certified Medication Technician (CMT) G and did not quiet when asked to do so. Resident #1 approached the medication room and was annoyed by the noise and yelling. Resident #1 asked Resident #3 to be quiet, and Resident #3 continued yelling and replied he/she could be as loud as he/she liked; -As CMT G got between Resident #1 and Resident #3, Resident #1 hit CMT G, and Resident #3 pushed Resident #1 down. Staff immediately separated the residents and put them on one-on-one supervision. The staff received orders to send Resident #3 to the hospital; -Resident #3 was on one-on-one with Licensed Practical Nurse (LPN) H. He/She went to his/her room for approximately 15 minutes and then went to the common area. Resident #3 yelled at LPN H and accused him/her for hating his/her ethnicity; -Resident #1 went to his/her room with CMT E, who provided one-on-one supervision. Resident #1, while escorted by CMT E, went to the dining room to get a snack. Resident #1 passed Resident #3 and Resident #2, who sat at dining room table talking. Resident #1 attempted to talk to Resident #3, at which time, CMT E asked Resident #1 to keep moving. Resident #2 stood up and told Resident #1 to leave. Resident #1 turned and reached for Resident #2, and Resident #2 struck Resident #1 in the mouth; -Conclusion/Outcome of the Investigation: While on one-on-one supervision awaiting transport to the hospital, Resident #3 spoke to Resident #2 about his/her altercation with Resident #1. Resident #1 heard his/her name while walking by. Resident #2 stood to tell Resident #1 to move on, perhaps as a chivalrous gesture. Resident #2 said, based on Resident #3's conversation, he/she felt the need to defend them. During an interview on 9/11/24 at 2:57 P.M., CMT E said the following: -He/She started one-on-one supervision with Resident #1 after the altercation with Resident #1 and #3; -Resident #1 wanted to go back to the dining room to get a snack, so he/she went with him/her; -Resident #3 was with LPN H and Resident #2 at the dining room table directly outside of Resident #1's hallway; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #1 headed over to the table (where Residents #2 and #3 sat). He/She (CMT E) told the resident not to stop and to keep moving, but Resident #1 went up to the table; -Resident #2 told Resident #1 to go away, then stood up from the table; -He/She didn't want to get between the residents, because he/she didn't want to get hurt; -Resident #2 hit Resident #1 first. During an interview on 9/11/24 at 3:45 P.M., the Director of Nursing (DON) said the following: -She expected staff to respond immediately to de-escalate a situation where a resident was having behaviors and protect the resident from harm; -On the day of the altercations, Resident #3 yelled at LPN H, who was providing one-on-one supervision, about being prejudice against him/her because of the resident's ethnicity; -LPN H stayed an arm's length away from Resident #3 to prevent further agitation; -The altercation (between Resident #1 and Resident #2) happened too fast; -Resident #1 heard a peer (Resident #3) say his/her name. Resident #1 walked toward the table where Resident #2 and Resident #3 sat. CMT E told Resident #1 to walk away just as Resident #2 stood up and hit Resident #1. During an interview on 9/18/24 at 2:11 P.M., the Interim Administrator said the following: -The staff provided resident safety per her expectation; -LPN H provided one-on-one supervision to Resident #3 and was not intimidated of the resident accusations (prejudice of his/her ethnicity), but kept a distance to prevent further agitating Resident #3; -He/She expected the staff to keep Resident #1 and Resident #3 apart after the altercation (involving Resident #1 and #3). CMT E told Resident #1 to move along away from the table (where Residents #2 and #3 sat) but Resident #1 didn't listen; -CMT E provided one-on-one supervision to Resident #1 and intervened to prevent the altercation between Resident #1 and Resident #2, but it happened fast; -If Resident #2 and Resident #3 were discussing the previous altercation (involving Resident #1 and Resident #3), then the staff should have cued the residents to change the subject. During an interview on 9/24/24 at 9:33 A.M., LPN H said the following: -Resident #3 did not want to stay in his/her room but wanted to be around peers in dining room; (continued on next page)

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