STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265646	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Belle Manor Care Center	1002 Central LA Belle, MO 63447

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 33955 Based on interview and record review, the facility failed to ensure one resident (Resident #7), of nine sampled residents,was free from physical restraints after the resident presented with verbal behaviors. Staff forced the resident to sit in a wheelchair by physically pushing the resident down into a wheelchair when the resident refused to walk to his/her room. The resident was normally able to ambulate independently. Once in the wheelchair, staff physically removed the resident's hands when the resident held onto the wheels of the chair to prevent staff from moving him/her. Staff placed footrests on the wheelchair when the resident used his/her feet to prevent the chair from moving so that staff could transport the resident to his/her room. The facility census was 41. The facility did not provide a policy on physical restraints upon request. 1. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 2/23/24, showed the following: -The resident was cognitively intact; -No behaviors present; -He/She was independent with ambulation; -Diagnoses of epilepsy (chronic brain disorder that causes repeated seizures, which are abnormal electrical discharges in the brain) and unspecified lack of expected normal physiological development in childhood. Review of the resident's Care Plan, dated 2/23/24, showed the following: -The resident was resistive to the nurse at times related to anxiety, with example of showering without his/her family member present; -Allow the resident to make decisions about treatment regimen to provide sense of control; -Encourage as much participation/interaction by the resident as possible during care activities; -Give clear explanation of all care activities prior to and as they occur during each contact; (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor the resident and his/her family member's behaviors towards each other; -Praise the resident when behavior is appropriate; -The resident liked coloring in adult coloring books, listening to music on his/her phone with headphones, walking to the country store, playing Bingo weekly, and going on outings. Review of the resident's Social Services Note, dated 11/13/24 at 9:16 A.M., showed the following: -The resident was out of control cursing and yelling; -He/She was scheduled to go to a physician's appointment but the resident's family member was unable to take the resident and the facility transporter was off; -The resident was so angry and couldn't control himself/herself and went off on everybody; -The resident thought someone should be called in on their day off to take him/her, when the staff told the resident no, the resident became angrier; -The resident went all over the facility cursing and did not stop; -Other residents were doing activities in the north dining room when the resident started cussing. The staff asked the resident to stay in his/her room until the resident cooled off; -The Social Services Director called the resident's guardian, but the guardian had to do something else and had to go. Review of the resident's Nurse Note, dated 11/13/24 at 11:15 A.M., showed the following: -The nurse asked the resident to go to his/her room several times; -The resident said he/she was waiting for Tylenol, which the nurse explained the resident could not have Tylenol at that time because the resident received it with morning medications and it was too soon; -The nurse asked the resident again to go to his/her room as the resident was being disruptive and had been asked by multiple staff; -The resident refused to go to his/her room on his/her own; -The nurse attempted to assist the resident into a standing position by hooking the nurse's right arm under the resident's left arm and was unable to get the resident to move, so the nurse asked for assistance from Certified Medication Tech (CMT) G; -The nurse and CMT G were able to assist the resident into a standing position using the same technique, one staff member one each side of the resident with their arms looped with the resident; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident continued to be resistive as the staff attempted to walk the resident to his/her room. At that time the nurse went behind the resident and held onto his/her hips while CMT G walked backwards in front of the resident holding his/her hands, while the staff continued to ask the resident to go to his/her room on his/her own so they didn't have to continue to disrupt the other residents this way and it was disrespectful to the other residents; -The staff and resident got in front of the nurses' station, then the resident refused to move his/her feet any further and began pushing her body against the nurse. CMT G hugged the resident around the waist to keep the resident in a standing position and asked another staff member to get a wheelchair; -The resident said the staff didn't know the other half of why he/she was upset and the nurse said the resident could tell them when he/she was in his/her room; -The nurse instructed the resident to sit in the wheelchair so they could continue down to his/her room, but the resident resisted, the staff applied pressure to resident's shoulders and upper thighs and lowered him/her into the chair; -The staff took the resident down to his/her room with resistance, as the resident kept grabbing the wheels and causing the chair to stop; -Once in the resident's room; -The staff locked the brakes on the wheelchair and left the room. During an interview on 11/14/24 at 12:00 P.M., Licensed Practical Nurse (LPN) E said the following: -The staff canceled the resident's appointment because his/her transportation was not available; -The resident was upset because he/she was looking forward to the trip; -The resident started cussing, yelling, stomping in the hallways, and slammed doors; -Another resident tried to go to the restroom but Resident #7 followed him/her into the restroom, so staff told the resident to stay out and give the other resident some privacy; -The nurse told the resident he/she was being rude and disrespectful to the other residents and asked the resident to go to his/her room until they could help the resident through the frustration, however, the resident said, no; -The Social Services Director asked the resident to go back to his/her room so they could talk and the resident said no; -Licensed Practical Nurse (LPN) E placed one hand on the resident's upper arm and another at the waist and guided the resident towards his/her room; -The resident suddenly stopped and refused to go any further; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN E went to get a CMT for assistance; -The resident sat in a high back chair in the back dining room and refused to move; -Both staff members wrapped an arm around both of the resident's arms and assisted him/her to stand up from the chair; -Both staff members guided the resident across the dining room and at the nurses' station the resident stopped; -The CMT G took both resident's hands and LPN E put both hands on the resident's waist to guide the resident towards his/her room, but the resident wouldn't move and instead attempted to fall backwards; -LPN E told the resident to stop and another employee obtained a wheelchair; -LPN E placed the wheelchair behind the resident and told him/her to sit down, but the resident refused; -LPN E placed his/her hand on the resident's shoulder and pushed down, so the resident sat down; -LPN E and the CMT G took the resident down to his/her room via wheelchair; -The staff left the resident in his/her room with another resident present. During an interview on 11/14/24 at 12:50 P.M., the resident said the following: -The resident was mad because an appointment was canceled again; -He/She was waiting at the nurses' station for Tylenol but the staff told him/her to go back to his/her room; -The resident told the staff he/she did not want to and was waiting on Tylenol but LPN E made him/her go anyway by force, leading him/her down the hall and pushing him/her in a wheelchair to the room. The resident did not want to go to his/her room; -LPN E told the resident to stay in his/her room until the resident could calm down; -The resident was not scared of staff, he/she was mad because he/she had to go back to his/her room; -He/She felt the staff treated him/her like a child but he/she was an adult. During an interview on 11/14/24 at 3:45 P.M., the Director of Nursing said the following: -The resident was cussing and yelling around other residents who were participating in activities; -The staff asked the resident to go to his/her room and calm down multiple times; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The staff got the resident up and the resident stood still; -The staff got a wheelchair for him/her to sit down; -LPN E and CMT G acted the way he/she expected; -The staff did not attempt any other interventions because the resident was not redirectable. During an interview on 11/14/24 at 4:15 P.M., and 11/27/24 at 11:00 A.M. the Administrator said the following: -The resident did have behaviors; -He/She previously had behaviors of yelling and cussing at the Administrator; -When the resident was in these moods, the resident did not redirect easily; -The behaviors were almost like a tantrum; -In the past, the resident became so mad that he/she punched the wall and door in his/her room; -The staff have told the resident the behavior was inappropriate and not tolerated; -The administrator expected staff to attempt other interventions on the resident's care plan before physically taking the resident to his/her room. During an interview on 11/15/24 at 2:18 P.M., the resident's Nurse Practitioner said the following: -He/She witnessed the resident's behavior on 11/13/24; -Several staff members spoke with the resident about going to his/her room because he/she was upsetting the other residents but the resident refused; -Two staff attempted to get the resident to walk but he/she refused; -The two staff members got the resident to sit in the wheelchair and started toward his/her room; -The resident put his/her feet down on the floor to prevent the staff from going any further so the staff put footrests on the wheelchair to prevent the resident from putting his/her feet down; -The staff started again but the resident grabbed hold of the wheels to prevent it from going any further; -The staff took the resident's hands off the wheels and continued to his/her room. MO245107

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F 0742 Level of Harm - Minimal harm or potential for 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. 46506 Based on interview and record review, the facility failed to ensure one resident (Resident #7) with a developmental delay and learning disability, in a review of nine sampled residents, received person centered interventions to address behaviors affecting others that did not make the resident feel like staff were treating him/her like a child. Staff told the resident to go to his/her room when the resident displayed disruptive behaviors. The staff physically took the resident to his/her room even when the resident refused instead of attempting other interventions to address the resident's behaviors. The facility census was 41. The facility did not provide a policy on providing care and services for residents with behavioral issues upon request. 1. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 2/23/24, showed the following: -The resident was cognitively intact; -No behaviors present; -He/She was independent with ambulation; -Diagnoses of epilepsy (chronic brain disorder that causes repeated seizures, which are abnormal electrical discharges in the brain) and unspecified lack of expected normal physiological development in childhood. Review of the resident's Care Plan, dated 2/23/24, showed the following: -The resident was resistive to the nurse at times related to anxiety, with example of showering without his/her family member present; -Allow the resident to make decisions about treatment regimen, to provide sense of control; -Encourage as much participation/interaction by the resident as possible during care activities; -Give clear explanation of all care activities prior to and as they occur during each contact; -Monitor the resident and his/her family member's behaviors towards each other; -Praise the resident when behavior is appropriate; -The resident liked coloring in adult coloring books, listening to music on his/her phone with headphones, walking to the country store, playing Bingo weekly, and going on outings. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Behavior Note, dated 5/18/24 at 2:19 P.M., showed the following: -The resident asked staff to take a photo of him/her to send to a friend online; -The staff explained, they were unable to take the photo; -The resident said it was the person he/she was dating and the person wanted naked photos; -The resident denied sending any photos. Review of the resident's Social Services Note, dated 5/20/24 at 4:02 P.M., showed the following: -The resident carved on the back of his/her room door because he/she was mad; -The social services director called the guardian regarding the resident's behaviors of carving in the door and asking staff to take pictures for a person online; -The guardian said maybe he/she should take the resident's the phone and tablet. Review of the resident's Care Plan showed no updates following the residents behaviors on 5/18/24 and 5/20/24. Review of the resident's Nurse Note, dated 7/11/24 at 3:35 P.M., showed the following: -The resident was upset with social services regarding a trip to visit a family member in the hospital; -The resident cursed at staff and was upset with a family member. Review of the resident's Social Service note, dated 7/11/24 at 4:00 P.M., showed the following: -The resident went into the social services director's office screaming and demanding the staff member to call his/her guardian about going with a sibling to see a parent at the hospital; -The social services director explained the guardian approved for the resident to leave with another family member; -The resident yelled, the family member needed to stay out of his/her business and the resident was done with the guardian. Review of the resident's Care Plan showed no updates following the resident's behaviors on 7/11/24. Review of the resident's Social Services Note, dated 7/31/24 at 1:47 P.M., showed the following: -The resident went to the Social Service Director's office and said a resident of the opposite sex asked him/her to go to bed with him/her; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was all over the other resident the day before; -The staff instructed the resident to stay away from the other resident. Review of the resident's Social Services Note, dated 8/5/24 at 1:47 P.M., showed the following: -The resident kept approaching a staff member from the kitchen and wanted the staff member to come help the resident in his/her room; -The resident wore only a bra and underwear, asking the staff member why he/she recently started working at the facility; -The administration told the kitchen staff to give the resident's snacks to the nurse to give to the resident. Review of the resident's Care Plan, dated 8/5/24, showed the following: -The resident has potential to be physically and verbally aggressive (hitting walls, slamming doors, using profanity), related to anger/temper; -Analyze times of day, places, circumstances, triggers, and what de-escalated behavior and document; -Give the resident as many choices as possible about care and activities; -The resident liked everything to be his/her way and becomes angry when asked to do something, i.e., to come out of his/her room during the day, triggers for physical aggression; -Monitor/document/report as needed any signs/symptoms of resident posing danger to self and others; -Psychiatric consult as indicated; -Redirect resident to his/her room to calm down so it does not interrupt other residents; -The resident had a behavior problem talking inappropriately about sex; -Explain to the resident that it is inappropriate for him/her to be in a state of undress in the building other than in his/her room or shower and that anytime anyone enters his/her room, the resident should be completely dressed; -The resident sometimes speaks of sex and wanting the young staff from kitchen to come into his/her room. He/She was in a state of undress; -The resident wanted to run around the building with inappropriate clothing that was not covering him/her. The staff redirected the resident to his/her room to dress appropriately. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 8/23/24, showed the following: (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was cognitively intact; -No behaviors present; -He/She was independent with ambulation; -Diagnoses of epilepsy (chronic brain disorder that causes repeated seizures, which are abnormal electrical discharges in the brain) and unspecified lack of expected normal physiological development in childhood. Review of the resident's Nurse Note, dated 9/11/24 at 1:16 P.M., showed the resident wore a night gown all day with a tear on the underarm allowing the side of his/her chest to be exposed. The resident was defiant even when the Administrator and Director of Nursing (DON) attempted to instruct the resident on rationale to change. The resident did not change out of the gown. Review of the resident's Nurse Note, dated 9/12/24 at 11:46 A.M., showed the following: -The resident pushed a resident in a wheelchair forcefully and allowed the other resident to go freely in the wheelchair; -The staff attempted to redirect the resident about the dangers in this, but the resident remarked back he/she did this all the time and became defiant; -The staff instructed the resident to get dressed as he/she was in night clothes, the resident said this was his/her home and he/she could dress as he/she pleased; -The staff attempted to explain as that was true, they were in a group setting and the resident needed to respect others as well. Review of the resident's social services note, dated 9/13/24 at 2:30 P.M., showed the following: -The Social Services Director spoke with the resident's guardian, regarding the resident's behavior that week and asked about who was coming to see the resident for an independent living facility (ISL); -The guardian said they were waiting on a court date for the resident's family member to take guardianship. Review of the resident's nurse note, dated 9/22/24 at 12:46 A.M., showed the following: -The resident came up to the nurses' station asking for Tylenol; -The nurse asked the resident why he/she was not in bed and the resident said he/she and another resident were watching a movie; -The nurse told the resident that it was midnight and the resident proceeded to argue with the nurse and said, it was not midnight but a little after 11:00 P.M.; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse showed the resident the time on his/her personal cell phone and the resident said he/she only followed the time on his/her own phone; -The nurse told the resident he/she needed to go to bed because it was late and the television was supposed to be turned off at 10:00 P.M., per the DON; -The resident said the DON was not his/her parent; -The nurse said he/she would talk with the Administrator about the resident being told to go to bed every night; -The resident continued to argue with the nurse then stormed off to another resident's room. Review of the resident's Care Plan showed no additional interventions were added regarding the resident's behaviors on 9//11/24, 9/12/24 and 9/22/24. Review of the resident's medical record showed no documentation the physician was notified of the resident's behaviors on 9/11/24, 9/12/24 and 9/22/24. Review of the resident's Social Services Note, dated 11/13/24 at 9:16 A.M., showed the following: -The resident was out of control cursing and yelling; -He/She was scheduled to go to a physician's appointment, but the resident's family member was unable to take the resident and the facility transporter was off; -The resident was so angry and couldn't control himself/herself and went off at everybody; -The resident thought someone should be called in on their day off to take him/her, when the staff told the resident no, the resident became angrier; -The resident went all over the facility cursing and did not stop; -Older residents were doing activities in the north dining room when the resident started cussing, the staff asked the resident to stay in his/her room until the resident cooled off; -These behaviors happened most every day, the resident always said he/she would tell his/her family; -The Social Services Director called the resident's guardian, but the guardian had to do something else and had to go. Review of the resident's nurse note, dated 11/13/24 at 9:45 A.M., showed the nurse heard the resident cussing from the hallway, so the nurse told the resident that the language was not appropriate at the facility, however, the resident did not acknowledge the nurse was talking and continued down the hallway. Review of the resident's Nurse Note, dated 11/13/24 at 10:07 A.M., showed the following: (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident said his/her family member could not take the resident to an appointment and asked the staff to call the Restorative Aide (RA) as the resident tried to get hold of the RA to see if he/she could take the resident to the appointment; -The staff explained social services would be in the facility and could help the resident; -The resident waited at every room the staff member entered and upon coming out of the rooms, asked for phone numbers of other staff and he/she wanted to go to the appointment; -The staff attempted to rationalize with the resident that they were doing all they could do on short notice; -The resident woke up another resident after the staff asked him/her not to do this. Staff attempted to reinforce this resident could not help Resident #7. Review of the resident's Nurse Note, dated 11/13/24 at 11:15 A.M., showed the following: -The nurse asked the resident to go to his/her room several times; -The resident said he/she was waiting for Tylenol; the nurse explained the resident could not have Tylenol at that time because the resident received it with morning medications and it was too soon; -The nurse asked the resident again to go to his/her room as the resident was being disruptive and had been asked by multiple staff; -The resident refused to go to his/her room on his/her own; -The nurse attempted to assist the resident into a standing position by hooking the nurse's right arm under the resident's left arm and was unable to get the resident to move, so the nurse asked for assistance from Certified Medication Tech (CMT) G; -The nurse and CMT G were able to assist the resident into a standing position using the same technique, one staff member one each side of the resident with their arms looped with the resident; -The resident continued to be resistive as the staff attempted to walk the resident to his/her room. At that time the nurse went behind the resident and held onto his/her hips while the CMT G walked backwards in front of the resident holding his/her hands, while the staff continued to ask the resident to go to his/her room on his/her own so they didn't have to continue to disrupt the other residents this way and it was disrespectful to the other residents; -The staff and resident got in front of the nurses' station, then the resident refused to move his/her feet any further and began pushing her body against the nurse. CMT G hugged the resident around the waist to keep the resident in a standing position and asked another staff member to get a wheelchair; -The resident said the staff didn't know the other half of why he/she was upset and the nurse said the resident could tell them when he/she was in his/her room; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse instructed the resident to sit in the wheelchair so they could continue down to his/her room, but the resident resisted, the staff applied pressure to resident's shoulders and upper thighs and lowered him/her into the chair; -The staff took the resident down to his/her room with resistance, as the resident kept grabbing the wheels and causing the chair to stop; -Once in the resident's room, the nurse asked him/her what was the other half of why he/she was upset, the resident refused to say; -The staff locked the brakes on the wheelchair and left the room; -The nurse returned five minutes later and took the wheelchair out of the room. The resident was in bed. Review of the resident's Activity Note, dated 11/14/24 at 9:23 A.M., showed the following: -On 11/13/24 the resident asked administration why the housekeepers could not transport him/her to the appointment; -The staff told the resident, the housekeepers had never transported anyone before and they were not able to do so; -The resident became irate with everyone in the building, cussing out the administrator and DON; -The Activity Director was in the morning activity and could hear the resident screaming at the Administrator and DON through the double doors over the music playing; -The resident went through the double doors and turned around to scream at the DON; -The Activity Director asked the resident to not cuss in front of the other residents because it was visibly upsetting them and making them agitated and a little frightened of the resident due to the outburst. The resident said he/she didn't care; -The resident was beyond the point of reason; -The staff redirected the resident several times but the resident did not care; -The outburst lasted from 9:00 A.M. until 12 P.M. Review of the resident's care plan showed no updates or interventions added regarding the resident's behaviors on 11/13/24. During an interview on 11/14/24 at 12:00 P.M., Licensed Practical Nurse (LPN) E said the following: -The staff canceled the resident's appointment because his/her transportation was not available; -The resident was upset because he/she was looking forward to the trip; (continued on next page)

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	265646	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Belle Manor Care Center	1002 Central LA Belle, MO 63447

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident wanted other staff members contacted to provide transportation because the facility's transportation driver had a day off; -None of the other staff were available to transport the resident to the appointment; -The resident started cussing, yelling, stomping in the hallways, and slammed doors; -Another resident tried to go to the restroom but Resident #7 followed him/her into the restroom, so staff told the resident to stay out and give the other resident some privacy; -The nurse told the resident he/she was being rude and disrespectful to the other residents and asked the resident to go to his/her room until they could help the resident through the frustration, however, the resident said, no; -The Social Services Director asked the resident to go back to his/her room so they could talk and the resident said no; -LPN E placed one hand on the resident's upper arm and another at the waist and guided the resident towards his/her room; -The resident suddenly stopped and refused to go any further; -He/She went to get a CMT for assistance; -The resident sat in a high back chair in back dining room and refused to move; -Both staff members wrapped an arm around both of the resident's arms and assisted him/her to stand up from the chair; -Both staff members guided the resident across the dining room and at the nurses' station the resident stopped; -CMT G took both of the resident's hands and LPN E put both hands on the resident's waist to guide the resident towards his/her room, but the resident wouldn't move and instead attempted to fall backwards; -LPN E told the resident to stop and another employee obtained a wheelchair; -LPN E placed the wheelchair behind the resident and told him/her to sit down, but the resident refused; -LPN E placed his/her hand on the resident's shoulder and pushed down, so the resident sat down; -LPN E and the CMT G took the resident down to his/her room via wheelchair; -The staff left the resident in his/her room with another resident present; -Around 2:30 P.M., the resident was up walking in the dining room, calm and quiet; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The staff did not attempt any other interventions because the resident was not redirectable; -The resident was dependent on on another resident for emotional support and guidance; -The other resident had a stroke in July 2024, which affected his/her speech and mobility; -The other resident was moved from next door to Resident #7 to the front hall, so the other resident would have more privacy and could focus on rehab; -Resident #7 was able to walk to the front hall to see the other resident but it was an adjustment; -When the resident was not redirectable, then the staff were supposed to tell the resident to go to his/her room. During an interview on 11/14/24 at 12:50 P.M., the resident said the following: -The resident was mad because an appointment was canceled again; -He/She was waiting at the nurses' station for Tylenol (pain medication), but the staff told him/her to go back to his/her room; -The resident told the staff he/she did not want to and was waiting on Tylenol but LPN E made him/her go anyway by force, leading him/her down the hall and pushing him/her in a wheelchair to the room; -LPN E told the resident to stay in his/her room until the resident could calm down; -The resident was not scared of staff, he/she was mad because he/she had to go back to his/her room; -He/She felt the staff treated him/her like a child but he/she was an adult. During an interview on 11/14/24 at 1:32 P.M., the Social Services Director said the following: -He/She scheduled the appointment and the resident's family member said he/she would take the resident to the appointment; -The transportation driver was off because no residents were scheduled for transportation; -The resident's family member called the morning of the appointment to report he/she was not available to transport the resident; -When the resident did not get his/her way, the resident exploded and became loud, cussing and other behaviors; -On 11/13/24, the resident went into the Administrator's office and started cussing and yelling at the Administrator; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Administrator told the resident his/her behavior was inappropriate and go to his/her room; -The resident refused so the staff had to work with him/her to get the resident in his/her room. During an interview on 11/14/24 at 3:45 P.M., the Director of Nursing said the following: -The resident was cussing and yelling around other residents who were participating in activities; -The staff asked the resident to go to his/her room and calm down multiple times; -The staff got the resident up and the resident stood still; -The staff got a wheelchair for him/her to sit down; -LPN E and CMT G acted the way he/she expected; -The staff did not attempt any other interventions because the resident was not redirectable. During an interview on 11/14/24 at 4:15 P.M., and 11/27/24 at 11:00 A.M. the Administrator said the following: -The resident did have behaviors; -He/She previously had behaviors of yelling and cussing at the Administrator; -When the resident was in these moods, the resident did not redirect easily; -The behaviors were almost like a tantrum; -In the past, the resident became so mad that he/she punched the wall and door in his/her room; -The staff have told the resident the behavior was inappropriate and not tolerated; -The administrator expected staff to attempt other interventions listed on the resident's care plan before physically taking the resident to his/her room. During an interview on 11/15/24 at 2:18 P.M., the resident's Nurse Practitioner said the following: -He/She witnessed the resident's behavior on 11/13/24; -Several staff members spoke with the resident about going to his/her room because he/she was upsetting the other residents but the resident refused; -Two staff attempted to get the resident to walk but he/she refused; -The two staff members got the resident to sit in the wheelchair and started toward his/her room; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident put his/her feet down on the floor to prevent the staff from going any further so the staff put footrests on the wheelchair to prevent the resident from putting his/her feet down; -The staff started again but the resident grabbed hold of the wheels to prevent it from going any further; -The staff took the resident's hands off the wheels and continued to his/her room; -Staff never asked the Nurse Practitioner to evaluate or assess the resident for behaviors; -He/She never saw the resident have this type of behavior previously. During an interview on 11/15/24 at 2:51 P.M., the resident's physician said the following: -The DON and other nurses kept him/her informed about the resident's behaviors; -When the resident did not sleep well his/her behaviors became worse; -He/She did not make any changes in the resident's medication orders or recommend therapy yet, but would when he/she thinks it was necessary and would benefit the resident. MO245107