| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265704 | A. Building<br>B. Wing | 06/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Estates of Perryville, Llc, The | 430 North West Street<br>Perryville, MO 63775 |

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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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on interview and record review, the facility failed to ensure one resident (Resident #1) was free from physical abuse when a staff member punched the resident in the face. Resident #1 was observed with escalating behaviors and pushed a staff member. Certified Nurse Aide (CNA) A approached the fighting resident and staff member and proceeded to punch Resident #1 with a closed fist, in the right eyesocket. This resulted in an injured eyelid and broken nose for Resident #1. The census was 101.<br><br>The administration was notified on 06/10/25 of the Past Non-Compliance Immediate Jeopardy (IJ) which occurred 06/05/25. On 06/05/25, upon notification, the facility administration immediately started an investigation, notified the police department and the Department of Health and Senior Services of the physical abuse. The facility terminated employment of CNA A and in-serviced all staff on the facility's policy and procedures for abuse and neglect. The IJ was corrected on 06/05/25,<br><br>Review of the facility's policy on Abuse, Neglect and Exploitation Policy, dated 04/08/24 showed:<br><br>- Each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. The resident must not be subject to abuse by anyone including but not limited to: facility staff; other residents; consultants or volunteers; staff of other agencies; family; legal guardians; friends or other individuals.<br><br>- Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain, or mental anguish.<br><br>Review of Resident #1's face sheet showed:<br><br>- The resident is his/her own responsible party;<br><br>- The diagnoses included major depression disorder (a mental disease characterized by persistent sadness), Post Traumatic Stress Disorder (PTSD) (a life changing mental health disorder that can occur after a traumatic event causing significant impair to daily life), Traumatic Brain Injury (TBI) (a brain injury caused by a physical force or blow to the head affect the person's cognitive function), Alzheimer's (a progressive disease causing loss of cognitive function), and Paranoid Schizophrenia (a mental disorder characterized by disruptions in thought, perception, and behavior. Specifically marked by symptoms of paranoia, delusions and hallucinations.)<br><br>Review of Resident #1's Active Order Summary (Physician's Orders) current as of 06/10/25 showed:<br><br>(continued on next page) |



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

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - An order for behavior monitoring every shift started 05/10/24; (Documentation of behavior monitoring was not provided.)<br><br>- An order for geodon (antipsychotic) 40 milligrams (mg) by mouth twice a day with meals for paranoid schizophrenia started on 06/06/25;<br><br>- An order for lorazepam (anti-anxiety) injection solution 2 mg/milliliter (ml) every 8 hours as needed for agitation for 14 days started 06/05/25;<br><br>- An order for lorazepam oral tablet 1 mg by mouth three times a day started 06/06/25;<br><br>- An order for risperidone (antipsychotic) oral tablet 2 mg two times a day for schizophrenia started 12/18/23.<br><br>Review of Resident #1's care plan dated 06/12/24 showed:<br><br>- The resident requires a supervised environment and supervision with all activities of daily living (ADL) care;<br><br>- The resident will become physically and verbally aggressive when not getting what he/she has asked for and will scream when staff attempt to de-escalate;<br><br>- Psychiatry to follow up and prescribe/manage medications;<br><br>-The resident smokes and will yell when wanting to smoke if not allowed to do so, this is his/her repetitive behavior;<br><br>- The resident has intellectual disabilities;<br><br>- There were no documented interventions in place for helping to manage the resident's escalating behaviors.<br><br>Review of Resident #1's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 03/12/25, showed:<br><br>- The resident has some cognitive inabilities;<br><br>- The resident requires supervision with all aspects of daily ADLs.<br><br>Review of the facility's investigation dated 06/05/25 showed:<br><br>- On 06/05/25 at approximately 6:00 A.M., Resident #1 approached Registered Nurse (RN) B and requested a cigarette and a soda;<br><br>- RN B told the resident he/she would have to wait until the scheduled smoke time at 8:00 A.M.;<br><br>- The resident was becoming agitated and the RN exited the office to avoid being in an enclosed office with the resident;<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - Certified Nurse Aides (CNAs) A, C, and D were in the hallway by the office and told the resident again he/she would have to wait until 8:00 A.M.;<br><br>- The resident grabbed a hold of CNA C and appeared to be pushing the CNA down the hall;<br><br>- CNA A approached the resident and CNA C, and struck the resident in the right eye causing bleeding;<br><br>- An ambulance was called, and the resident was taken to the hospital;<br><br>- The hospital noted a nasal fracture and blood in the resident's lower eye lid.<br><br>During an interview on 06/10/25 at 11:50 A.M., RN B said he/she has received no formal training in mental health prior to working at the facility. He/she said the resident is triggered by wanting to smoke and becomes agitated when told no. The staff is aware of this trigger and behavior due to the resident doing it every day. He/she said nothing else was offered to the resident, due to he/she was taking report at that time. When the resident became agitated, he/she walked out of the office into the hallway. The resident grabbed CNA C and CNA A walked up and punched the resident in the right eye with a closed fist. The resident walked off and then said, is my eye bleeding. RN B said it is not safe to work at the facility. There is no recourse when a resident attacks or becomes agitated.<br><br>During an interview on 06/10/25 at 12:10 P.M., CNA D said he/she was in the hallway, and heard RN B tell the resident that he/she would have to wait until 8:00 A.M. to smoke. The resident was very agitated, and they could not calm him/her down. CNA D said he/she was not looking at the resident when CNA A punched him/her. The resident walked off and asked if he/she was bleeding. He/she said they have rules and regulations, but no training in mental health prior to working.<br><br>During an interview on 06/10/25 at 12:15 P.M., CNA C said the resident was agitated because RN B told him/her to wait to smoke until smoke break. The resident grabbed him/her and had both hands on his/her shirt collar. CNA A stepped in, drew back his/her closed fist. CNA C closed his/her eyes and felt CNA A punch the resident causing the resident to spin around and become disoriented. The resident released CNA C and walked away into the shower. The resident then returned saying is my eye bleeding. CNA C said there was no warning from CNA A. He/She just stepped in, punched Resident #1 and stepped back. They provide rules to read, but no training prior to starting work.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 06/10/2025 at 12:30 P.M., CNA A said on 06/05/25, at approximately 5:30 A.M., the resident walked out of his/her room with a cigarette. The residents are not supposed to have cigarettes in their room. CNA A told the resident it was not time to smoke. The resident became agitated and acted like he/she was going to throw a table at CNA A. CNA A said he/she told the resident that it was not time to smoke and that he/she (the resident) was aware of the rules. CNA A said the resident has been aggressive with staff before. CNA A told the resident to calm down and the resident walked away, upset. CNA A said the resident came back out and lunged at him/her again and was told again to stop by CNA A. The resident entered the nurse's office and told RN B that he/she wanted a cigarette and a soda. After being told no again, the resident seemed more agitated, and RN B came out of the office. The resident charged at CNA C and it appeared the resident was going to swing at CNA C. CNA A felt the resident was going to hit him/her due to the resident still being angry and he/she swung and hit the resident. CNA A said his/her hand was open. CNA A said it was self-defense. CNA A said he/she only hit the resident once and could have hit more, but did not. Most people would have hit more than once. CNA A said he/she did not hit the resident hard. After the hit, the resident went into the shower room and CNA A believes Resident #1 self-inflicted the injuries. The facility does not offer any training or guidance for this type of problem. CNA A said the staff are in danger with the residents who have these behaviors.<br><br>During an interview on 06/10/25 at 1:30 P.M., Resident #1 said he/she had wanted a cigarette and was really upset. The resident said he/she would never hit a girl. The resident said he/she did not have his/her hands on CNA C. Someone did have hands on his/her shoulders and the resident said he/she was only trying to get loose. The resident said he/she did not realize CNA A had punched him/her in the eye, but only saw a flash of light. No one had ever hit him/her before. The resident said he/she had just wanted a cigarette, but after getting punched the staff provided the resident with a cigarette.<br><br>During an interview on 06/10/25 at 1:45 P.M., local law enforcement (LE) said the resident did not want to press charges. He/she feels the staff at the facility know the residents have mental problems and they instigate them by denying them coffee or cigarettes. When the resident reacts and becomes aggressive, they want LE to come and take the resident away.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 06/10/25 at 11:00 A.M., the Director of Nurses (DON) said the resident has a history of demanding to smoke before the scheduled smoke breaks. If the resident is told no, he/she will react and become aggressive. She said staff reported that on 06/05/25, the resident came out of the room at approximately 5:45 A.M. The resident went to the nurses' office on B hallway. He/she wanted to smoke and have a soda. The day shift charge nurse, RN B told the resident no, he/she would have to wait until the designated smoke break. This upset the resident and caused more agitation. The nurse came out of the office into the hallway to avoid close contact with the resident. Three CNAs, A, C, and D were in the hallway, and they also told the resident he/she would have to wait. This continued to anger the resident. At this time, the resident grabbed onto CNA C by the shirt and was pushing CNA C down the hallway. CNA A then approached the resident and struck the resident in the right eye with a closed fist. She said the nurse did not offer to let a staff member take the resident to smoke. The staff did not attempt to de-escalate the resident with any other options. She said that this is a trigger for the resident and the staff is aware of this. If staff had tried to offer other options, it might have prevented the resident from being so agitated. She said the staff gets training and in-servicing on abuse and neglect. They are trained on de-escalation, but have no formalized mental health training in place. They are supposed to read a training manual prior to taking the floor. They are to sign a sheet that they have read the manual. The facility does not monitor and there is no way to ensure they have read the rules and policies provided in the manual.<br><br>During an interview on 6/10/25 at 1:50 A.M., the Medical Director (MD) said CNA A would have had to hit the resident very hard to crack the resident's nose. The MD said there is an element of danger in working with these type of behaviors, but staff should never hit any resident. The staff cannot accommodate this resident every time the resident wants something or they would have to do it for all residents.<br><br>MO255323, MO255327 |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>Based on interview and record review, the facility failed to have documenation of one resident with serious mental illness and intellectual disability diagnoses (Resident #1's) Level I preadmission screening/resident review (PASRR) assessment (used to identify individuals with mental illness or intellectual/developmental disabilities (IDD) completed before admission to the nursing facility or the more indepth Level II PASRR screening in the resident's record to ensure they were able to meet the resident's behavioral needs. The census was 74.<br><br>The facility did not provide a policy related to PASRR screenings.<br><br>Review of Resident #1's medical records showed:<br><br>-The resident is his/her own responsible party;<br><br>-The resident had diagnoses of post-traumatic stress disorder ((PTSD)-a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event), major depression disorder (a mental disease characterized by persistent sadness), Traumatic Brain Injury (TBI) (a brain injury caused by a physical force or blow to the head affect the person's cognitive function), Alzheimer's (a progressive disease causing loss of cognitive function) and Paranoid Schizophrenia (a mental disorder characterized by disruptions in thought, perception, and behavior;<br><br>-No PASRR level I screen found;<br><br>-No PASRR level II screen found.<br><br>Review of Resident #1's care plan, dated 06/12/24, showed:<br><br>- Level I/ Level II PASRR screening completed. Resident determined to have severe mental illness with diagnoses including PTSD and intellectual disabilities;<br><br>- The following interventions were included:<br><br>- Address, report, and implement plan to manage refusals/ noncompliance For example, Notify Provider/ Responsible Party of instances of noncompliance, ascertain immediate safety, and/or sending to acute setting for evaluation of mental deterioration;<br><br>- Assess and plan for level of supervision required to prevent harm or self/ others;<br><br>- Medication set and administration by staff and monitor compliance with prescription;<br><br>- Monitor and plan for assaultive behaviors, as well as how to de-escalate and help regulate moods/behaviors;<br><br>- Monitor for elopement or medication refusals, symptoms of rapid decline in mood, escalating aggressive or sexual behavior, confusion or bizarre thoughts;<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Monitor therapeutic effects in managing mental health symptoms, including labs as ordered;<br><br>- Provide a structured/ stable environment in order to maintain mood stability/ safety;<br><br>- Provide for individual personal space and sensory support.<br><br>The facility did not provide Resident #1's PASRR.<br><br>During an interview on 06/17/25, a Central Office Medical Review Unit (COMRU) nurse stated a Level 2 screening had been completed on the resident in the past, however, the facility would be required by the Department of Mental Health to complete a replacement application since the Level 2 screening was greater than a year old, to ensure it accrately reflects the resident's current behavioral health needs.<br><br>MO255323, MO255327 |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>Based on interview and record review, the facility failed to identify, assess, and provide supportive interventions for one resident (Residents #1) with a diagnosis of post traumatic stress disorder ((PTSD) - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event). The facility's census was 101.<br><br>The facility did not provide a policy on trauma-informed care or behavioral health management.<br><br>Review of Resident #1's face sheet showed:<br><br>- The resident was his/her own responsible party;<br><br>- The resident had diagnoses of PTSD, major depression disorder (a mental disease characterized by persistent sadness), Traumatic Brain Injury (TBI) (a brain injury caused by a physical force or blow to the head affect the person's cognitive function), and Alzheimer's (a progressive disease causing loss of cognitive function).<br><br>Review of Resident #1's Active Order Summary (Physician's Orders) current as of 06/10/25 showed:<br><br>- An order for behavior monitoring every shift started 05/10/24;<br><br>- An order for geodon (antipsychotic) 40 milligrams (mg) by mouth twice a day with meals for paranoid schizophrenia started on 06/06/25;<br><br>- An order for lorazepam (anti-anxiety) injection solution 2 mg/milliliter (ml) every 8 hours as needed for agitation for 14 days started 06/05/25;<br><br>- An order for lorazepam oral tablet 1 mg by mouth three times a day started 06/06/25;<br><br>- An order for risperidone (antipsychotic) oral tablet 2 mg two times a day for schizophrenia started 12/18/23.<br><br>Review of Resident #1's care plan dated 06/12/24 showed:<br><br>- The resident requires a supervised environment and supervision with all activities of daily living care;<br><br>- The resident will become physically and verbally aggressive when not getting what is asked for and will scream when staff attempt to de-escalate;<br><br>- The resident smokes and will yell when wanting to smoke if not allowed to do so, this is his/her repetitive behavior;<br><br>- The resident has intellectual disabilities;<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - The resident's PTSD is triggered if he/she does not get his medications on time. The interventions included following the directions given by staff and working on his/her coping skills. No further directions for staff on de-escalation (redirection or alternatives);<br><br>- There were no documented interventions in place for helping resident to manage his/her escalating behaviors.<br><br>Review of Resident #1's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 03/12/25, showed:<br><br>- The resident has some cognitive inabilities;<br><br>- The resident requires supervision with all aspects of daily activities of life (ADL).<br><br>During an interview on 06/10/25 at 11:50 A.M., Registered Nurse (RN) B said he/she has received no formal training prior to working at the facility. He/she is agency staff. He/she said the resident is triggered by wanting to smoke and becomes agitated when told no.<br><br>During an interview on 06/10/25 at 12:15 P.M., CNA C said the resident is triggered by wanting to smoke and being told no. He/she does it to try to get cigarettes.<br><br>During an interview on 06/10/25 at 11:00 A.M., the Director of Nurses (DON) said the resident has a history of demanding to smoke before the scheduled smoke breaks. If the resident is told no, he/she will react and become aggressive. She said the staff are aware of the resident's triggers and should attempt to keep him/her from escalating. The DON said his/her PTSD can be triggered when he/she perceives his/her medications as being given late. She is unaware of what interventions are in place for that on the care plan.<br><br>MO255323, MO255327 |

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| F 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.<br><br>Based on interview and record review, the facility failed to provide staff with appropriate behavioral health training to develop competencies and skill sets in order to to provide services to ensure resident safety and attain the highest practicable physical, mental, and psychosocial well-being for one sampled resident (Resident #1) when staff failed to implement de-escalation interventions when Resident #1 began exhibiting increased behaviors. The facility census was 74.<br><br>The facility did not provide a policy on behavioral health management.<br><br>Review of Resident #1's face sheet showed:<br><br>- The resident is his/her own responsible party;<br><br>- The resident has diagnoses of post-traumatic stress disorder ((PTSD)-a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event), major depression disorder (a mental disease characterized by persistent sadness), Traumatic Brain Injury (TBI) (a brain injury caused by a physical force or blow to the head affect the person's cognitive function), Alzheimer's (a progressive disease causing loss of cognitive function).<br><br>Review of Resident #1's Active Order Summary (Physician's Orders) current as of 06/10/25 showed:<br><br>- An order for behavior monitoring every shift started 05/10/24; No documentation of behavior monitoring completed by the facility was provided.<br><br>- An order for geodon (antipsychotic) 40 milligrams (mg) by mouth twice a day with meals for paranoid schizophrenia started on 06/06/25;<br><br>- An order for lorazepam (anti-anxiety) injection solution 2 mg/milliliter (ml) every 8 hours as needed for agitation for 14 days started 06/05/25;<br><br>- An order for lorazepam oral tablet 1 mg by mouth three times a day started 06/06/25;<br><br>- An order for risperidone (antipsychotic) oral tablet 2 mg two times a day for schizophrenia started 12/18/23.<br><br>Review of Resident #1's care plan, dated 06/12/24, showed:<br><br>- The resident requires a supervised environment and supervision with all ADL care;<br><br>- The resident will become physically and verbally aggressive when not getting what is asked for and will scream when staff attempts to de-escalate;<br><br>- The resident smokes and will yell when wanting to smoke if not allowed to do so, this is his/her repetitive behavior;<br><br>(continued on next page) |

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| F 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - The resident has intellectual disabilities;<br><br>- There are no documented interventions in place for keeping resident from escalating behaviors;<br><br>- The staff should attempt to accommodate the requests and needs in an effort to prevent escalation.<br><br>Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 03/12/25, showed:<br><br>- The resident has some cognitive inabilities;<br><br>- The resident requires supervision with all aspects of daily activities of life (ADL).<br><br>During an interview on 06/10/25 at 11:00 A.M., the Director of Nurses (DON) said the resident has a history of demanding to smoke before the scheduled smoke breaks. If the resident is told no, he/she will react and become aggressive. She said the staff are aware of the resident's triggers and should attempt to keep him/her from escalating. There is no reason the staff staff on de-escalation, but do not have any formal training on mental health disorders. She said staff reported that on 06/50/25, the resident came out of the room at approximately 5:45 A.M. The resident went to the nurses' office on B hallway. He/she wanted to smoke and have a soda. The day shift charge nurse, Registered Nurse (RN) B told the resident no, he/she would have to wait until the designated smoke break. This upset the resident and caused more agitation. The nurse came out of the office into the hallway to avoid close contact with the resident. Three Certified Nurse Aides (CNAs), A, C and D were in the hallway, and they also told the resident he/she would have to wait. This continued to anger the resident. At this time, the resident grabbed onto CNA C by the shirt and was pushing the CNA C down the hallway. CNA A then approached the resident and struck the resident in the right eye. She said the nurse did not offer to let a staff member take the resident to smoke. The staff did not attempt to de-escalate the resident with any other options. She said that this is a trigger for the resident and the staff is aware of this. If staff had tried to offer other options, it might have prevented the resident from being so agitated. She said the staff does get training and in-servicing on abuse and neglect. The four staff members involved are all agency staff. They are supposed to read a training manual prior to working the floor. They are to sign a sheet that they have read the manual. The facility does not monitor and there is no way to ensure they have read the rules and policies provided in the manual.<br><br>During an interview on 06/10/25 at 11:50 A.M., RN B said he/she has received no formal training prior to working at the facility. RN B said the resident is triggered by wanting to smoke and becomes agitated when told no. The resident will lash out at staff when angry. He/she said it is impossible to accommodate the resident every time he/she wants to smoke or have a soda. He/she said nothing else was offered, due to he/she was taking report at that time. When the resident became agitated, he/she walked out of the office into the hallway. RN B said it is not safe to work at the facility. There is no recourse when a resident attacks or becomes agitated. There is no need for mental health training as it allows for resident's to be taken down or restrained and this is a no touch facility.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265704 | A. Building<br>B. Wing | 06/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Estates of Perryville, Llc, The | 430 North West Street<br>Perryville, MO 63775 |

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

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| F 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/10/2025 at 12:30 P.M., CNA A said on 06/05/25, at approximately 5:30 A.M., the resident walked out of his/her room with a cigarette. The residents are not supposed to have cigarettes in their room. CNA A told the resident it was not time to smoke. The resident became agitated and acted like he/she was going to throw a table at CNA A. CNA A said he/she told the resident that it was not time to smoke and that he/she (the resident) was aware of the rules. CNA A said the resident has been aggressive with staff before. CNA A told the resident to calm down and the resident walked away, upset. CNA A said the resident came back out and lunged at him/her again and was told again to stop by CNA A. The resident entered the nurse's office and told RN B that he/she wanted a cigarette and a soda. After being told no again, the resident seemed more agitated, and RN B came out of the office. The resident charged at CNA C and it appeared the resident was going to swing at CNA C. CNA A felt the resident was going to hit him/her due to the resident still being angry and he/she swung and hit the resident. CNA A said his/her hand was open. CNA A said it was self-defense. CNA A said he/she only hit the resident once and could have hit more, but did not. Most people would have hit more than once. CNA A said he/she did not hit the resident hard. After the hit, the resident went into the shower room and CNA A believes Resident #1 self-inflicted the injuries. The facility does not offer any training or guidance for this type of problem. CNA A said the staff are in danger with the residents who have these behaviors.<br><br>During an interview on 06/10/25 at 1:45 P.M., local law enforcement (LE) said his/her people see so many problems at this facility which are the results of poor decisions by staff. Staff know the residents have mental problems, but continue to instigate them by denying them coffee or cigarettes. When the resident reacts and becomes aggressive, they want LE to come and take the resident away. |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, record review and interview, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for one resident (Resident #1) with severe mental illness and behaviors, when Resident #1 displayed agitated behaviors and staff did not attempt to de-escalate. The census was 74.<br><br>The facility did not provide a policy on behavioral health management.<br><br>Review of Resident #1's face sheet showed:<br><br>- The resident is his/her own responsible party;<br><br>- The resident has diagnoses of post-traumatic stress disorder ((PTSD)-a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event), major depression disorder (a mental disease characterized by persistent sadness), Traumatic Brain Injury (TBI) (a brain injury caused by a physical force or blow to the head affect the person's cognitive function), Alzheimer's (a progressive disease causing loss of cognitive function).<br><br>The facility did not provide a PASRR for Resident #1<br><br>Review of Resident #1's Active Order Summary (Physician's Orders) current as of 06/10/25 showed:<br><br>- An order for behavior monitoring every shift started 05/10/24; No documentation of behavior monitoring completed by the facility was provided.<br><br>- An order for geodon (antipsychotic) 40 milligrams (mg) by mouth twice a day with meals for paranoid schizophrenia started on 06/06/25;<br><br>- An order for lorazepam (anti-anxiety) injection solution 2 mg/milliliter (ml) every 8 hours as needed for agitation for 14 days started 06/05/25;<br><br>- An order for lorazepam oral tablet 1 mg by mouth three times a day started 06/06/25;<br><br>- An order for risperidone (antipsychotic) oral tablet 2 mg two times a day for schizophrenia started 12/18/23.<br><br>Review of Resident #1's care plan, dated 06/12/24, showed:<br><br>- The resident requires a supervised environment and supervision with all ADL care;<br><br>- The resident will become physically and verbally aggressive when not getting what is asked for and will scream when staff attempts to de-escalate;<br><br>(continued on next page) |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - The resident smokes and will yell when wanting to smoke if not allowed to do so, this is his/her repetitive behavior;<br><br>- The resident has intellectual disabilities;<br><br>- There are no documented interventions in place for keeping resident from escalating behaviors;<br><br>- The staff should attempt to accommodate the requests and needs in an effort to prevent escalation.<br><br>Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 03/12/25, showed:<br><br>- The resident has some cognitive inabilities;<br><br>- The resident requires supervision with all aspects of daily activities of life (ADL).<br><br>During an interview on 06/10/25 at 11:00 A.M., the Director of Nurses (DON) said the resident has a history of demanding to smoke before the scheduled smoke breaks. If the resident is told no,he/she will react and become aggressive. She said the staff are aware of the resident's triggers and should attempt to keep him/her from escalating. There is no reason the staff staff on de-escalation but do not have any formal training on mental health disorders. She said staff reported that on 06/50/25, the resident came out of the room at approximately 5:45 A.M. The resident went to the nurses' office on B hallway. He/she wanted to smoke and have a soda. The day shift charge nurse, RN B told the resident no, he/she would have to wait until the designated smoke break. This upset the resident and caused more agitation. The nurse came out of the office into the hallway to avoid close contact with the resident. Three CNA ' s, A, C and D were in the hallway, and they also told the resident he/she would have to wait. This continued to anger the resident. At this time, the resident grabbed onto the CNA C by the shirt and was pushing the CNA C down the hallway. The CNA A then approached the resident and struck the resident in the right eye. She said the nurse did not offer to let a staff member take the resident to smoke. The staff did not attempt to de-escalate the resident with any other options. She said that this is a trigger for the resident and the staff is aware of this. If staff had tried to offer other options, it might have prevented the resident from being so agitated. She said the staff does get training and in-servicing on abuse and neglect. The four staff members involved are all agency staff. They are supposed to read a training manual prior to taking the floor. They are to sign a sheet that they have read the manual. The facility does not monitor and there is no way to ensure they have read the rules and policies provided in the manual.<br><br>During an interview on 06/10/25 at 11:50 A.M., RN B said he/she has received no formal training prior to working at the facility. RN B said the resident is triggered by wanting to smoke and becomes agitated when told no. The resident will lash out at staff when angry. He/she said it is impossible to accommodate the resident every time he/she wants to smoke or have a soda. He/she said nothing else was offered, due to he/she was taking report at that time. When the resident became agitated, he/she walked out of the office into the hallway. RN B said it is not safe to work at the facility. There is no recourse when a resident attacks or becomes agitated. There is no need for mental health training as it allows for resident's to be taken down or restrained and this is a no touch facility.<br><br>(continued on next page) |

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|---|---|
| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/10/25 at 1:45 P.M., local law enforcement (LE) said the resident did not want to press charges. LE was not aware Resident #1 would be a special victim at first, and is now requesting information on the resident and referring this matter to the Prosecutor. LE said his/her people see so many problems which are the results of poor decisions by staff. Staff know the residents have mental problems, but continue to instigate them by denying them coffee or cigarettes. When the resident reacts and becomes aggressive, they want LE to come and take the resident away.<br><br>During an interview on 06/10/25 at 1:50 A.M., the Medical Director (MD) said CNA A would have had to hit the resident very hard to crack the resident ' s nose. MD said there is an element of danger in working with these type of behaviors but staff should never hit any resident. The staff cannot accommodate Resident #1 every time the he/she wants something or they would have to do it for all residents.<br><br>MO255323, MO255327 |