STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265775	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center of Lemay Inc	9353 South Broadway Saint Louis, MO 63125

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44950 Based on observation, interview and record review, the facility failed to ensure one resident's right to be free from physical abuse was not violated (Resident #1) when a resident (Resident #2) punched the resident in the back of the head with a closed fist three times. Resident #2 attempted to strike Resident #1 a fourth time but staff intervened and separated the residents. These two residents had an incident occur approximately one month ago, in which Resident #2 hit Resident #1 in the eye. This incident caused Resident #1 to have a laceration over his/her left eyebrow. The sample was 3. The census was 47. Review of the facility's undated Abuse, Prevention and Prohibition policy, showed: -Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. 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 serving the residents, family member or legal guardians, friend, or other individuals; -Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Review of Resident #1's medical record, showed: -A quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/7/24, showed: -Resident is rarely/never understood; -Diagnoses included dementia and depression. -A progress note, dated 3/4/24 at 9:43 A.M., showed resident was sitting in the dining room eating at the table with another resident when the other resident reached out and hit this resident in the face causing resident's left eye (above) to bleed. Placed a call to the physician, physician made aware. Also, placed a call to the resident's family and made aware of the incident. The resident's left eye was cleaned and applied triple antibiotic ointment and bandage. The resident denies pain at this time. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-A progress note, dated 4/24/24 at 1:16 P.M., showed resident's Power of Attorney (POA) contacted and informed of another resident hitting him/her in the back of his/her head. POA informed that education was provided to both residents and separated before incident escalated. Vital signs taken and within normal limits. Physician notified. -Review of the medical record, did not show skin assessment or neurological assessment performed after the resident-to-resident altercation for Resident #1. Review of the resident's care plan, revised 1/4/24, showed: -Focus: The resident has a communication problem: Hard of Hearing (HOH); -Goal: The resident will be able to make basic needs known on a daily basis through review date; -Intervention: Be conscious of resident position when in groups, activities, dining room to promote proper communication with others. Ensure/provide a safe environment, encourage resident to continue stating thoughts even if resident is having difficulty; -Focus: The resident has a behavior problem; -Goal: The resident will have a reduction in behavior problems: verbal and physical aggression, anxiety, refusal of care by review date; -Interventions: Administer antipsychotic medications as ordered, monitor behavior episodes and attempt to determine underlying cause, anticipate and meet the resident's needs, caregivers to provide opportunity for positive interaction, attention. Observation and interview on 4/30/24 at 9:55 A.M., showed Resident #1 in his/her room. The resident sat in his/her wheelchair. The resident was unable to answer about any incidents with another resident. The resident turned away and started to talk to himself/herself. Review of Resident #2's medical record, showed: -A quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included non-traumatic brain dysfunction and Alzheimer's dementia; -A progress note, dated 3/4/24 at 9:23 A.M., showed resident was in the dining room having breakfast and another resident was sitting at the same table when this resident reached and hit the other resident causing the other resident to bleed. The other resident was removed from the situation immediately and administrator was informed. Physician made aware and family made aware. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-A progress note, dated 4/24/24 at 3:41 P.M., showed Certified Nursing Assistant (CNA) brought the resident to the Director of Nursing (DON) and communicated that he/she had hit another resident while in dining room for lunch. Resident noted to be in a clam state sitting with legs crossed with elbow on right arm rest with fact resting on hand. Asked resident what happened in the dining room between him/her and the resident. Resident stated (he/she) was talking shit and I turned around and hit (him/her) back of head. I asked him/her to demonstrate with this nurse with his/her arm. Resident with closed fist hit on this nurse arm three times non forcibly. Asked if this is how hard that he/she hit him/her and the resident stated yes. Per this nurse, inspected his/her hands. No bruising, swelling, or bleeding or any injury to hand noted. Resident extensively encouraged about not to hit anybody and if he/she feels like he/she is becoming agitated to seek out staff assistance for interventions which would including calling his/her son/daughter for him/her to talk. Resident in agreement. Spoke with resident's son/daughter and made him/her aware of interventions. Son/Daughter thanked this nurse for calling and will talk to the resident. Resident assisted into bed per resident request. No skin issues. Denied any pain or discomfort. Review of Resident #2's care plan, dated 4/26/24, showed: -Focus: The resident has potential to demonstrate physical behaviors when agitated/overstimulated; -Goal: Resident will not harm self or others through the review date; -Intervention: Resident has a history of striking others when agitated, when resident becomes agitated intervene before agitation escalates. -Focus: The resident has a behavior problem; -Goal: The resident will have fewer episodes of behavioral outburst/aggressive behavior by the review date; -Intervention: Intervene as necessary to protect the rights and safety of others, monitor behavior episodes and attempt to determine underlying cause, anticipate and meet the resident's needs. -Focus: The resident has a mood problem; -Goal: The resident will have improved mood state, happier, calmer appearance, no signs/symptoms of depression, anxiety or sadness through the review date; -Intervention: Behavioral health consults as needed, monitor/document/report to physician as needed mood patterns signs/symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols. During an interview on 4/30/24 at 9:45 A.M., Resident #2 said he/she did not recall the incident. He/She said there are no issues with any resident. Review of the facility's investigation, showed on 4/24/24 at approximately 11:40 A.M.: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Summary of alleged incident: While in the dining room, Resident #2 hit Resident #1 in the back of the head about three times. This was stopped and witnessed by a CNA who removed him/her and brought him/her to the DON office to report the issue. -Conclusion of the investigation, provided by the Administrator on 4/30/24, showed: On 4/24/24 at roughly 11:40 A.M., residents were gathering in the dining room for lunch. Resident #1 was sitting at his/her table rambling nonsense. Resident #2 was wheeling himself/herself into the dining room and upon passing Resident #1's table, he/she got upset with what Resident #1 was saying and hit him/her in the back of the head. CNA C immediately stopped Resident #2 and Certified Medication Technician (CMT) B assisted in separating the two residents. Both residents were assessed by the nurse with no findings. POAs, Physician, and Psychiatrist were notified. -Resident #2 has a medical diagnosis of dementia with mood disorder and Resident #1 has a medical diagnosis of dementia with agitation. Both residents are wheelchair bound and self propelling/wanderers. The psychiatrist, saw both residents today, 4/25/24, and they have no recollection of the incident and there were no changes made. -Resident #2 recently saw neurologist, 4/5/24, and Remeron (antidepressant, used to treat depression) was increase to 30 milligrams (mg). During this appointment, the neurologist educated the resident's POA on the significant progression of (his/her) dementia and stated (he/she) doesn't have much longer. On 4/22/24, the care plan was held with the resident's POA to discuss his/her decline mentally and physically and as a result, hospice evaluated/started 4/24/24. -Staff were educated about Resident #1 being moved to a back table in the dining room away from the entrance of the dining room to reduce the two residents crossing paths and educated about keeping residents separated when possible. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/30/24 at 9:50 A.M., CMT B said he/she heard about the first incident and was told to keep them apart. The day of the second incident, he/she was at the medication cart in the dining room passing medications. The resident sat facing the front of the dining room and Resident #2 sat at the table behind Resident #1. CMT B said he/she saw Resident #2 hit Resident #1 in the back of his/her head two to three times with a closed fist. Resident #2 looked back before attempting to hit Resident #1 again. Another aide, CNA C, got a hold of the resident's arm before he/she could hit Resident #1 a fourth time. CMT B said he/she went to Resident #1 and took the resident out of the dining room. CMT B asked the resident if he/she was ok. The resident responded, why would (he/she) do me like that? CMT B said when he/she asked Resident #1 if he/she hurt and wanted Tylenol, the resident responded yes. CMT B is not sure why Resident #2 struck Resident #1. Resident #1 was rambling/mouthing like he/she normally does. The next thing you know, Resident #2 turned around and hit him/her. CMT B guessed Resident #1's voice gets to Resident #2. CMT B said a couple days later, Resident #1 sat at the back of the dining room and Resident #1 started to go after Resident #1 again. CMT B said he/she went right over to Resident #2 and redirected him/her out of the dining room before the resident got to Resident #1 a third time. CMT B brought the resident to the hallway outside of his/her room. CMT B told the Charge Nurse about that incident. CMT B said he/she feels bad for Resident #1. It almost seems like Resident #2 is now going after him/her. Resident #1 suffered a cut above his/her left eyebrow after the first incident. This time, there were no visible injuries. CMT B does not understand why Resident #2 attacked Resident #1 again. Staff really have to keep them apart. CMT B said the psychologist was at the facility the other day. CMT B felt Resident #2 knew what he/she was doing even though he/she does have a decline. The day the second incident occurred, the DON and CNA asked the resident a couple questions. The resident told the nurse he/she was going after Resident #1. Staff just have to keep watching and make sure Resident #2 stays away from Resident #1. During an interview on 4/30/24 at 10:00 A.M., the Social Worker (SW) said there have been two incidents between Resident #2 and Resident #1. She did not see either incident. Both happened in the dining room. The SW was told Resident #2 hit Resident #1. Resident #1 got to rambling and not sure if that annoyed Resident #2. Resident #2 tried to tell her that he/she did not hit Resident #1. When the SW told the resident there were witnesses, the resident just said ok. Resident #1 is very loud and talks about anything and everything. Resident #1 was not sent out after the second incident and she is not aware of any incidents since that second one. She believes they moved Resident #1's spot in the dining room. Resident #2 has memory issues but is more with it than Resident #1. During an interview on 4/30/24 at 10:05 A.M., Dietary Aide E said he/she saw Resident #2 hit Resident #1 once. Resident #2 stays next to the dining room door so staff can keep closer eye on him/her. Resident #1 sits in the back on the other side of the dining room. Dietary Aide E feels bad for Resident #2 because he/she is not really with it. During an interview on 4/30/24 at 11:35 A.M., Licensed Practical Nurse (LPN) A said he/she was in the DON's office when the second incident occurred. CNA C brought the resident into the DON's office and said Resident #2 had just hit Resident #1. LPN A asked Resident #2 what happened. Resident #2 said Resident #1 was talking shit. Resident #2 then showed LPN A how he/she hit Resident #1 with a closed fist. LPN A assessed the resident's hand, then assessed Resident #1. LPN A said Resident #1 was assessed the next day as well. LPN A said everyone was inserviced and moved Resident #1 to a different table so not to be in close proximity to Resident #2. LPN A had not been told of another attempt. He/She has not seen behavior issues for Resident #2. Resident #1 is not with it. Staff did not say if Resident #1 provoked Resident #2. Resident #2 just said Resident #1 was just talking shit. LPN A knows every shift was inserviced but not sure if all staff was in-serviced or just nursing staff. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/30/24 at 11:45 A.M., the resident witness said he/she only knew about the second incident. He/She was at the table with Resident #1. He/she said Resident #2 hit Resident #1 in the back of the head/shoulder with a closed fist. Now the facility is keeping them separated. During an interview on 4/30/24 at 11:50 A.M., CMT F said Resident #1 sat in the front of the dining room at first. Then after the second incident, he/she was moved to the back of the dining room. Resident #2 has a history of behaviors and this was the second incident. CMT said Resident #2 has not tried to go after Resident #1 since the second incident. Staff keep them separated. During an interview on 4/30/24 at 1:04 P.M., the DON said after the first incident, they moved Resident #2 closer to the inside of the dining room by the kitchen so more staff can keep an eye on him/her. The psychologist came out to do a consult and medication review. So far they did not change behavior interventions, the resident had never hit anyone before these incidents. For the second incident, the CNA said he/she propelled Resident #2 and as he/she passed Resident #1, the resident struck at him/her. The CNA said they were able to pull the resident back. The DON said now that they have Resident #1 moved, the two residents should not have to cross paths because Resident #1 has to go a separate way. Both residents can propel themselves. The DON believed Resident #1 was already seeing psychologist and that Resident #2 saw the psychologist after the first incident. The DON does not think it is possible it will happen again. The staff know now and will really monitor. The DON is not sure if Resident #2 smokes but Resident #1 should not be in the way. The smoke time is well after lunchtime. She expected staff to know what both residents look like and to keep them separated. She said they did a neurological assessment, skin assessment, head, and pain assessment on Resident #1. She said it is hard for them to completely avoid each other but now there should be no way to cross paths in the dining room. During an interview on 4/30/24 at 1:24 P.M., CNA C said he/she was in the dining room for the second incident. She was sitting at the back of the dining room, feeding residents. Different aides were bringing residents in the dining room. Resident #1 was already seated. Resident #2 propelled him/herself in the dining room. He/She went behind Resident #1 and hit the resident in the back of the head at least twice. CNA C heard CMT B yell out. He/She went over to Resident #2 and grabbed his/her arm before he/she struck the resident again. CNA C then propelled the resident out of the dining room to the DON's office to inform the DON of the incident. CNA C said staff had been instructed to watch Resident #2 before the second incident. Resident #2 told the DON when he/she wheeled past Resident #1, the resident was talking crap, so he/she hit the resident. CNA said she felt like Resident #2's dementia has worsened. Resident #2 has not acted normal for a while. She is not aware of Resident #2 attempting to go up to Resident #1 after the second incident. CNA C said it is possible for Resident #2 to go over to Resident #1 but there is always an aide in the dining room when they are in there. After the first incident, staff were told to keep them separate. Staff were inserviced and just told to keep an eye on them. Staff are supposed to report if Resident #2 makes any attempt towards Resident #1. During an interview on 4/30/24 at 1:50 P.M., a housekeeping staff cleaning the dining room said the smoke break was already over. The afternoon smoke break is typically between 1:00 P.M. and 1:30 P.M. Staff has already taken the residents who smoke outside. They go outside through the far door in the back, which is the next door down from where Resident #1 sat. During an interview on 4/30/24 at approximately 2:30 P.M., the Administrator said she expected staff to keep both residents separated and safe. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	MO00235200

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F 0744 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 dementia. 44950 Based on interview and record review, the facility failed to ensure one resident (Resident #2), diagnosed as having dementia with behavioral disturbance and exhibiting increased symptoms/behaviors such as striking the same resident (Resident #1) in the head twice on two separate occasions (3/4/24 and 4/24/24), received the appropriate treatment and services to attain or maintain his/her highest practicable physical, mental and psychosocial well-being, by failing to implement an ordered psychiatric consult or update the resident's care plan until after the second incident. The first incident caused a laceration above Resident #1's left eyebrow. The sample size was 3. The census was 47. Review of Resident #2's hospital records, prior to the facility admission, dated 9/26/23, showed: Patient is presenting with concern for self neglect and possible injury to himself/herself with firearm. He/She was brought in by family to emergency room (ER) on 9/23 after reportedly hitting his/her head near the support beam of his/her car port. He/She reports to me no loss of consciousness. Apparently family recently checked on him/her and found a hole in the ceiling as well as a shotgun that appeared to have been moved with blood on it as well. They were concerned that patient may have been using the shotgun inappropriately and could have hurt himself/herself. Per notes, patient denies touching the gun. He/She was recommended for admission to the behavioral health center for assessment and treatment for mood disorder as well as dementia with behavioral disturbances. Upon my exam he/she is stable and appears calm. He/She reports no major medical issues at this time and feels ok overall. He/She is not able to tell me which medications he/she takes for his/her chronic medical conditions however. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/25/24, showed: -Severe cognitive impairment; -Diagnoses included non-traumatic brain dysfunction and Alzheimer's dementia. Review of the resident's electronic Physician Order Sheet (ePOS) showed: -An order, 10/4/23, Remeron (antidepressant) oral 15 milligrams (mg). One tablet by mouth at bedtime related to Alzheimer's disease with early onset; -An order, dated 2/9/24, Refer to psychiatrist for psychiatric evaluation per physician request. Review of the resident's medical record, showed: -A progress note, dated 3/4/24 at 9:23 A.M., resident was in the dining room having breakfast and another resident was sitting at the same table when this resident reached and hit the other resident causing the other resident to bleed. The other resident was removed from the situation immediately and Administrator was informed. Physician made aware and family made aware; (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A progress note, dated 3/13/24 at 12:48 P.M., resident brought from dining room to nursing station per Certified Nursing Assistant (CNA) due to started crying in dining room and had not eaten lunch. This nurse asked him/her why he/she was crying. The resident verbalized that he/she wanted to see his/her son/daughter. Asked if resident would like nurse to call son/daughter. Resident stated yes. Per this nurse, called his/her son/daughter and resident talked to him/her. The resident stopped crying and was asked if he/she would like for his/her lunch to be brought to room. Resident declined at this time verbalized he/she was going to his/her room to lay down; -A progress note, dated 4/5/24 at 12:36 P.M., resident returned from neurologist appointment accompanied by son/daughter. Paperwork given upon return with new orders as follow: Increase Remeron to 30 mg at bedtime. Order noted and sent to primary care physician and other providers in his/her network in agreement at this time. Review of the resident's ePOS, showed: -An order, dated 4/5/24, Refer to psychiatrist for psychiatric evaluation per physician request; -An order, dated 4/5/24, Remeron oral 30 mg. One tablet by mouth at bedtime related to Alzheimer's disease with early onset. Review of an Initial Psychiatric Evaluation, dated 4/11/24, by the Nurse Practitioner (NP) for the psychiatrist, showed: -Presenting problem: Resident is referred for a psych evaluation. Resident has a history of major neurocognitive disorder (MNCD, an acquired neuropsychiatric disorder, characterized by a clinically significant decline from a previous level of cognitive functioning) with depression; -Medical: Diabetes, chronic kidney disease, stroke, falls, current urinary tract infection (UTI); -Mental Status: Oriented to person only. Insight/judgement are fair. Sleep and appetite fair. Isolative to room. Little participation in activities. Current treatment for UTI. Mood fair. Denies anxiety. Denies psychotic symptoms; -Plan: Continue the recently increased Remeron dose for depression. Encourage out of room activities. Consider treatment for MNCD. Psychiatrist to see in one month. Review of the progress notes, showed: -4/25/24 at 8:10 A.M., reached out to psychiatrist regarding incident that took place yesterday with altercation with another resident for a medication review. Psychiatrist states he/she will be in the facility as soon as he/she can to evaluate/treat; (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/24/24 at 3:41 P.M., CNA brought the resident to the Director of Nursing (DON) and communicated that he/she had hit another resident while in dining room for lunch. Resident noted to be in a clam state sitting with legs crossed with elbow on right arm rest with fact resting on hand. Asked resident what happened in the dining room between him/her and the resident. Resident stated (he/she) was talking shit and I turned around and hit (him/her) back of head. I asked him/her to demonstrate with this nurse with his/her arm. Resident with closed fist hit on this nurse arm three times non forcibly. Asked if this is how hard that he/she hit him/her and the resident stated yes. Per this nurse, inspected his/her hands. No bruising, swelling, or bleeding or any injury to hand noted. Resident extensively encouraged about not to hit anybody and if he/she feels like he/she is becoming agitated to seek out staff assistance for interventions which would including calling his/her son/daughter for him/her to talk. Resident in agreement. Spoke with resident's son/daughter and made him/her aware of interventions. Son/Daughter thanked this nurse for calling and will talk to the resident. Resident assisted into bed per resident request. No skin issues. Denied any pain or discomfort. Review of the Psychiatric Evaluation, dated 4/25/24, showed: -Chief Complaint: Resident referred emergently for a psychiatric consultation by the primary care physician. The resident apparently had gotten in an altercation with an older resident earlier today though it is unclear what exactly caused that. The resident himself/herself could provide very little in terms of specific or meaningful complaints; -Past Psychiatric History: Is notable for history of dementia of the Alzheimer's type as well as depression. It is unclear if he/she had previously been seen by a mental health professional; -Mental Status Examination: The patient was alert and oriented to person only. His/Her mood is good. His/Her affect is pleasantly confused. His/Her speech is elicitable though limited to brief replies. Judgment and insight are poor as is focus and concentration. Thought processes are somewhat illogical and nonlinear. There are no overt hallucinations or delusions noted at this time. He/She reportedly is eating adequately and sleeping adequately. No real change in his/her cognitive, function, or affective presentation is appreciated; -Assessment: Major neurocognitive disorder most likely of the Alzheimer's type with agitation. -Recommendations: -At this time we will monitor the patient's symptoms closely for any repeat episodes of agitation and their possible triggers. That being said, he/she may benefit from a regular dose anti-agitant medication; -We will continue the memantine (medication used to treat memory loss and the symptoms of Alzheimer's disease) and mirtazapine (Remeron) at their current dosages for now. I do note that he/she has lost a bit of weight lately; -We will communicate our findings and recommendations to primary care physician and the staff; -A message was left for the patient's power of attorney to update them relative to my psychiatric recommendations and to try and obtain more history; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265775	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center of Lemay Inc	9353 South Broadway Saint Louis, MO 63125

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Follow up in approximately one month by the nurse practitioner and myself for psychotropic medication management and supportive psychotherapy. Review of the resident's care plan, dated 4/26/24, showed: -Focus: The resident has potential to demonstrate physical behaviors when agitated/overstimulated; -Goal: Resident will not harm self or others through the review date; -Intervention: Resident has a history of striking others when agitated, when resident becomes agitated intervene before agitation escalates; -Focus: The resident has a behavior problem; -Goal: The resident will have fewer episodes of behavioral outburst/aggressive behavior by the review date; -Intervention: Intervene as necessary to protect the rights and safety of others, monitor behavior episodes and attempt to determine underlying cause, anticipate and meet the resident's needs; -Focus: The resident has a mood problem; -Goal: The resident will have improved mood state, happier, calmer appearance, no signs/symptoms of depression, anxiety or sadness through the review date; -Intervention: Behavioral health consults as needed, monitor/document/report to physician as needed mood patterns signs/symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols. Review of a Social Service progress note, dated 4/30/24/24 at 12:58 P.M., showed it was reported to Social Services (SS) that on several occasions, once with a hospice worker and once with Administration that resident has been getting a bit handsy. He/She is not touching in inappropriate places but is doing things such as running his/her hand up a person's arm. The resident was recently signed up for hospice and it was on of their staff that he/she did this with. He/She recently has had a few incidents of hitting another resident as well. SS has spoken with him/her about these, however with his/her decreased cognition/memory, it is doubtful that he/she remembers. Staff were in-serviced and were made aware of this change in his/her behavior. This is not the norm for him/her. SS will continue to monitor and assist as needed. Review of the care plan, showed no interventions to address the resident's inappropriate touching of others. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/24 at 9:50 A.M., Certified Medication Technician (CMT) B said he/she heard about the first incident and was told to keep them apart. The day of the second incident, he/she was at the medication cart in the dining room passing medications. The resident sat facing the front of the dining room and Resident #2 sat at the table behind the other resident. CMT said he/she saw Resident #2 pound the other resident in the back of his/her head two to three times with a closed fist. Resident #2 looked back before attempting to hit the other resident again. Another aide, CNA C, got a hold of the resident's arm before he/she could hit the other resident a fourth time. CMT B said he/she went to the other resident and took the resident out of the dining room. CMT B asked the resident if he/she was ok. The resident responded, why would (he/she) do me like that? CMT B said when he/she asked the other resident if he/she hurt and wanted Tylenol, the resident responded yes. CMT B is not sure why Resident #2 struck the other resident . The other resident was rambling/mouthing like he/she normally does. The next thing you know, Resident #2 turned around and hit him/her. CMT B guessed the other resident's voice gets to Resident #2. CMT B said a couple days later, the other resident sat at the back of the dining room and the other resident started to go after the other resident again. CMT B said he/she went right over to Resident #2 and redirected him/her out of the dining room before the resident got to the other resident a third time. CMT B brought the resident to the hallway outside of his/her room. CMT B told the Charge Nurse about that incident. CMT B said he/she feels bad for the other resident. It almost seems like Resident #2 is now going after him/her. The other resident suffered a cut above his/her left eyebrow after the first incident. This time, there were no visible injuries. CMT B does not understand why Resident #2 attacked the other resident again. Staff really have to keep them apart. CMT B said the psychologist was at the facility the other day. CMT B feels that Resident #2 knows what he/she is doing even though he/she does have a decline. The day the second incident occurred, the DON and CNA asked the resident a couple questions. The resident told the nurse he/she was going after the other resident. Staff just have to keep watching and make sure Resident #2 stays away from the other resident. During an interview on 4/30/24 at 10:00 A.M., the Social Worker (SW) said there have been two incidents between Resident #2 and the other resident. She did not see either incident. Both happened in the dining room. The SW was told Resident #2 hit the other resident. The other resident got to rambling and not sure if that annoyed Resident #2. Resident #2 tried to tell her that he/she did not hit the other resident. When the SW told the resident there were witnesses, the resident just said ok. The other resident is very loud and talks about anything and everything. Resident #2 has memory issues. During an interview on 4/30/24 at 1:04 P.M., the DON said after the first incident, they moved Resident #2 closer to the inside of the dining room by the kitchen so more staff can keep an eye on him/her. The psychologist came out to do a consult and medication review. So far they did not change behavior interventions, the resident had never hit anyone before these incidents. For the second incident, the CNA said he/she propelled Resident #2 and as he/she passed the other resident, Resident #2 struck at him/her. The CNA said they were able to pull the resident back. The DON said now that they have the other resident moved, the two residents should not have to cross paths because Resident #1 has to go a separate way. The DON believed Resident #1 was already seeing psychologist. The DON does not think it is possible it will happen again. The staff know now and will really monitor. She said it is hard for them to completely avoid each other but now there should be no way to cross paths in the dining room. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/24 at approximately 2:30 P.M., the Administrator said she is not sure why the resident had a psychiatrist consult order for 2/9/24 and 4/5/24 but he/she was not seen until April 11th. She expected staff to keep both residents separated and safe. She expected staff to notify management of any changes to behavior. MO00235200