STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265786	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Rehab and Healthcare Center	1415 West White Oak Independence, MO 64050

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** Based on observation, interview, and record review, the facility failed to ensure Resident #72 and #238 were free from abuse when the residents got into a resident to resident altercation. Staff failed to separate the residents in accordance with their policy after the altercation and the residents remained roommates for 48 hours. Both residents reported being scared of the other resident. Staff failed to ensure Resident #240 was free from abuse when the resident entered Resident #215's room leading to an altercation. Resident #240 had significant facial bruising and family reported the resident to be sad and would not come out of his/her room after an altercation with Resident #215. The facility failed to ensure five sampled residents (Resident #26, #38, #187, #238, and #240) were free from physical abuse from Resident #307 who had a known history of verbal and physical aggression. All residents resided on a locked memory care unit. Thirty five residents were sampled. The facility census was 259. Review of the facility's Abuse Prevention and Prohibition Program policy, dated 10/24/22, showed: -The purpose of the policy was to ensure the facility established, operationalized, and maintained an abuse prevention and prohibition program designed to screen and train employees, protect residents, and to ensure a standardized method for prevention, identification, investigation, and reporting of abuse, neglect and mistreatment, misappropriation of property and crime in accordance with federal and state requirements. -Each resident had the right to be free from mistreatment and abuse. -The facility had a zero-tolerance for abuse and mistreatment. -The administrator was responsible for coordination and implementing the facility's abuse prevention policies, procedures, training programs and systems. -The facility ensured protection of residents during an abuse investigation. -If the allegations were regarding a resident-to-resident altercation, the residents were separated immediately, pending the investigation. 1. Review of Resident #72's admission Record showed the resident admitted to the facility on [DATE] with the following diagnoses: (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Alzheimer's Disease (a slowly progressive disease of the brain that is characterized by impairment of memory and eventually by disturbances in reasoning, planning, language, and perception). -Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). -Bipolar Disorder (a mental health condition that causes extreme mood swings. These include emotional highs, also known as mania or hypomania, and lows, also known as depression). -Anxiety Disorder (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus). -Depressive Disorder (a persistent mood disorder characterized by sadness and loss of interest or pleasure in daily activities). Review of Resident #72's care plan, dated 10/7/19, showed: -The resident was an elopement risk/wanderer and ambulates about the unit related to impaired cognition. -The resident had a behavior problem such as: --Sexually inappropriate behaviors. --Hallucinations. --Delusions. -The staff to monitor the resident and record/report to the physician any risk for: --Harming others. --Increased anger. --Labile mood or agitation. --Feels threatened by others. --Thoughts of harming someone. -Staff to intervene as appropriate. Review of Resident #72's Annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 3/14/25, showed the resident assessed as mildly cognitively impaired. No behaviors were documented. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #238's admission Record showed the resident admitted to the facility on [DATE] with the following diagnoses: -Psychosis (a mental state involving loss of contact with reality and causing deterioration of normal social functioning) NOS (Not otherwise specified). -Dementia. -Major depressive Disorder. -Anxiety Disorder. -Post Traumatic Stress Disorder (PTSD-a psychiatric condition that may occur in people who have experienced or witnessed a traumatic event or series of traumatic events. The individual often experiences the event or events as emotionally or physically harmful or life-threatening). -Mild Cognitive Impairment. -Muscle Weakness. -Unsteadiness on Feet. -Cognitive Communication Deficit. Review of Resident #238's admission MDS, dated [DATE], showed the resident assessed as mildly cognitively impaired. Hallucinations and delusions were noted. Review of Resident #238's care plan, dated 1/15/25, showed: -The resident had impaired cognitive function related to dementia. -Staff to cue, reorient and supervise as needed. -The resident had depression related to dementia. -The staff to keep environment noise at a minimum as possible. -The resident had a diagnosis of PTSD, which has affected his/her overall health/well-being. -Behaviors related to this trauma have included: --Hallucinations. --Delusions. --Paranoia. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-- Seeing/hearing people. -Staff to ensure that other residents were not in the resident's room or invading his/her space. -Staff to redirect other residents from the resident's room or area. -Staff to make sure the resident remained safe. Review of Resident #238's progress note, dated 5/10/25 at 9:16 A.M., showed the patient in a physical altercation with another patient, patient does have a skin tear on his/her left arm and face. Patient stated he/she fell, started neuros, vital signs are stable per patient. Staff called his/her family, admin (administrator), and house supervisor. Review of Resident #72's progress note, dated 5/10/25 at 9:04 A.M., showed the patient in a physical altercation with another resident, patient said he/she was defending himself/herself. He/She had a skin tear on his/her left arm staff cleaned and covered, patient did not fall, family called and informed, house supervisor and administrator called as well, left note for the nurse practitioner in the binder. Review of the facility undated incident report showed: -On 5/10/25 it was reported Resident #72 and Resident #238 were in an unwitnessed disagreement. -Resident #72 stated Resident #238 came to his/her side of the room and threw water on him/her due to his/her television being too loud. -Resident #72 stated Resident #238 then threw his/her television on the floor and made contact with him/her, which resulted in both residents being on the floor. -Resident #238 stated he/she went to Resident #72's side of the room and told Resident #72 to turn his/her television down, and Resident #72 turned his/her television up louder. -Resident #238 stated he/she then threw water at Resident #72 and his/her legs gave out and he/she fell on the floor. -Resident #238 stated after he/she fell on the floor, Resident #72 made contact with him/her. -Resident #238 had a skin tear on his/her left forearm and an abrasion to his/her cheek (either side of the face, below the eye). -Resident #72 had a skin tear on his/her left forearm. -On 5/11/25, the house supervisor and the DON placed Resident #238 on frequent observations. Review of Resident #238's Weekly Skin Observation, dated 5/10/25 at 1:30 P.M., showed: -Abrasion to the right side of his/her chin, 0.1 x 2 centimeter (cm). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Skin tear to his/her left forearm, 1.6 x 2.1 x 0.1 cm. Review of Resident #72's Weekly Skin Observation, dated 5/10/25 at 7:11 P.M., showed the resident had a skin tear to his/her left forearm. Observation and interview on 5/12/25 at 11:10 A.M., with Resident #238 showed: -The resident was in his/her room with the curtains and door shut, watching television. -The resident had bruising on his/her left side of face, bruising around his/her mouth and lips, and a bandage on his/her left arm. -The resident said he/she and his/her roommate got in a fist fight this past Friday. He/She notified staff. He/She went to have the roommate turn down his/her television and he/she lost balance and fell to the floor. The resident said at that time, his/her roommate jumped on top of me, pinning me down on the floor, and began punching me. He/She was finally able to get from underneath Resident #72 (roommate) and pull himself/herself off the floor by using the resident's furniture. The resident to resident altercation was about 10 minutes long and then staff entered the room. He/She hit his/her head while falling to the floor during the altercation. -The resident cried while recalling the scenario and stated, I have been scared to even leave my side of the room. Observation and interview on 5/12/25 at 11:25 A.M., showed Resident #72: -The resident lay in his/her bed. -The resident said his/her roommate (Resident #238) came on his/her side of the room a couple days ago, asked him/her to turn down the television and started swinging on him/her. The roommate then threw his/her plastic cup of water on him/her and threw his/her television on the floor. The roommate lost his/her footing and fell on the floor, but was shortly able to get himself/herself up from the floor. Staff then came into the room. -The resident had visible bruising on his/her right arm. During an interview on 5/14/25 at 9:42 A.M., Certified Nurses Aide (CNA) F said: -He/She broke up the incident between the residents on 5/10/25 at about 9:15 A.M. -The residents were in their room when the resident to resident altercation occurred -Resident #238 was upset because another resident had come into their room. -Resident #238 put on the light because the other resident wandered into his/her room. He/she went in and assisted the other resident out of the room. Resident #238 was still upset. -Resident #238 wanted to talk to the social worker about the other resident coming into the room and he/she told Resident #238 there was no social worker on the weekend. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Resident #238 put the light on again. -He/She went into the resident's room. The whole floor was wet. Resident #72's belongings were also on the floor. Resident #238 was sitting in his/her recliner. Resident #72 was standing in the middle of the floor, trying to catch his/her breath. -Resident #238 had blood all over his/her face. -Resident #72 had a scratch on his/her lower arm. -He/She asked Resident #72 what happened and he/she responded Resident #238 attacked him/her and he/she was defending him/herself. -He/She asked Resident #238 what happened and he/she responded Resident #72 would not turn the television down and it was too loud, so he/she stated hammering on Resident #72 and then he/she fell to the ground. -He/She did not receive any further instruction on what to do with the residents to keep them both safe. -The supervisor went upstairs and got an extra CNA to sit with Resident #238 in his/her room. -Resident #72 stated right after the altercation, he/she was scared to go back in the room, because Resident #238 had attacked him/her. -He/She later entered the resident's room to check on Resident #238 who stated he/she was going to strangle Resident #72 if he/she came back in their room. -Resident #72 remained at the nurse's station for about 2 hours and then went back to his/her room unsupervised. During an interview on 5/12/25 at 12:31 P.M., the Director of Nursing (DON) said: -He/She was aware of the resident to resident altercation between Resident #72 and Resident #238, because he/she was notified by staff members when it occurred. -He/She was aware Resident #238 had bruising on his/her lips and mouth, and an abrasion to his/her left side of face, and a wound on his/her left arm. -He/She was aware Resident #72 had bruising on his/her left arm. -He/She would have expected the aggressor of the incident to be placed on 1:1 observation, the residents to be separated, and the family and physician to be notified. -Resident #238 was the aggressor and family of both residents had been notified. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The house supervisor notified him/her of the resident to resident altercation and it occurred because Resident #72 had his/her television on loud and Resident #238 asked Resident #72 to turn it down. Resident #238 then threw a water pitcher at Resident #72 and the two residents began punching each other. During an interview on 5/12/25 at 12:54 P.M., the Social Services Director said: -He/She received a notification about the resident to resident altercation. -He/She visited with Resident #238 on 5/11/25. -Resident #238 presented slightly agitated during his/her visit with him/her. -Resident #238 stated it was bullshit and that the zombies keep coming into my room. During an interview on 5/12/25 at 2:50 P.M., the DON said: -The residents have been together for a few months and this was their first incident. -Resident #238 was placed on 1:1 after the incident on 5/10/25 at 9:30 A.M., he/she was removed from 1:1 during the night shift related to staffing. -Resident #238 was placed back on 1:1 observation on 5/12/25, after facility staff were told that resident #238 expressed fear to the surveyor. -There was a plan to change rooms after the incident when he/she can find another resident who would be compatible with Resident #238. -Resident #238 would now remain on 1:1 observation until a room change occurred. -He/She was going to find out how Resident #238 got taken off 1:1 observation over the weekend. During an interview on 5/13/25 at 1:57 P.M., Regional Director of Operations said: -He/She was not working on 5/10/25. -He/She became aware of the resident to resident altercation on the evening of 5/10/25. -He/She was told that if a resident to resident was unwitnessed it was not reportable. -As far as he/she knew, the residents felt safe until 5/12/25. During an interview on 5/13/25 at 2:27 P.M., the Nurse Practitioner (NP) said: -He/She was not notified when the resident to resident incident occurred on 5/10/25. -He/She found out about the incident when he/she came to work on 5/12/25. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/She saw both residents on 5/12/25. -He/She was under the impression Resident #72 had his/her television too loud and as a result, Resident #238 went over to Resident #72 and they ended up hitting each other. -On 5/12/25, he/she observed Resident #72 had red marks on his/her right forearm about 5 cm long. -On 5/12/25, he/she observed Resident #238 had purple bruises on his/her lips, and abrasion on his/her left eye, and a red mark on his/her right side of cheek. -From his/her observation, it appeared Resident #238 was hit in the face by Resident #72. During an interview on 5/14/25 at 10:37 A.M., the Physician said: -He/She was aware of the resident to resident altercation. -He/She could not recall when he/she was notified of the altercation. -He/She expects the facility to follow the policy after a resident to resident altercation. -He/She expects that all residents be made to feel and kept safe at all times. -The residents should have been separated and not behind closed doors after the incident. During an interview on 5/23/25 at 1:38 P.M., the DON said: -The abuse policy stated residents involved in resident to resident altercations should be separated, but did not say for how long. -He/she defined abuse as being done intently. On the memory care unit the facility had a lot of behaviors that arose and he/she would have to look up the guidelines on if those behaviors were considered abuse. -Willful intent was to hurt someone was main definition of abuse and that no negative outcome was needed to be classified as abuse. -All residents have the right to be free from abuse. -He/she did not identify the resident to resident incident between Resident #72 and Resident #238 as abuse. -Resident #72 and Resident #238 remained in the same room after the altercation on 5/10/25 through 5/12/25. 2. Review of Resident #240's admission Record showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Dementia. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Cognitive communication deficit (difficulty with communication stemming from problems with cognitive processes like attention, memory, and problem-solving). -Restlessness. -Depression. Review of Resident #240's admission MDS, dated [DATE], showed the resident assessed as cognitively impaired. No behaviors documented. Review of Resident #240's care plan, dated 4/10/25, showed: -The resident was an elopement risk/wanderer. -The resident was disoriented to place. -Staff to monitor the resident's location every 15 min and document. -Staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book. -The resident was at risk for falls. -The resident had activities of daily living self-care performance deficit related to impaired cognition. -The resident had a behavior problem that caused him/her to wander into other residents' rooms related to his/her confusion. -The staff to intervene as necessary to protect the rights and safety of others. -The staff to remove the resident from situations and take to alternate location as needed when wandering. Review of Resident #215's Quarterly MDS, dated [DATE], showed the resident: -admitted to the facility on [DATE]. -assessed as cognitively impaired. -had a diagnosis of dementia. -had a history of verbal behaviors. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #240's progress note, dated 4/27/25 at 5:00 P.M., showed Licensed Practical Nurse (LPN) D documented overhearing some commotion on west hall while residents were heading to dinner and on rushing over to investigate found resident lying prone next to Resident #215's doorway, shouting. On turning over the resident he/she was noted with a hematoma to his/her right eyebrow. Another resident was noted next to him/her, shouting at him/her too. Resident #240's range of motion was within normal limits. Bruising to bilateral knees noted and a small skin tear right wrist which was cleansed and covered. Some more bruising noted to left elbow. The resident stated he/she fell. The resident assisted up and walked to the nurse's station where neurological assessments were initiated. Ice pack applied to hematoma for 20 minutes. House supervisor, physician, and durable power of attorney notified. Review of Resident #240's progress note dated 4/27/25 at 5:52 P.M., showed LPN E was acting as house supervisor when the charge nurse caring for Resident #215 called him/her down to the unit. When he/she arrived at unit, was told Resident #215 had an altercation with another resident at approximately 5:00 PM. The other resident (Resident #240) sat at the nurse's station with a bump along the right eyebrow and a skin tear to the right wrist. Nurse stated no one witnessed the altercation, but the nurse stated he/she heard screams and observed the other resident (Resident #240) laying on the ground in front of Resident #215's room. When the nurse approached the situation, Resident #215 was heard saying Do you want another one. After assessing the injured resident (Resident #240), LPN E went to see Resident #215 to get his/her description of the incident. Resident #215 was asked what happened between him/her and the other resident and he/she stated, he/she came in my room. He/She was not supposed to be in my room, I didn't want him/her in there, so I pushed him/her out. LPN E asked how he/she pushed the resident out, if he/she could describe the motion and he/she stated, I pushed him/her out by the shoulders like this. While holding up his/her arms to meet either side of my shoulders without actually touching me. When LPN E asked the other resident (Resident #240) how he/she sustained the bump to his/her face, he/she stated it happened when he/she fell down. LPN E called the DON to notify him/her of the situation and was instructed Resident #215 needed to be sent out to be evaluated and to place Resident #215 on a 1:1 until he/she was taken out of the facility. Resident #215 was placed on a 1:1 immediately and LPN E called Resident #215's family member to notify him/her of what was going on. After explaining the situation and answering all questions he/she had, the family member stated he/she would come pick Resident #215 up and take him/her to the hospital. The DON notified the family member would be transporting the resident to the hospital. Resident will continue on 1:1 until he/she leaves with his/her family. Review of the facility Incident Report, dated 4/27/25, showed: -There was a resident to resident incident between Resident #240 and Resident #215. -Around 5:00 P.M., LPN D overheard a commotion on the west hall and upon entering the hallway, LPN D saw Resident #240 lying in a face down position on the floor next to Resident #215's room. -Resident #215 was standing next to Resident #240 and stated, Do you want another one? -Resident #240 told LPN D that he/she fell. -Resident #215 stated, he/she came into my room. He/She was not supposed to be in my room. I didn't want him/her there, so I pushed him/her out. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Resident #215 stated, I pushed him/her out by his/her shoulders. -Resident #240 had a hematoma above his/her right eye, a skin tear to his/her right wrist, bruising to his/her bilateral knees, and bruising to his/her left elbow. -Resident #240 was cognitively impaired. -Resident #215 was cognitively impaired. -The facility did not substantiate the incident as abuse due to being unwitnessed. Review of Resident #240's skin assessment dated [DATE] showed: --Bruising on the resident's left elbow. --Bruising on the resident's right knee. --Bruising on the resident's left knee. --Hematoma to the resident's right eyebrow. --Bruising to the resident's right upper arm. --Skin tear to the resident's right wrist. During an interview on 5/21/25 at 3:15 P.M., LPN D said: -He/She was working as the charge on 4/27/25 when the resident to resident altercation occurred between Resident #240 and Resident #215. -He/She heard commotion down the hall and upon arrival to the incident, he/she observed Resident #240 face down on the floor with Resident #215 standing over Resident #240 yelling at him/her and stated, Do you want another one? -He/She then helped Resident #240 up off the floor and started his/her nursing assessments, which included: --Head to toe assessment, pain scale, and neurological checks. -Resident #240 stated he/she was in pain. -He/She called the physician and the house supervisor to notify them of the resident to resident altercation. -Resident #215 was placed on one on one observation. -Resident #240's face was visibly bruised and swollen and he/she took Resident #240 to the nurse's station and applied ice to the resident's face for 20 minutes. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Facial bruising and noted injuries on the resident's skin assessment were all received from the resident to resident altercation that occurred the day prior on 4/27/25. During an interview on 5/21/25 at 9:35 A.M., LPN E said: -He/She was working as the unit manager on 4/27/25 when the resident to resident altercation occurred between Resident #240 and Resident #215. -He/She was the one who assessed the Resident #240's skin after the resident to resident altercation. The resident had bruising on his/her left elbow, his/her knees, and his/her upper arm, a hematoma on the eyebrow and a skin tear. -The injuries noted on Resident #240's skin assessment dated [DATE] were a result from the resident to resident altercation on 4/27/25. -He/She interviewed Resident #240 after the incident occurred who stated he/she fell. -He/She interviewed Resident #215 after the incident occurred who stated Resident #240 was coming in his/her room, so he/her pushed Resident #240. -He/She placed a progress note in the risk management system stating Resident #215 pushed Resident #240, which caused Resident #240 to fall and receive injuries. During an interview on 5/13/25 at 2:30 P.M., the NP said: -There was a resident to resident altercation between Resident #240 and Resident #215 a couple weeks ago that caused significant bruising on Resident #240's face. -The bruising was the result of Resident #240 being shoved by Resident #215, which caused Resident #240 to fall to the ground. During an interview on 5/14/25 at 9:58 A.M., Resident #240's Durable Power of Attorney (DPOA) A said: -He/She was aware Resident #240 went into another resident's room a couple weeks ago and the other resident pushed Resident #240 down and he/she bumped his/her head and twisted his/her knee. -He/She came to visit the resident a couple weeks ago, after the resident to resident altercation and saw significant bruising on the resident's face. -He/She denied the resident as having the facial bruising prior to the resident to resident altercation. -He/She visited the resident on a regular basis at least once per week. -The facility had the resident's knee x-rayed and there were no fractures noted on the x-ray after the altercation a couple weeks ago. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The facility contacted him/her and stated Resident #240 fell on 5/11/25. -The facility had not contacted him/her regarding any other resident to resident altercations. -He/She felt the resident had become increasingly sad and smiled less since being moved to the locked unit and the altercations. -The family does not feel the resident was safe from other residents on the locked unit. 3. Review of Resident #307's admission record showed the resident admitted to the facility on [DATE] and some of his/her diagnoses included dementia with agitation, unsteadiness on feet, PTSD, and selective mutism (an anxiety disorder where a person, capable of speaking, becomes unable to speak in specific situations or with certain people, despite speaking normally in other settings. It's not a choice, but rather an anxiety-related inability to speak). Review of Resident #307's baseline care plan, dated 3/5/25, showed the resident had the potential for behaviors and a diagnosis of PTSD. Review of Resident #307's care plan, developed on 3/7/25, showed: -The resident had a diagnosis of PTSD, which affected his/her overall health and well-being. -The resident had been in prison for 27 years. -Behaviors related to this trauma included agitation towards others and selective mutism. -The desired outcome was the resident would be provided assistance to address the effects of trauma during the review period as demonstrated by no trauma-related behaviors and expressions of feelings of safety and support. -Interventions included: --Evaluate recommendations of psychiatric and behavioral health professionals and implement as appropriate. -Another problem identified was the resident had impaired cognitive function related to dementia. -The desired outcome was the resident would maintain his/her current level of cognitive function through the review date. Review of Resident #307's admission MDS, dated [DATE], showed the resident had moderately impaired cognitive skills for decision-making and no behaviors documented. Review of Resident #307's Level I (initial screening of individuals who have or may have a mental illness and/or an intellectual disability or related condition prior to their admission to a nursing facility. A positive Level 1 screen necessitates an in-depth evaluation of the individual, by the state-designated authority, known as Level II , which must be conducted prior to admission to the facility), submitted 4/16/25, showed: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The resident had diagnoses of PTSD and dementia. -The resident did not have any area of impairment due to serious mental illness. -The resident experienced one psychiatric treatment episode that was more intensive than routine follow-up care. -Due to mental illness, the resident experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community or intervention by housing or law enforcement officials. -The resident was moderately withdrawn/depressed. -The resident's aggression was documented as at maximum level. -The resident's unstable mental condition was monitored by a physician or licensed mental health professional at least monthly and behavior symptoms are currently exhibited or psychiatric conditions are currently exhibited. -The resident displayed consistent unsafe/poor decision-making requiring reminders, cues, or supervision at all times to plan, organize and conduct daily routines and has issues with memory, mental function, or ability to be understood/understand others. Review of Resident #26's admission record showed the resident admitted to the facility on [DATE] and some of his/her diagnoses included major depressive disorder, dementia, and PTSD. Review of Resident #26's care plan, updated 3/16/25, showed: -The resident had impaired cognitive function and required assistance from staff with his/her daily care needs related to his/her diagnosis of dementia. -The resident reported his/her roommate hit him/her while he/she was in bed. Review of Resident #26's quarterly MDS, dated [DATE], showed the resident assessed as cognitively intact. Review of resident #26's incident note, dated 3/16/25 at 11:00 A.M., showed: -Resident #26 reported that while he/she was lying in bed, Resident #307 punched him/her in the left side of his/her chin with a closed fist. -Resident #26 reported he/she got up to leave the room and Resident #307 stood with two closed fists in front of him/her staring at him/her. -There were no apparent injuries. Review of the facility investigation, dated 3/16/25, showed on 3/16/25 Resident #26 reported Resident #307 approached him/her while lying in bed and made contact with his/her head. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/21/25 at 1:05 P.M., LPN K said: -On 3/16/25, Resident #26 reported Resident #307 hit him/her in the face. -Resident #26 was alert and could tell what was going on. -There were no apparent injuries. During an interview on 5/16/25 at 12:57 P.M., CNA F said Resident #26 told him/her that Resident #307 hit him/her. During an interview on 5/14/25 at 2:36 P.M., Resident #26 said he/she felt safe now. He/She was unable to describe what happened on 3/16/25. During an interview on 5/23/25 at 1:50 P.M., the DON said no one witnessed Resident #307 hit Resident #26. 4. Review of Resident #238's admission record showed the resident admitted to the facility on [DATE] and some of his/her diagnoses included dementia, major depressive disorder, anxiety disorder (psychiatric disorder that involve extreme fear, worry and nervousness), and PTSD. Review of Resident #238's undated care plan showed he/she had a diagnosis of dementia and he/she was mostly independent with self-care needs. Review of Resident #238's quarterly, MDS dated [DATE], showed the resident assessed as having moderately impaired cognitive skills. Review of Resident #238's nurse's note dated 3/22/25 showed Resident #238 sat on the bed when Resident #307 was standing over Resident #238 grabbing Resident #238's hand trying to get Resident #238 out of bed. Review of the facility investigation, dated 3/22/25, showed: -Resident #238 said he/she was asleep in bed when Resident #307 began shaking him/her. -Resident #238 said it woke him/her up and he/she saw Resident #307 shaking his/her fist above him/her. -Resident #238 said Resident #307 attempted to swing at him/her, but missed. -Resident #238 said

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the resident with an appropriate discharge notice and failed to allow one supplemental resident (Resident #307) to return to the facility after having been transferred to the hospital or found an alternate facility to accept him/her out of 31 supplemental residents. The facility census was 259. Review of the Transfer and Discharge Planning policy, dated 10/24/22, showed: -The purpose of the policy was to ensure adequate preparation and assistance was provided to residents prior to transfer or discharge from the facility. -Social Services staff participated and assisted the resident with transfers and discharges and preparing the Discharge Summary and Discharge Care Plans as part of the Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of their clients). -Social Services staff conducted a Discharge Planning Assessment and helped orient the resident to the impending discharge. -Social Services staff coordinated discharge with the IDT, the resident, and the residents' representative. -Social Services staff documented the discharge planning, preparation, and the resident's post discharge needs on the discharge planning assessment form in the electronic health record. -Social Services staff coordinated with the resident and the resident's family to discuss discharge needs. -Social Services staff assisted in developing the Discharge Summary and Discharge Care Plan that was developed by the IDT team. -The receiving provider will receive necessary information to facilitate a smooth transition and continuity of care. -A copy of the Discharge Summary was provided to the resident and/or the resident's family member upon discharge when return was not anticipated. -Summary of the resident's stay included diagnosis, course of illness, treatment, and pertinent lab, radiology, and other consultation results. -A copy of the discharge summary and discharge care plan was maintained in the residence medical record. 1. Review of Resident #307's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dementia (a group of thinking and social symptoms that interferes with daily functioning). Metabolic encephalopathy (a brain disorder that arises from electrolyte imbalances, organ dysfunction or toxic exposure). -Post Traumatic Stress Disorder (PTSD - when a person has difficulty recovering after an experience or witnessed a terrifying event). -Selective Mutism (a rare disorder that prevents a person from speaking). -Chronic kidney disease (When the kidneys could no longer filter the blood). -Suicidal ideations (Thoughts about or planning suicide). Review of Resident #307's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 3/10/25, showed the following staff assessment of the resident: -Had moderately impaired cognitive skills for decision-making. -Some of his/her diagnoses included Alzheimer's Disease (a progressive loss of brain cells that leads to memory loss and the decline of other thinking skills), Dementia and PTSD. -Displayed mood signs and/or symptoms that indicated mild depression. Review of the resident's Nurse Practioner's Consultation, dated 3/17/25, showed: -The resident had a resident to resident altercation over the weekend and he/she was the aggressor. -He/She hit the other resident in the face. -He/She has had other issues prior to a recent evaluation at a Psychological facility. -He/She was currently sitting with a one to one staff member at the facility. Review of the resident's Brief Interview for Mental Status, dated 5/9/25, showed the resident was not able to complete the interview. Review of the resident's care plan, dated 5/11/25, showed: -He/She had a behavioral history of violence, being territorial and agitation toward others. -He/She was aggressive with his/her roommate, dated 3/16/25. -He/She was in another resident's room being aggressive toward him/her, dated 3/22/25. -He/She was aggressive with two other residents, dated 4/21/25. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was aggressive with another resident, dated 5/11/25. -He/She was sent out to a Geriatric/Psychiatric (Geri/Psych Psych facility for elderly) facility on 3/28/25. -He/She was placed on one-on-one observation dated 4/21/25. -He/She was sent to a Geri/Psych facility for evaluation related to aggressive behaviors, dated 4/22/25. -He/She was placed on one-on-one observation dated 5/11/25. Review of the resident's Facility Transfer Form, dated 5/13/25 at 9:58 A.M., showed the resident was being transferred to a nearby hospital to obtain a medical clearance for Psychological admission due to combative and aggressive behavior. Review of the Notice of Proposed Discharge for the resident, dated as effective 5/13/25, showed: -The resident was being discharged to a nearby hospital because the discharge was necessary for his/her welfare, and his/her needs could not have been met by the facility. -The family member verbalized understanding of the document on 5/13/25. -The Social Services Director signed it on 5/14/25. Review of the Notice of the second Proposed Discharge for the resident, dated as effective 5/13/25, showed: -The resident was being discharged to a nearby hospital for the following reasons: --The discharge was necessary for his/her welfare, and his/her needs could not have been met by the facility. --The safety of individuals in the facility was endangered by his/her presence. -The family member verbalized understanding of the document on 5/13/25. -The Social Services Director signed it on 5/14/25. Review of the resident's nurse's note, dated 5/13/25, showed the resident was discharged to the hospital for evaluation for medical clearance for psychiatric admission due to combative and aggressive behaviors. Review of the resident's progress note, dated 5/13/25, showed: -The Assistant Director of Nursing (ADON) documented that he/she spoke with the resident's responsible party about his/her recent increased behaviors. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was sent to the hospital during the day shift. -They were working with the hospital to find appropriate placement for the resident. -The facility did not feel it was capable of providing the care needed during this time. During an interview on 5/19/25 at 11:57 A.M., the Ombudsman said: -The facility normally emailed discharges to him/her. -Sending the resident to the hospital was not an appropriate location for a discharge. -He/She had not received an email for notification of discharge for the resident on 5/13/25. -He/She was not in the office, so he/she was not sure if the facility had sent it in the mail. Review of an email from the Ombudsman to the surveyor, dated 6/4/25 at 10:27 A.M., showed the Ombudsman said they never received any type of discharge notice regarding the resident. During an interview on 5/20/25 0 at 9:16 A.M., the ADON said: -They were working on trying to find alternate placement for the resident. -The Administrator had directed him/her to find alternate placement for the resident. -The Administrator had spoken with the Regional Director of Operations and the Hospital Liaison. -He/She was not in on the discussion of why they couldn't meet the resident's needs. -He/She had no part in making the decision to not allow him/her to return to the facility. -He/She was asked to call the family and inform them the resident was not coming back to the facility from the hospital. During an interview on 5/20/25 at 2:04 P.M., the Social Services Director said: -He/She did the discharge letters. -He/She usually found out after a resident went to the hospital that the resident was sent out of the facility. -He/She would always find out if there was verbal acknowledgement when the resident was sent out to the hospital and not to return to the facility, if not, he/she would reach out to inform the resident's family they were not coming back to the facility. -He/She was told the resident was going to the hospital after the resident's discharged on 5/13/25 (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The next morning he/she was informed the resident was not coming back to the facility by other staff members. -On 5/13/25 he/she gave the discharge notice for 5/12/25 to go to hospital, so only one box was checked for reason, as he/she thought the resident would be returning to the facility. -The second discharge notice stated the resident was being discharged completely. -He/She did not know if it was a 30-day discharge notice or if it was an immediate discharge notice. -Later he/she heard from other staff it was supposed to have been an immediate discharge notice. -He/She would normally have helped with finding alternate placement for the resident. -He/She would have sent out referrals to other nursing homes. -He/She was told the resident was going to a nearby hospital, but then heard that he/she went to a different hospital. -He/She was not sure how to document the paperwork since the resident had already been discharged . -He/She sent referrals to 16 facilities on Friday 5/16/25. -In the referral he/she stated that the resident was in the hospital. -He/She had not talked to anyone at the hospital. -There was a Clinical Liaison who worked out of the facility that gave him/her a list of facilities to send the referrals to. -When the resident went to the hospital, he/she thought he/was just going to the hospital and would return so he/she had not sent any referrals at that point, because he/she thought the resident was just in the hospital. -On Friday 5/16/25 he/she was told to send out referrals to other facilities. During an interview on 5/21/25 at 2:35 P.M., the Clinical Liaison said: -The resident was at the hospital and he/she had been notified by the Administrator due to resident to resident altercations that after a psychiatric hospital stay, they were not going to allow the resident to return to the facility. -He/She notified the hospital they were not taking the resident back. -He/She gave the hospital some ideas of places for a referral. -He/She had not seen the resident while he/she was in the hospital. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/25 at 12:26 PM., the Hospital Case Manager said: -The resident was still at the hospital. -The Clinical Liaison said the facility refused to accept the resident back. -They were having a hard time finding a place that would accept the resident. During an interview on 5/23/25 at 1:50 P.M., the Director of Nursing (DON) said: -He/She was not in charge of the discharge notices. -He/She knew the facility was to allow the resident to return to the facility after a stay at the hospital. During an interview on 5/23/25 at 3:21 P.M., the Administrator said: -He/She was aware of the requirements for discharge notices and understood what it meant. -He/She knew they could not discharge a resident to the hospital and not take them back to the facility, they would have to take the resident back after he/she was discharged from the hospital. -He/She thought the resident was still at the hospital. -He/She would have to check with his/her admission people to see where the resident was. They were both gone for the weekend. -The clinical liaison was working with the hospital to try to find different placement for the resident. -They were not taking the resident back and they were aware of the requirement to let the resident return. MO00254351

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide appropriate treatment and behavioral health services per policy for one sampled resident (Resident #307) who had a known history of physical aggression and wandering. The resident admitted on [DATE], with a history of post-traumatic stress disorder (PTSD-can develop after experiencing or witnessing a traumatic event in which symptoms can include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event) to a locked memory care unit. The facility staff failed to consistently implement a plan of care related to behavioral health services to reduce resident behavior and maintain resident safety. The facility staff failed to update the plan of care after incidents of aggression with new interventions. The facility did not have a system in place to ensure the interdisciplinary team (IDT) was involved in assessing the resident's behavioral needs and implementing new interventions after each altercation. As a result of the facility failure to provide behavioral treatment and services for the resident has been sent the emergency room and hospitalized on multiple occasions and continued to have physical behaviors towards other residents. Thirty five residents were selected for sample. The facility census was 259 residents. Review of the facility's Behavior-Management policy, undated, showed: -The purpose of the policy was to: --Implement the most desirable and effective interventions to change, modify, decrease, or eliminate behaviors that were distressing to the resident and/or were decreasing or negatively impacting the resident's quality of life. --The facility was responsible for providing behavior health care and services that created an environment that promoted emotional and psychosocial well-being that met each resident's needs and included individualized approaches to care. -The key components of behavior management were: --Identification of residents whose behaviors may pose a risk to others. --Develop individual and practical care strategies base on assessed needs. --Implement the behavior management program. --Provide ongoing assessment, monitoring, and evaluation of effectiveness of behavior management program including the effectiveness of psychoactive drugs. -The goal of the IDT (a group of health care professionals with various areas of expertise who work together toward the goals of their clients) was to promptly identify behavior management issues and develop an effective management program. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When a resident displayed behavior symptoms (crying, yelling, hitting, etc.), Licensed Nursing Staff assessed the behavioral symptoms to determine possible causal factors, contacted the attending physician, and implemented non-drug interventions to alleviate the behavioral symptoms. -The facility must provide necessary behavioral health care and services which include: --Ensure that necessary care and services were person centered and reflect the resident's goals for care and maximize the residents' dignity, autonomy, privacy, socialization, independence, choice, and safety. --Ensure that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being. -Licensed nursing staff document the behaviors in the resident's medical record. -Staff document notification of the attending physician, notification of the resident's family and/or responsible party, and the incident within 24 hours of the incident. -The charge nurse assigns a staff member to monitor the resident as needed to protect the resident as well as others. -Nursing staff continues to monitor the residents' behavior to determine what events precipitated the behavior and document the following information: --Date and time of behavior. --Location of resident when the behavior occurred. --Description of the behavior. --What may have caused the behavior. --Any interventions used and the effect it had on the resident. -In assessing the resident for potential behavioral factors, licensed nursing staff consider factors and document in the medical record: --Physical condition of the resident (pain, discomfort, hunger or thirst, fatigue, toileting needs). --Environmental conditions (room temperatures, noise, overcrowding). --Psychosocial or emotional stressors (change in the resident's customary routine, frustration, fear of the unknown, possible abuse by other residents, incompatibility with roommate, inability to communicate needs). -Managing behavior problems includes building a positive and trusting relationship with the resident. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Use effective verbal and nonverbal communication techniques. --Redirect or divert the resident's attention to positive topic, activity, or object. 1. Review of Resident #307's admission record showed the resident admitted to the facility on [DATE] and some of his/her diagnoses included dementia (a progressive mental disorder characterized by memory problems, impaired reasoning and personality changes) with agitation, unsteadiness on feet, PTSD, and selective mutism (an anxiety disorder where a person, capable of speaking, becomes unable to speak in specific situations or with certain people, despite speaking normally in other settings. It's not a choice, but rather an anxiety-related inability to speak). Review of Resident #307's Level I Pre-admission Screening and Resident Review (PASARR-used to identify all individuals who have a mental illness and/or an intellectual disability or related condition prior to their admission to a nursing facility), submitted 3/12/25, showed: -The resident had diagnoses of PTSD and dementia. -The resident did not have any area of impairment due to serious mental illness. -The resident experienced one psychiatric treatment episode that was more intensive than routine follow-up care. -Due to mental illness, the resident experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community or intervention by housing or law enforcement officials. -The resident was moderately withdrawn/depressed. -The resident's aggression was documented as at maximum level. -The resident's unstable mental condition was monitored by a physician or licensed mental health professional at least monthly and behavior symptoms are currently exhibited or psychiatric conditions are currently exhibited. -The resident displayed consistent unsafe/poor decision-making requiring reminders, cues, or supervision at all times to plan, organize and conduct daily routines and has issues with memory, mental function, or ability to be understood/understand others. Review of Resident #307's baseline care plan, dated 3/5/25, showed: -The problems identified included the resident had the potential for behaviors and had a diagnosis of PTSD. -Interventions included: --The resident will verbalize feelings associated with their past trauma through the next review. --Social Services visits as needed. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Provide and encourage favorite activities for distraction. --Medication as ordered. --Observe behaviors and try to determine cause. Review of Resident #307's social history and initial assessment completed by the former Social Worker, dated 3/7/25, showed: -The resident was in prison for 27 years. -The reason for the resident's admission to the facility was due to dementia with agitation and PTSD. -The resident was not able to write letters or sign documents. -The resident was not able to read or understand his/her own mail. -The resident was confused, had a flat affect, walked independently, was nonverbal, had good vision, and poor hearing. -There was no section to add triggers or care interventions. Review of Resident #307's trauma informed care, dated 3/7/25, showed the former Social Worker documented: -The trauma of being in prison for 27 years affected his/her overall health and well-being. -The resident's PTSD was due to being in prison for 27 years. -There was no section to add triggers or care interventions. Review of Resident #307's care plan, developed on 3/7/25, showed: -The problem identified was the resident had a diagnosis of PTSD, which affected his/her overall health and well-being. -The resident had been in prison for 27 years. -Behaviors related to this trauma included agitation towards others and selective mutism. -The desired outcome was the resident would be provided assistance to address the effects of trauma during the review period as demonstrated by no trauma-related behaviors and expressions of feelings of safety and support. -Interventions included: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Evaluate recommendations of psychiatric and behavioral health professionals and implement as appropriate. --Make sure the resident knows when someone enters his/her room. --Do not sneak up on the resident or startle him/her. --Write down your name and what you are doing on his/her communication board. --Back away slowly if the resident becomes agitated and make sure he/she is safe. --Psychiatric and behavioral health referrals. --Reassure the resident of his/her safety on the unit. -Another problem identified was the resident had impaired cognitive function related to dementia. -The desired outcome was the resident would maintain his/her current level of cognitive function through the review date. -Interventions included: --Administer medications as ordered. --Cue, re-orient, and supervise the resident as needed. --Write simple yes/no questions to determine his/her needs. --Inform Social Services of behavior episodes and attempt to determine underlying cause. -Another problem identified was the resident had a behavioral history of violence, being territorial, and agitation towards others. -The desired outcome was he/she would have fewer episodes of being agitated towards others. -Interventions included: --Intervene as necessary to protect the rights and safety of others. --Approach in a calm manner. --Divert the resident's attention. --Take him/her to an alternate location as needed. -Another problem identified was the resident had a diagnosis of PTSD and behaviors related to this trauma have included agitation towards others and selective mutism. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The desired outcome was he/she would be provided assistance to address the effects of trauma as demonstrated by no trauma-related behaviors and expressions of feelings of safety and support. -Interventions included: --Make sure the resident knows you are in his/her room. --Do not sneak up on or startle the resident. --Write on his/her communication board. --Back away slowly if the resident becomes agitated. --Make sure the resident is safe. Review of Resident #307's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 3/10/25, showed the following staff assessment of the resident: -Had adequate hearing and vision. -Did not speak. -Was rarely or never understood by others and rarely or never understood others. -Had short-term and long-term memory impairment. -Knew the location of his/her room. -Had moderately impaired cognitive skills for decision-making. -Displayed mood symptoms that indicated mild depression (a mood disorder that consists of intense sadness and a loss of interest or loss of pleasure in activities and/or life). -Had no behavioral symptoms. -Had no range of motion limitations. -Walked with supervision. -Required supervision only for most self-cares. -Had diagnoses that included dementia and PTSD. Review of Resident #307's nurse's note, dated 3/16/25 at 5:15 P.M., showed: -Another resident (Resident #26) reported this resident approached him/her while he/she was lying in his/her bed and punched him/her in his/her chin at 11:00 A.M. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The other resident then reported he/she removed himself/herself from the room then turned around to get his/her cell phone and saw Resident #307 with both fists balled up staring at him/her. -New orders were received for Complete Blood Count (CBC - a test that gives information about blood cells), Basic Metabolic Panel (BMP - a blood test that measures sugar levels, electrolytes, fluid balance, and kidney function), and a urine analysis (UA - a test of urine used to detect and manage a wide range of disorders, such as urinary tract infections, kidney disease and diabetes) for the next morning. -Resident #26 was moved to another room. -There were no apparent injuries observed to the resident. Review of the facility investigation, dated 3/16/25, showed on 3/16/25 around 11:00 A.M.: -Resident #26 reported Resident #307 approached him/her while he/she was lying in bed and made contact with his/her head. -Labs were ordered. -Resident #307 was provided with a private room. -They completed abuse and neglect in-servicing. -The training provided to employees included abuse and neglect. -Behavior management training was not documented as included in the training that was provided to staff. -Resident #307 was unable to give a description of what happened. Review of Resident #307's nurse's note, dated 3/16/25, showed Resident #307 was placed on one-on-one care at 12:30 P.M., because Resident #26 reported Resident #307 punched him/her in the chin. Review of Resident #307's behavior care plan, updated 3/16/25, showed a private room was provided and labs were ordered due to Resident #307 being aggressive with Resident #26. Review of Resident #307's nurse practitioner's (NP) note, dated 3/17/25, showed: -The resident had an altercation with another resident and was placed on one-on-one observation. -The resident was very confused and did not speak. -He/She did not see a one-on-one care giver and he/she would talk to nursing administration about that. -The resident had agitation, PTSD, and Alzheimer's disease (a progressive loss of brain cells that leads to memory loss and the decline of other thinking skills) with agitation. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Labs would be drawn including CBC, BMP, and UA CNS (culture and sensitivity) if indicated. -A new order for Ativan 0.5 milligrams (mg) every six hours as needed for 14 days. -He/She would find out about the one-on-one monitoring of Resident #307. Review of Resident #307's nurse's note, dated 3/18/25, showed the resident's primary care physician reviewed the resident's CBC and CMP results and gave no new orders. During an interview on 5/21/25 at 1:05 P.M., Licensed Practical Nurse (LPN) K said: -On 3/16/25, Resident #26 reported to him/her Resident #307 hit him/her in the face. -Resident #26 was alert and could tell you what was going on. -The Director of Nursing (DON) told him/her to move Resident #26 to another room and place Resident #307 on one-on-one observation and he/she did that. -Resident #307 didn't like anyone close to him/her. -Resident #307 got upset if anyone walked in his/her room. -Resident #307 would stand in his/her doorway and stare. -Resident #307 just wanted to be alone. -Resident #307 did not allow one-on-one supervision in his/her room, so staff had to sit outside his/her room. During an interview on 5/14/25 at 12:31 P.M., the DON said after Resident #26 reported Resident #307 hit him/her in his/her face while he/she was asleep in bed, new interventions for Resident #307 included a private room due to Resident #307 being territorial. During an interview on 5/23/25 at 1:50 P.M., the DON said: -No one witnessed Resident #307 hit Resident #26. -Resident #307 was territorial. Review of the resident to resident altercation note, dated 3/20/25, showed: -The altercation was discussed with the IDT. -Intervention included Resident #26 was moved to another room. Review of the facility investigation, dated 3/22/25, showed: -Resident #238 said he/she was asleep in bed when Resident #307 began shaking him/her. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #238 said it woke him/her up and he/she saw Resident #307 shaking his/her fist above him/her. -Resident #238 said Resident #307 attempted to swing at him/her, but missed. -Resident #238 said he/she grabbed Resident #307's arms to keep him/her from attempting to hit him/her again. -Resident #238 said an employee entered the room and immediately separated the residents. -There were no apparent injuries. -Interventions included immediately separated residents, re-directed Resident #307 to his/her private room, and skin assessment. Review of Resident #307's March 2025 nurse's notes showed no documentation regarding 3/22/25. Review of Resident #307's care plan, updated 3/22/25, showed: -Resident #307 was in another resident's room being aggressive towards the other resident. -There were no new interventions documented on the resident's care plan after the 3/22/25 incident. During an interview on 5/23/25 at 10:30 A.M., Resident #238 said he/she was hit in the side of the head by somebody who was sick and confused and it made him/her mad. Review of the resident to resident altercation note, dated 3/24/25, showed: -The IDT discussed the resident to resident altercation. -The residents were separated. -Head to toe assessment was completed with no concerns noted. Review of Resident #307's behavior note, dated 3/24/25 at 8:00 A.M., showed: -Resident #307 was observed taking food from other residents at his/her table aggressively during breakfast. -Staff intervened and gently redirected Resident #307. -After breakfast, Resident #307 was found in several residents' rooms on multiple occasions and was kindly redirected to his/her room each time. -Resident #307 was found in another resident's room with the other resident's breakfast scattered on the floor. -Resident #307 was returned to his/her room with two staff assisting. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-During Resident #307's shower, he/she became agitated and resisted assistance from the shower aide and refused to continue showering and attempted to leave the shower room. --Resident #307 was placed on one-on-one observation. Review of the facility investigation dated 3/24/25 showed: -Resident #307 took food from Residents #130, #139, and #215. -Resident #307 was in Resident #43's room with food scattered on the floor. Resident #43 was not in his/her room. -Resident #307 was placed on one-on-one care. -Resident #307 was sent out to the hospital on 3/24/25. -Resident #307 returned to the facility with new medication orders. -The facility worked on getting Resident #307 accepted to a psychiatric facility. -The cover page showed abuse and neglect in-servicing was completed, but the investigation showed no abuse and neglect in-servicing for 3/24/25. -Review of the investigation showed staff did not document that behavior management training was provided to staff. -There was no documented IDT meeting for 3/24/25. Review of Resident #307's behavior care plan, updated 3/24/25, showed facility staff updated the care plan with interventions that included one-on-one observation due to behaviors for an unspecified time and to send the resident to the hospital for a medication review (resident returned from the hospital on 3/25/25). Review of Resident #307's one-on-one records, dated 3/24/25, showed one-on-one observation was provided day, evening, and night shifts on 3/24/25. Staff did not document the time the resident left for the hospital and when he/she returned to the facility. During an interview on 5/16/25 at 12:19 P.M., Certified Nurse Aide (CNA) K said: -He/She saw Resident #307 in the dining room taking other residents' food on an unknown date. -He/She's never been assigned to do one-on-one observation with Resident #307. -They have had training on behaviors, but he/she didn't remember when. -The training he/she received regarding Resident #307 was to remove him/her from the area. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She didn't know any of Resident #307's triggers, but one of Resident #307's triggers may be when other residents wander into his/her room. -Resident #307 wandered and got into other residents' beds. -Mostly they did one-on-one observation or sent Resident #307 out for behaviors or aggression. -He/She doesn't feel like there's enough staff on their unit because they do have aggressive residents and a few residents with behaviors. -It's hard to keep track of the residents with behaviors and be able to prevent anything from happening. During an interview on 5/16/25 at 2:02 P.M., the former Social Worker said: -Resident #307 took food off other residents' trays. -To his/her knowledge, the facility did not provide any training/education on Resident #307's triggers and/or interventions for staff to use with Resident #307. -When Resident #307 had behaviors, they would go over them in risk management meetings weekly. -They did one-on-one observation of Resident #307 a lot of times to try to prevent him/her from getting into someone else's room. -They also sent Resident #307 out for evaluation in the emergency room or for psychiatric stays. -They didn't talk about how to minimize Resident #307's triggers or how to keep him/her calm. During an interview on 5/16/25 at 1:33 P.M., Certified Medication Technician (CMT) G said Resident #307 punched him/her in the arm when he/she was trying to get him/her to exit the dining room when the resident was taking food off trays. During an interview on 5/21/25 at 1:05 P.M., LPN K said Resident #307 at times would move to someone else's seat in the dining room and wasn't re-directable. Review of Resident #307's NP note, dated 3/24/25, showed: -The resident had resident-to-resident altercations over the weekend. -The resident was aggressive and agitated. -He/She tried to walk the resident to his/her room with another staff member and the resident tried to fight them. -The resident was now on one-on-one monitoring. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She consulted with the resident's primary care physician and they were adding Depakote 125 mg three times a day. -Nursing administration was in the process of getting the resident out for a psychiatric evaluation. Review of Resident #307's nurse's note, dated 3/24/25 at 4:45 P.M., showed Resident #307 left the facility via ambulance to a local hospital for a psychiatric evaluation. During an interview on 5/14/25 at 12:31 P.M., the DON said: -Resident #307 was sent to the hospital on 3/24/25, because he/she was going in and out of other residents' rooms, knocked a breakfast tray on the floor, and his/her aggression was ramping up. Review of Resident #307's nurse's note, dated 3/25/25 at 1:00 A.M., showed: -The resident returned from the hospital with two bottles of Trazodone (an antidepressant medication used to treat depression) 50 mg at bedtime for sleep and Depakote sprinkles (an anticonvulsant medication generally used to prevent seizures or as a mood stabilizer) 125 mg at bedtime for mood. -The resident was presently in his/her room sitting on his/her bed awake. Review of Resident #307's Medication Administration Record (MAR), dated March 2025, showed: -The following physician orders: --3/5/25: Trazodone 50 mg at bedtime for insomnia. --3/5/25: Quetiapine ((brand name Seroquel) an antipsychotic (class of medicines used to treat psychosis and other mental and emotional conditions) medication) 50 mg twice daily for mood. --3/17/25: Lorazepam (an anti-anxiety medication) 0.5 mg, give every six hours as needed for anxiety and agitation for 14 days. --3/24/25: Depakote Delayed Release 125 mg three times a day for agitation and behaviors. -Trazodone, Quetiapine, and Depakote were administered as ordered through 3/28/25. -Lorazepam was not administered 3/17/25-3/28/25 including after any of the resident to resident incidents. Review of Resident #307's attending physician's progress note dated 3/25/25 showed: -The resident had PTSD. -He/She was not aware of any breakthrough psychiatric issues at this time except for the fact he/she went out to a psychiatric facility after some violent behavior. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-We are trying to get the resident to an in-patient psychiatric place. Review of the facility investigation, dated 3/27/25, showed: -Resident #230 was found on the floor in his/her room and Resident #307 was in Resident #230's bed. -It could not be determined whether Resident #307 pulled Resident #230 out of his/her bed or not. -Resident #230 was severely cognitively impaired. -Resident #230 was unable to give a description of what happened. -There was no documentation regarding whether staff attempted to interview Resident #307. -There was no documentation regarding having an IDT meeting to discuss the incident. -No additional interventions were added. -Resident #307 was sent to a psychiatric facility on 3/28/25. Review of Resident #307's behavior note, dated 3/27/25, showed: -The resident was found in another resident's room lying on his/her bed while the resident that resides in the room was lying on the floor. -Resident #307 was escorted out of the room and to his/her own room. -Resident #307 was placed on one-on-one monitoring. Review of Resident #307's care plan, updated 3/27/25, showed the resident was found in another resident's bed, no new interventions were added to the care plan. Review of Resident #307's care plan, updated 3/28/25, showed the resident was discharged to a psychiatric facility. During an interview on 5/16/25 at 12:19 P.M., CNA K said: -He/She found Resident #230 on his/her floor and Resident #307 was in Resident #230's bed. -He/She and the nurse helped get Resident #307 out of Resident #230's bed and walked Resident #307 out of Resident #230's room. -Resident #307 was placed on one-on-one observation after being found in Resident #230's bed. During an interview on 5/16/25 at 12:39 P.M., CMT F said: -He/She worked the evening on 3/27/25. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-After Resident #307 was wandering into different resident rooms and found in another resident's bed, he/she was assigned one-on-one observation of Resident #307. -He/She was told to keep an eye on Resident #307 with one-on-one observation. -During his/her one-on-one observation of Resident #307 on 3/27/25, Resident #307 was in his/her room, went to the television area, and then tried to get into another unknown resident's room, so he/she re-directed Resident #307. -He/She said he/she told Resident #307 no and he/she followed his/her instructions. -They educated him/her to back up and not get too close to Resident #307. -He/She was trained to remove Resident #307 from the area in a situation like when he/she was found in another resident's bed. -He/She didn't know of any of Resident #307's triggers other than maybe when other residents wander into his/her room. -Resident #307 wandered himself/herself and got into other resident beds at times. -The facility's response to any of Resident #307's behaviors was usually doing one-on-one observation or sending him/her out to the hospital or other facility. -He/She doesn't feel like there's enough staff on their unit, because they have aggressive residents and a few residents with behaviors. -It's hard to keep track of all the residents and prevent everything. Review of Resident #307's Social Services Note, dated 3/28/25, showed: -The resident was having behaviors such as taking food off other residents' plates, pulling residents out of bed, and showing residents his/her fist. Review of Resident #307's discharge assessments showed the resident was discharged on 3/28/25 to an in-patient psych facility after a bed opened up. Review of Resident #307's behavior care plan, updated 3/28/25, showed the updated intervention included sending the resident to a geriatric psychiatric facility. During an interview on 5/14/25 at 12:31 P.M., the DON said the facility sent Resident #307 out to geriatric psychiatric facility for medication adjustment and evaluation in response to the events on 3/28/25. Review of Resident #307's Level I PASARR, submitted 4/16/25, showed: -The resident had diagnoses of PTSD and dementia. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident did not have any area of impairment due to serious mental illness. -The resident experienced one psychiatric treatment episode that was more intensive than routine follow-up care. -Due to mental illness, the resident experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community or intervention by housing or law enforcement officials. -The resident was moderately withdrawn/depressed. -The resident's aggression was documented as at maximum level. -The resident unstable mental condition was monitored by a physician or licensed mental health professional at least monthly and behavior symptoms are currently exhibited or psychiatric conditions are currently exhibited. -The resident displayed consistent unsafe/poor decision-making requiring reminders, cues, or supervision at all times to plan, organize and conduct daily routines and has issues with memory, mental function, or ability to be understood/understand others. Review of Resident's #307's tracking forms showed the resident returned to the facility on 4/18/25. Further review of the resident's care plan, updated 3/28/25, showed staff did not update the resident's care plan with new interventions for his/her behaviors after he/she returned from the hospital. Review of Resident #307's MAR dated April 2025 showed: -A physician's order dated 4/18/25 for Trazodone 50 mg at bedtime for insomnia (the same order the resident had upon discharge on [DATE]) was administered 4/18/25-4/21/25. -A physician's order, dated 4/18/25, for Depakote Sprinkles 125 mg, three tablets, three times daily (increased from Depakote Delayed Release 125 mg three times a day for agitation and behaviors) was administered 4/18/25-4/21/25. -A new physician's order, dated 4/19/25, for Sertraline 25 mg, three tablets daily for PTSD was administered 4/19/25-4/22/25. -A physician's order, dated 4/23/25, for Seroquel 50 mg three times daily for PTSD was administered 4/19/25-4/21/25 (increased from two times a day to three times a day). -A new physician's order, dated 4/18/25, for Melatonin 3 mg, two tablets at bedtime for insomnia was administered 4/18/25-4/21/25. -A physician's order dated 4/18/25 for Trazodone 50 mg every 24 hours as needed at bedtime for insomnia was not administered 4/18/25-4/21/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265786	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Rehab and Healthcare Center	1415 West White Oak Independence, MO 64050

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-As needed Lorazepam was not ordered. Review of the facility investigation, dated 4/21/25, showed staff documented on 4/21/25 around 11:15 A.M: -Resident #307 has selective mutism and dementia. -Resident #187 had Alzheimer's Disease. -Resident #307 was sitting in a chair watching television when Resident #187 walked by and stopped next to Resident #307. -Resident #307 was witnessed reaching up and hitting Resident #187 with a closed fist on Resident #187's right hip. -No words were exchanged between Resident #307 and Resident #187. -There were no apparent injuries. -Resident #307 was protective of his/her personal space. -It appeared Resident #187 stopped next to Resident #307 and he/she felt he/she needed Resident #187 out of his/her personal space, resulting in Resident #307 striking Resident #187 to get him/her to move out of his/her way. -Resident #307 was placed on one-on-one supervision. -The facility provided education on abuse and de-escalation of behaviors for residents with dementia. -There was no documentation regarding whether an interview was attempted with Resident #307 regarding the incident. -There was no documentation of an IDT meeting being held. Review of Resident #307's nurse's note, dated 4/21/25, showed: -Resident #307 was sitting in his/her chair when Resident #187 st