STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265823	A. Building B. Wing	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Health Care Center, LLC	11400 Mehl Avenue Florissant, MO 63033

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 - Immediate jeopardy to resident health or safety 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 interview and record review, the facility failed to ensure a resident's right to be free from abuse was not violated, when one resident (Resident #4) was involved in a physical altercation with another resident (Resident #3). In two separate incidents, Resident #3 hit Resident #4 in the mouth when Resident #4 wandered into Resident #3's room. The sample size was 5. The census was 139. Review of the facility's Abuse and Neglect Policy, revised 1/5/23, included: -Purpose: To outline procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/property, and to define terms of types of abuse/neglect and misappropriation of funds and property. To ensure immediate reporting of all abuse allegations to the Administrator or designee and the Director of Nursing (DON) or designee and outside persons or agencies To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed. - Definitions: -Physical Abuse-Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment or management. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Physical abuse also includes corporal punishment, which is physical punishment used as a means to correct or control behavior. -Policy: -III. Mistreatment, Abuse, or Neglect: -Mistreatment, neglect or abuse of residents is prohibited by this Facility. This includes physical abuse, sexual abuse. verbal abuse, mental abuse and involuntary seclusion. -Abuse includes deprivation of goods or services by staff that are necessary to attain or maintain physical, mental, and psychosocial well-being In these cases, staff has the knowledge and ability to provide care and services, but chose not to do it, or acknowledge the request for assistance from a resident, which results in care deficits to a resident. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-This Facility is committed to protecting our residents from abuse by anyone including, but not limited to, Facility staff, other residents. consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. -VI. Prevention and Identification: The Facility will provide residents, family and staff, information on how and to whom they may report concerns, incidents and grievances without the fear of retribution and provide feedback on the concerns that they have expressed; -Environmental Assessment: Assess the environment for circumstances which may make abuse, neglect, or misappropriation of resident , items more likely to occur. Examples include, but are not limited to, resident's room far from the nurses station, in a room with all cognitively impaired residents, dimly lit areas; -Resident Assessment: As part of the resident social history assessment staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis; -Pattern Assessment: Review accident/incident reports, missing items reports, and safety committee reports to assess possible patterns or trends of suspicious bruising of residents, unexplained accidents, or other occurrences that may constitute abuse, neglect or theft. Based on an assessment of the reports, the Facility will further investigate and/or determine whether a change in Facility practices is warranted; -Staff Supervision: On a regular basis, supervisors will monitor the ability of the staff to meet the needs of residents and staffs understanding of individual resident care needs. Situations such as inappropriate language, insensitive handling, or impersonal care will be corrected as they occur. Incidents short of willful abuse will be handled through counseling, training, and if necessary or repeated, the Facility's progressive discipline policy. -VII. Reporting and Investigating Allegations: -Reporting to Supervisor/Administrator/DON: Employees and vendors are required immediately to report any occurrences of potential mistreatment including alleged violations, mistreatment, neglect, abuse, sexual assault, and injuries of unknown source and misappropriation of resident property they observe, hear about or suspect to a Supervisor or the Administrator. All residents, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential mistreatment to a Supervisor or the Administrator or to the Compliance Hotline. Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-This Facility does not condone resident abuse by anyone, including employees, physicians, consultants volunteers, and staff of other agencies serving the resident, family members, legal guardians, sponsors other residents, friends, or other individuals. It is the responsibility of employees, Facility consultants, attending physicians, family members, and visitors etc., to promptly report any incident or suspected incident of abuse/neglect/misappropriation of funds to Facility management immediately. If such incidents occur after hours the Administrator or designee and DON or designee will be notified at home or by cell phone and informed of any such incident; -Report to State, Law Enforcement, and Others; The facility must ensure that all alleged violations involving abuse, neglect, exploitation, mistreatment, or sexual assault including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation in made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency. While specific forms are not required, the DHSS (Department of Health and Senior Services) Initial Reporting Form and Follow-up investigation Form are attached. If the abuse involves alleged suspicion of crime, it must also be reported to local law enforcement within those time frames. See Elder Justice Act - Reporting Reasonable Suspicion of a Crime. The facility will also notify the resident or their guardian legal representative.; -Investigation: Upon learning of the report of abuse or neglect, the Administrator shall initiate an incident investigation. The nursing staff is additionally responsible for reporting and investigating the appearance of bruises, lacerations, or other abnormalities as they occur; -Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation, and reporting to the Administrator or designee; -Appointing An Investigator: Once the Administrator or designee determines that there is a reasonable possibility that mistreatment occurred, the Administrator or designee will appoint a person to take charge of the investigation. The person in charge of the investigation will obtain a copy of any documentation relative to the incident. The investigation will include assessment of all residents involved and interventions to ensure protective oversight of all residents and involved residents in the Facility. Interventions could include; nursing staff separating alleged perpetrator and alleged victim including moving the residents to separate halls, Physician involvement, intensive monitoring of 15 minute face checks of the alleged perpetrator and alleged victim; this may include more intensive monitoring of 5 minute face checks based on the behavioral, psychiatric or medical needs of the resident, Legal Guardian notification, possible hospitalization or immediate discharge. More intensive monitoring will be determined by Administrative staff after an assessment of the resident is completed; -Confidentiality: The investigator shall do as much as possible to protect identities of any employees and residents involved in the investigation, until the investigation is concluded. After a conclusion based on the facts of the investigation is determined, internal reports, interviews and witness statements shall be released to those with a need to know. Even if the Facility Investigation is not complete, the Administrator will cooperate with any DHSS investigation. The Administrator or designee will keep the resident or guardian/resident representative informed of the progress of the investigation as appropriate; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #4's care plan, revised 11/8/23, showed: -Focus: Resident has manifestations of behaviors related to his/her mental illness that may create disturbances that affect others. These behaviors include wandering into peer's rooms and laying on the bed and rummaging through items. Resident was a drummer throughout his/her life and swings his/her arms around putting him/her at risk for unintended injury; -Goal: Resident will minimize episodes of inappropriate behaviors that can affect others; -Interventions: Administer and monitor medications as ordered, Give positive feedback for good behavior, If resident is disturbing others, encourage him/her to go to a more private area to voice concerns/feeling to assist in decreasing episodes of disturbing others. Notify guardian /physician as needed. Provide 1:1 as needed per administration discretion. Review of Resident #4's care plan, revised 11/17/23, showed: -Focus: Resident has potential to be verbally/physically aggressive related to diagnosis of dementia and mild cognitive impairment; -Goal: resident will demonstrate effective coping skills through the review date; -Interventions: Assess and anticipate the resident's needs: food, thirst, toileting needs, comfort level, body positioning, paint. Provide physical and verbal cues to alleviate anxiety. Give positive feedback, assess verbalization of source of agitation, assist to set goals for more pleasant behavior., encourage seeking out of staff member when agitated. When resident becomes agitated: Intervene before agitation escalates. Guide away from source of distress. Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later. Review of Resident #4's care plan, initiated 2/24/24, showed: -Focus: On 2/23/24, Resident wandered into a peer's room and laid in his/her bed. Peer grabbed resident by the shirt to pull him/her out of bed and ripped his/her shirt; -Goal: Resident will have protective oversight through next review; -Interventions: Staff separated the residents. Skin assessment completed and red marks were noted to the right side of his/her chest. While staff was trying to obtain vital signs, resident refused and threw the equipment. Facility is making sure resident purchases snacks and drinks to keep in his/her room in hopes to minimize his/her wandering behaviors that lead to altercations. Facility has sent referrals to other facilities. Review of Resident #4's progress note, showed: -3/9/24 at 7:37 A.M., Continue on 1:1 monitoring. No abnormal behaviors noted. -3/10/24 at 3:07 P.M., Resident is very good with 1:1 activities. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-3/11/24 at 4:14 A.M., Resident was sleeping in his/her room. Certified Nursing Assistant (CNA) went to check on the resident and found him/her in another resident's room with the left side of his/her lip swollen and with a small cut, the other resident had his/her hand in a fist. Call place to DON, Assistant Director of Nursing (ADON), and Administrator. Voice message left for each of them. -3/11/24 at 5:37 A.M., Physician notified of resident altercation and Administration aware of resident altercation. -3/11/24 at 5:40 A.M., DON notified of resident altercation. -3/11/24 at 6:23 A.M., Son/Daughter notified of resident's altercation. Review of Resident #4's care plan, showed no update on 3/11/24. Review of Resident #3's admission MDS, dated [DATE], showed: -Cognitively intact; -Hearing: Adequate; -Vision: Adequate; -Speech: Clear, Resident is understood and understands others; -Mobility: No upper or lower impairment, uses walker for mobility; -Wandering: Blank; -Physical Behavior directed towards others: Behavior not exhibited; -Verbal Behavior directed towards others: Behavior not exhibited; -Other Behavior not exhibited toward others: Behavior not exhibited; -Diagnoses include end stage renal disease (ESRD), arthritis, dementia, schizophrenia and cataracts. Review of Resident #3's care plan, initiated 1/19/24, showed: -Focus: Resident has potential to be verbally/physically aggressive related to diagnosis of schizoaffective disorder, unspecified dementia, violent behavior, restlessness and agitation; -Goal: Resident will demonstrate effective coping skills through the review date; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Interventions: Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Assess and address for contributing sensory deficits. Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc. Provide physical and verbal cues to alleviate anxiety; give positive feeding, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out staff member when agitated. Give resident as many choices as possible about care and activities. Review of Resident #3's progress notes, showed: -3/11/24 at 4:26 A.M., Another resident was found in this resident's room with his/her left lip swollen and a small cut to it, this resident has his/her hand in a fist; -3/11/24 at 5:35 A.M., Physician notified of residents altercation and Admin aware of resident altercation; -3/11/24 at 5:43 A.M., DON notified of resident altercation; -3/11/24 at 3:05 P.M., Resident observed on the hall displaying increased agitation towards peers and staff. Code green (behavioral emergency) called. Staff answered, resident noted to charge at staff and displaying increased physical aggression. Resident then noted to throw things in his/her room. 911 called. EMS arrived at 2:50 P.M. Resident refused to speak with EMS. ADON came to unit where he/she was able to vent feelings and concerns. Resident continues to refuse to go to hospital for further treatment. Resident educated and encouraged to allow further treatment. Resident continues to refuse. Upper management and physician made aware. Resident educated that staff will place him/her in a different room. Resident stated understanding. No pain or discomfort noted at this time. New order Haldol (antipsychotic, used to treat nervous, emotional, and mental conditions) 5 mg by mouth (PO)/intramuscularly (IM) every 8 hours as needed (PRN). Staff will continue to monitor for protective oversight; -3/11/24 at 7:13 P.M., Resident was calm this evening. Resident was singing with staff and showed no signs of physical aggression. Review of Resident #4's progress note, showed: -3/12/24 at 7:54 A.M., Resident remains on 1:1 monitoring. During shift change resident wandered into another resident's room and was hit in the lip. Resident is being sent to the hospital for evaluation. No complaints of pain or discomfort voiced or noted at this time. Management guardian, doctor has been made aware. -3/12/24 at 4:12 P.M., Resident returned to facility per ambulance and two attendants. Resident showing no signs of agitation at this time. Resident has no new orders. Resident is voicing no complaints of pain or discomfort at this time. -3/12/24 at 10:42 P.M., Resident remains of 1:1 for protective oversight. Resident rested in his/her room most of the evening. No acute distress noted at this time. Resident ate well this evening and went to sleep. Review of Resident #4's care plan, revised 3/12/24, showed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Focus: Resident is impulsive and grabs items within his/her reach often, especially food/drink items related to diagnosis of unspecified dementia and cognition impairment; -Goal: Ensure protective oversight is provided through next review; -Interventions: Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Minimize potential for the resident's disruptive behaviors by ensuring staff is providing intense monitoring. Monitor behavior episodes and attempt to determine underlying cause. Document behavior and potential causes. -Focus: On 3/12/24, Resident wandered into a peer's room and the peer struck him in the lip; -Goal: Resident will have no injury through next review; -Interventions: Staff intervened immediately and separated the residents. Staff will continue to monitor the resident for wandering behaviors. Referral is in progress to find a facility that can meet his/her needs. Skin assessment completed and no injures noted. Neurochecks initiated and within normal limits. Resident sent to the emergency room (ER) for a medical evaluation. Review of Resident #3's progress notes, showed: -3/12/24 at 7:02 A.M., Resident observed in his/her room displaying increased agitation toward peers/hitting another resident that had walked into his/her room in the lip. Code green called. Staff answered. Resident noted to charge at staff continuing to display increased physical aggression. Resident then noted refusing to go to the ER. Resident educated and encouraged to allow further treatment. Resident continue to refuse. Upper management and physician made aware. Resident educated that staff will place him/her in a different room if behaviors continue. Resident stated understanding. No pain or discomfort noted at this time. Staff will continue to monitor for protective oversight. Management, doctors made aware. No guardian listed at this time/self. -3/12/24 at 11:10 A.M., Resident continued to display progressed signs of agitation. Resident refused medications, refused injections on multiple attempts when asked. 911 called due to aggression which assisted (by) three EMS. Resident continued to be non-compliant, at this point being a threat to him/herself and others. Requiring an injection from EMS after a half an hour trying to convince the resident to go. Resident has been transferred to the hospital for further evaluation. Social service has been made aware that that resident needs to have guardianship. Management and doctors made aware. Vitals refused. -3/13/24 at 10:11 A.M., Resident arrived back to center from hospital with new orders verified by a nurse from the physician office. Resident is noted as his/her own responsible party and was made aware of new medication change. Review of Resident #3's care plan, initiated 3/12/24, showed: -Focus: On 3/12/24, peer wandered into resident's room and resident struck his/her peer; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Goal: Resident will have fewer behavioral episodes through next review; -Interventions: Staff intervened immediately and separated the residents. Resident was placed on 1:1 monitoring, and room moves were made. The resident refused assessment or any care. 911 was notified and responded. Resident refused to go to the ER and is his/her own person. EMS made several attempts to get him/her to the ER, but he/she continued to refuse. Room moves made. Resident continued to have codes throughout the shift. He/She became physically aggressive with staff. 911 called again and responded with St. Louis police department. 5 milligram (mg) Versed (benzodiazepine, sedative) given IM in right gluteal via EMS. Resident was finally calm and able to be transferred to the stretcher. He/she was sent to hospital ER for medical and psych evaluation. Review of the facility's investigation, for the 3/12/24 incident between Resident #4 and Resident #3, showed: -On 3/12/24, two staff members heard a noise and yelling from Resident #3's room. They heard Resident #3 telling someone to get out. Resident #4 then came out of Resident #4's room with a busted lip. Residents were immediately separated; -Resident #3 had no injury or complaints of pain; -Resident #4 had no active bleeding from lip. No complaints of or signs/symptoms of pain. Neuro checks define within normal limits (WNL); -Resident #4 unable to give a statement; -Resident #3 could not explain his/her actions; -CNA E stated he/she heard a noise from Resident #3's room and Resident #3 stating to get out. When CNA E got to the room, Resident #4 was coming out with a busted lip; -CNA F stated he/she heard yelling from the back of the hall. He/She went to see what was going on and saw Resident #4 with a busted lip; -Both residents were sent to the ER for evaluation; -Allegation was substantiated; -Resident #3 had a recent gradual dose reduction (GDR), chlorpromazine (antipsychotic, used to treat schizophrenia, bipolar disorder, and acute psychosis) was increased back to 25 mg twice a day; -Resident #4 was placed on 1:1 for protective oversight and was discharged to another facility on 3/13/24 to a more appropriate level of care. Review of the Nurse Practitioner (NP) follow up note, electronically signed 3/13/24 at 7:48 P.M., showed: -Chief complaint: Follow up ER (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-History of Present Illness: 3/11/24, Received call from Licensed Practical Nurse (LPN) A, Resident was involved in a peer-to-peer altercation. The peer came into resident's room. Resident with no injuries. 3/12/24 received a call from LPN B reporting that resident was in a peer-to-peer altercation this A.M. and has continued aggressive behaviors. Resident is his/her own person and does not want to go to the hospital but he/she is a threat to himself/herself and others, 911 was contacted and he/she will be escorted to the hospital. Resident returned from the ER today with a new order for hydroxyzine PRN anxiety. -Plan: Altercation with peer. Evaluated in ER. No acute injury or pain. Reviewed appropriate behaviors with patient. Verbalized understanding. Redirect as possible. Continues on hall restriction if ordered. Ok to continue hydroxyzine for anxiety. During an interview on 3/19/24 at 10:15 A.M., Certified Nursing Assistant (CNA) C said Resident #3 gets along pretty good with everyone. He/She just did not want Resident #4 in his/her room. Resident #4 should have been on a 1:1 but was not. The incident on 3/12/24 should not have happened. During an interview on 3/19/24 at 11:08 A.M., LPN D said the day of the incident on 3/12/24, he/she did not arrive to work at the facility until approximately 10:00 A.M. LPN D is not sure if Resident #4 was on 1:1 monitoring. The only odd occurrence was Resident #3 appeared upset later. He/She was upset when asked to change his/her room. They tried to send him/her out, but the resident refused. During an interview on 3/19/24 at 11:10 A.M. CNA E said he/she wrote a statement about the incident on 3/12/24. CNA E said he/she had just arrived that morning. Resident #4 did not have a 1:1 but he/she is not sure if the resident was supposed to. Resident #4 walked into a resident's room. CNA E got Resident #4 to leave that room. CNA E then went into the day room to check on residents in there. As CNA E left the day room, he/she heard Resident #3 hollering down the hall get out of my room. When he/she got down there, staff were already with Resident #3 and Resident #4, who had wandered down there. CNA E reported the incident to the night nurse since the incident occurred at shift change. During an interview on 3/19/24 at 11:20 A.M., LPN B said he/she was the assigned nurse for both residents on 3/12/24. LPN B said Resident #4 was supposed to be on a 1:1. When a resident is on a 1:1, they are supposed to always have a staff member with them that is no more than an arm length away. LPN B said this incident occurred during the change of shift and is not sure why the resident did not have someone with him/her. LPN B said he/she did not witness the incident. He/She responded to the Code [NAME] when it was called. LPN B said normally Resident #3 is calm but that day he/she was something else. Later, they called to get the resident taken to the hospital. It took three EMS and police to get him/her out of here. LPN B said the residents who are on 1:1 monitoring are listed on the 24 hour report sheet or nurses can print out the hot rack notes (part of the progress notes in the EMR) to know. During an interview on 3/19/24 at 11:50 A.M., the Administrator said Resident #4's lip was swollen after he/she was struck by Resident #3 on 3/12/24. The facility's investigation described Resident #4's lip as busted. During a review of the EMR with the Administrator and DON, the Administrator was not aware of the 3/11/24 incident with Resident #4 and Resident #3. The Administrator did not think the incident occurred on 3/11/24 just 3/12/24 but wanted to check to clarify if the information charted is correct. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/19/24 at 1:40 P.M. LPN A said the incident on 3/11/24 happened in the middle of the night around 3:00 A.M. Resident #4 should have been a 1:1 but the resident did not have one due to short staffing. There were two CNAs on the unit. One of the CNAs started to do another set of resident rounds. He/She thought Resident #4 was still asleep. This time, Resident #4 was not in his/her room. The CNA found Resident #4 in Resident #3's room. When the CNA walked in Resident #3's room, Resident #4 had a cut to his/her lip which was a little swollen. Resident #3 had his/her fist balled up. There was a little drop of blood on Resident #4's lip which the CNA wiped off. The CNA brought Resident #4 up to nurses station. The other CNA was in the day room with a different resident. LPN A is not sure what caused the cut on Resident #4's lip but believes when Resident #3 hit Resident #4, his/her lip probably got cut on his/her tooth. LPN A did not send either resident out to the hospital. He/She completed the neurochecks and kept a close eye on Resident #4. Resident #4 was not acting any differently. Resident #3 did not have any unusual behavior the rest of the shift. The incident was reported to management, the DON, the ADON, the physician, and the resident's son/daughter. The son/daughter was not happy. LPN A does not think the incident would have happened if Resident #4 was 1:1 like he/she was supposed to be. This is because Resident #4 would have never gotten to Resident #3's room. When a resident has a 1:1, they have a staff person with them at all times within arm's length. The other nurse who worked that night was on break when the incident occurred. That nurse called the Administrator. Both residents were normal the rest of the night. LPN A thought the CNA kept Resident #4 with him/her the rest of the night. The incident on 3/12/24 must have been a different incident. This incident did not happen at shift change. LPN A said Resident #4 needed to go to facility that could better meet his/her needs. During an interview on 3/19/24 at 2:44 P.M., the Administrator provided a list of residents on 1:1, dated 3/9/24, Resident #4 was not on there. The Administrator said the list is printed at the beginning of the week and done a week at a time. If an incident occurs after the list is made and a resident needs a 1:1, then that resident is added to the list. Resident #4 was added the day of the 3/12/24 incident. Resident #4 was kept on monitoring for the first 72 hours. He/She was not kept past the 72 because the incident was not behavior related. Resident #4 just wanders. During an interview on 3/19/24 at 3:25 P.M., the Administrator and DON said they do not think Resident #4 should have been on a 1:1 after the incident on 3/11/24. Resident #4 was on a 1:1 for almost a year. The DON said in the past, the facility's go to was to just place residents on a 1:1. The facility cannot do that with each and every person. They have to look at each incident and check intent and reason, then try other stuff before they go to the 1:1. The other thing with the 1:1 is that it requires a staff person continuously for 24 hours. The Administrator and DON said the incident on 3/11/24 should have been investigated. They expected staff to report it and then they send to DHSS and do a full investigation. MO00233067

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34926 Please refer to Event ID 7FZ113. Based on interview and record review, the facility failed to follow their abuse and neglect policy by not reporting timely after an allegation of physical abuse was made for one resident and an allegation of sexual abuse was made for another resident. This affected two residents (Resident #101 and Resident #109). The sample was 11. The census was 146. Review of the facility's Abuse and Neglect Policy, revised 1/5/23, included: -Purpose: --To outline procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/property, and to define terms of types of abuse/neglect and misappropriation of funds and property. To ensure immediate reporting of all abuse allegations to the Administrator or designee and the Director of Nursing or designee and outside persons or agencies. To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed. -Reporting to Supervisor/Administrator/Director of Nursing: --Employee and vendors are required immediately to report any occurrences of potential mistreatment including alleged violations, mistreatment, neglect, abuse, sexual assault, and injuries of unknown source and misappropriation of resident property they observe, hear about or suspect to a Supervisor or the Administrator. All residents, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential mistreatment to a Supervisor or the Administrator or to the Compliance Hotline. Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated. -This Facility does not condone resident abuse by anyone, including employees, physicians, consultants, volunteers, and staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. It is the responsibility of employees, Facility consultants, attending physicians, family members and visitors etc, to promptly report any incident or suspected incident of abuse/neglect/misappropriation of funds to Facility management immediately. If such incidents occur after hours the Administrator or designee and Director of Nursing or designee will be notified at home or by cell phone and informed of any such incident. -Report to State, Law Enforcement, and Others: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--The facility must ensure that all alleged violations involving abuse, neglect, exploitation, mistreatment, or sexual assault including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation in made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency. While specific forms are not required, the DHSS Initial Reporting Form and Follow-up Investigation Form are attached. If the abuse involves alleged suspicion of crime, it must also be reported to local law enforcement within those time frames. See Elder Justice Act - Reporting Reasonable Suspicion of a Crime -The facility will also notify the resident or their guardian legal representative. -Investigation: --Upon learning of the report of abuse or neglect, the Administrator shall initiate an incident investigation. --The nursing staff is additionally responsible for reporting and investigating the appearance of bruises, lacerations. or other abnormalities as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation, and reporting to the Administrator or designee. 1. Review of the facility's in-service date 4/17/24, showed: -The in-service education included the abuse and neglect policy, who is a designated reporter and when to report an incident and to whom it should be reported; -Registered Nurse (RN) E signed the in-service indicating he/she received and understood the education; -Certified Nursing Assistant (CNA) C signed the in-service indicating he/she received and understood the education; -Certified Medication Technician (CMT) D signed the in-service indicating he/she received and understood the education; -Floor Technician (FT) B was not listed on the in-service roster indicating he/she did not receive the in-service education. Review of Resident #101's Admission Record showed the resident was admitted to the facility on [DATE] with diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), hearing loss, legal blindness and dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs or trunk). Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 1/29/24, showed: -Cognitively intact; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ability to hear (with hearing aid or hearing appliances if normally used): Adequate. No difficulty in normal conversation, social interaction, listening to TV; -Hearing Aid or other hearing appliance used: No; -Speech Clarity: Unclear Speech: Slurred or mumbled words; -Ability to express ideas and wants, consider both verbal and nonverbal expression: Usually understood. Difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability to understand others, understanding verbal content, however able (with hearing aid or device if used): Understands. Clear comprehension; -Ability to see in adequate light: Moderately impaired. Limited Vision, not able to see newspaper headlines but scan identify objects. -Corrective Lenses: No; -How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? Never; -Psychosis: None; -Behavioral Symptoms: --Physical behavioral symptoms directed towards others: Behavior not exhibited; --Verbal behavioral symptoms directed towards others: Behavior not exhibited; --Other behavioral symptoms not directed toward others: Behavior not exhibited; -Rejection of Care: Behavior not exhibited; -Wandering: Behavior not exhibited. Review of the resident's electronic progress notes for the months of April 2024 and May 2024, showed: -4/28/24 at 8:00 P.M.: Staff will continue to monitor for protective oversight; -4/29/24 at 7:18 A.M.: Late Entry: Resident stated staff member put (his/her) hands around my neck and choked me. Head to toe skin assessment. No apparent injury noted. No bruising or discoloration noted. Placed call to the resident's physician and guardian and made them aware of incident. Administrator, Director of Nursing (DON) and Social Service aware. No complaints of pain of discomforted at present time; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/30/24 at 9:06 A.M.: Law enforcement was notified of the staff to resident incident that occurred on 4/28/24; -4/30/24 at 9:53 A.M.: Resident's guardian notified Social Services Director (SSD) of an assault on resident by staff member. Allegation was investigated and law enforcement was called in. SSD spoke with resident on how he/she was feeling; resident appeared to be doing fine and stated he/she was doing ok. SSD will follow up with resident over the next 72 hours. Review of the facility's online report to the Missouri Department of Health and Senior Services (DHSS) showed the facility reported the incident to DHSS on 4/29/24 at 4:19 P.M. Review of the facility's Administrator/RN Investigation dated 4/30/24, showed: -Date of incident: 4/29/24; -Type of incident: Alleged abuse; -Person(s) involved in the incident: --Resident #101; --Dietary Aid (DA) A; -Witnesses: --FT B; --CNA C; --CMT D; -Statements received from witnesses: Yes; -Statement received from affected person(s): Yes; -Supportive intervention documentation attached: Yes; -Guardian notified of the incident: Yes; -By whom: Social worker; -Date and time notified: 4/29/24 at 2:00 P.M.; -Physician notified of incident: Yes; -By whom: Resident Care Coordinator (RCC); -Date and time: 4/29/24 at 2:30 P.M.; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Documentation of incident completed: Yes; -By whom: RCC; -Disciplinary action required: Yes; -Narrative Note: The resident went to the kitchen door attempting to get coffee and was unsuccessful as DA A sent him/her away from the door. The resident walked to the back of the dining room then came back up to the dietary door where the alleged abuser was standing. The resident walked up asking DA A for coffee again when DA A started to take a stance with the resident, causing the resident to move his/her hands towards DA A. DA A then attempted to grab the resident in the neck area. Another resident was standing there and he/she was able to get the resident to move back from DA A. CMT D walked into the dining room and noticed that DA A was holding the resident's arms. CMT D then rushed up to see what was going on and officially removed the resident away from DA A. CMT D began to question DA A and was told that the resident wanted coffee and was told that there was none left, DA A added that the resident then came back trying to gain entrance into the kitchen so DA A was attempting to stop the resident. CMT D did not see DA A's hands around the resident's neck. CMT D simply thought it was a misunderstanding. CMT D also took the time to educate DA A, who is a new worker and had been working in the facility for maybe a week. The resident's sister called the social worker on 4/29/24, to ensure that the facility knew what had occurred. We then started a full investigation. Head to toe assessment done on the resident showed no injuries; -Conclusion/Outcome of the Investigation: All other residents were interviewed to ensure they are safe and that they felt safe. Abuse and neglect in-service also began again, in light of what happened. We also interviewed staff that may have seen this event and carried out disciplinary actions. I went to assess the resident again for any physical or mental wound. He/She appears to be ok. None noted at this time. The resident is VERY hard of hearing which poses a problem as well. If he/she can't hear to understand and in this case the staff was new, it can cause an issue for the resident and staff; -Care plan changes and interventions: Facility will follow up on the resident's hearing aids to see why he/she doesn't have them and get them. Will speak to his/her family as well; -Employee witness statement obtained; -The care plan must reflect new interventions as a result of this behavior emergency crisis: See about why he/she is not wearing hearing aids. -Signed by the Administrator and DON, dated 5/1/24. Review of the facility provided video evidence on 5/2/24 at 12:38 P.M., showed: -Resident #101 was noted in the dining room walking towards the kitchen area and DA A walked to stand in front of the resident; -At time stamp 00:09, DA A grabbed for the resident using his/her right hand, the resident grabbed DA A's right hand with his/her left hand; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At time stamp 00:11, DA A grabbed towards resident's right shoulder/neck area with his/her left hand, then also moved his/her right hand to the resident's throat with the resident still trying to hold the right hand back; -At time stamp 00:15, the resident was able to step back and push DA A's hands off his/her throat; -At time stamp 00:16, FT B stepped in between DA A and the resident. FT B did not remove the resident from the situation or request DA A to move away from the resident; -At time stamp 00:25, FT B turned his/her back on DA A and the resident and started walking away; -At time stamp 00:26, CMT D was approaching at this time. DA A started stepping forwards again towards the resident; -At time stamp 00:28, CMT D put his/her arm out and blocked DA A from moving towards the resident and motioned for him/her to walk away and started speaking with the resident; -At time stamp 00:32, DA A was no longer visible in the video. FT B was walking towards the direction of DA A; -At time stamp 00:34, FT B stood between the resident and the direction DA A walked; -At time stamp 00:49, CMT D was still standing in the same place in the dining room talking with the resident, and the video ended. During an interview on 5/2/24 at 1:45 P.M., Resident #101 said: -He/She is very hard of hearing; -When attempting to write questions for the resident since he/she had difficulty hearing/understanding, the resident said he/she was legally blind and could not read the question; -DA A grabbed him/her around the throat for asking for coffee; -He/She was not hurt at the time, just surprised; -He/She knows one thing, he/she will never ask for coffee again if this is what is going to happen; -He/She feels safe in the facility since DA A no longer works at the facility; -Resident was unable to understand any other questions asked. During an interview on 5/2/24 at 2:35 P.M., DA A said: -One of the residents walked up to him/her by the kitchen door requesting coffee; -DA A told the resident there was no more coffee; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident told DA A to move out of his/her way. The resident was going to try to go in the kitchen; -DA A told the resident no; -The resident raised his/her arms and then DA A raised his/her arms; -DA A then grabbed the resident's neck and was in defense mode; -Someone called a Code [NAME] (emergency behavior call for assistance) but no one came; -He/She had not been properly trained. He/She had orientation and started the next day in the kitchen; -In orientation, he/she learned one step ahead of the other. That means if a resident attacks you, you can defend yourself; -They didn't teach to ask for help or verbally de-escalate. They taught us nothing and then he/she started the next day; -He/She tried to get set up for the 1:1 training; -He/She was told to tell residents who ask that there was no more coffee; -The kitchen was being closed as it was almost 8:00 P.M.; -DA A doesn't make coffee and was told not to by the Supervisor; -He/She said the residents get coffee at breakfast, lunch and dinner; -The resident showed aggressiveness by raising his/her arms; -He/She resident grabbed DA A's arm and he/she was showing strength; -DA A showed his/her defense move and grabbed the resident's neck; -When asked if they discussed abuse -verbal and physical at orientation, he/she said they didn't get into any details; -If he/she had proper training he/she wouldn't be going through this; -He/She was never told the proper protocol; -He/She defended himself/herself; -When asked if he/she would consider his/her actions physically abusive, he/she said you can't skip to that part when asking about his/her actions. This was a reaction to the resident showing his/her physical strength. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/24 at 3:23 P.M., CMT D said: -He/She was on the CMT cart and walking to the kitchen for ice when he/she heard someone yell out Code Green; -CMT D noted DA A holding Resident #101 by the throat; -CMT D ran over and told DA A You can't hold (him/her) like that; -CMT D did not see the altercation. He/She did not enter the dining room until after it was over and FT B intervened; -CMT D did not report the incident to Administration because he/she saw RN E in the dining room performing blood sugar checks when he/she entered the dining room; -CMT D assumed RN E would write up the incident and notify Administration when RN E finished blood sugar checks. During an interview on 5/2/24 at 3:34 P.M., CNA C said: -He/She was standing in the doorway of the smoking room, smoking general population, when he/she heard a commotion coming from the dining room. He/She looked up and saw DA A with his/her hands on Resident #101; -He/She yelled a Code Green; -He/She saw two staff members intervene; -He/She did not report the incident because he/she thought the staff who intervened would tell the nurse and report it; -He/She received a written disciplinary warning and was in-serviced on abuse/neglect, when to report and resident rights on 4/30/24, which was his/her first day back to work after the incident occurred; -He/She will report it himself/herself from now on. During an interview on 5/2/24 at 3:50 P.M., FT B said: -He/She was standing in the dining room and witnessed the altercation; -He/She did not report the incident because someone else called the Code Green, so he/she wasn't aware that he/she needed to report it; -He/She assumed the person who yelled Code [NAME] would report it and it would be on video and they would question him/her about it; -He/She did receive a written warning for not reporting the incident; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She did receive abuse and neglect in-servicing earlier in April and again after this incident; -He/She now knows to report all incidents, even if he/she thinks someone else is reporting it also. During an interview on 5/3/24 at 10:39 A.M., RN E said: -He/She did not witness the incident; -The dining room was loud and he/she did not hear the incident or the staff yell out Code Green; -No one reported the incident to him/her; -He/She did not assess the resident after the incident; -To his/her knowledge, the other nurse on duty, Licensed Practical Nurse (LPN) F, was not notified and did not assess the resident either; -Staff should have notified him/her or LPN F of the incident; -If he/she was notified, he/she would have pulled DA A off the floor immediately and sent him/her home; -He/She would have then notified Administration, the resident's physician and family; -He/She did not work the next day and did not know about the incident until the DON called on 4/29/24 to ask if he/she was aware of the situation and what actions were taken, if any. During an interview on 5/3/24 at 10:48 A.M., the DON said: -He/She was not aware of the incident until Resident #101's family member called the SSD and the SSD notified him/her on 4/29/24; -The Administrator was already on his/her way into the facility at the time of notification; -The facility began the investigation immediately; -Staff statements were taken and resident interviews were performed; -The resident's physician was notified and his/her family member was called back with an update; -The police were called and DA A was arrested for assault; -Staff was in-serviced on abuse/neglect, when to report and resident rights on 4/29/24; -Staff had been previously in-serviced on abuse/neglect and when to report on 4/17/23, so they should have known to report it; -DA A was recently hired and educated on the Abuse and Neglect policy during orientation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview of 5/2/24 at 12:30 P.M., the Administrator said: -The incident occurred on 4/28/24, but was not sure what time the incident occurred; -The facility was unaware of the incident until Resident #101's sibling called and notified them of the incident on 4/29/24; -Staff were present when the incident occurred and did not report the incident to administration; -Staff present did receive disciplinary action, a final warning due to the severity of the incident; -There was video of the incident; -DA A was terminated immediately after viewing the video; -The police were called on 5/30/24 and DA A was charged with simple assault and arrested; -The facility immediately started in-servicing staff on abuse and neglect, when to report and resident rights. 2. Review of Resident 109's annual MDS, dated [DATE], showed: -Cognitively intact; -Behavioral Symptoms: -Physical behavioral symptoms directed towards others: Behavior not exhibited; -Verbal behavioral symptoms directed towards others: Behavior not exhibited; -Other behavioral symptoms not directed toward others: Behavior not exhibited; -Diagnoses include anxiety, manic depression, schizophrenia, seizures and Post Traumatic Stress Disorder (PTSD). Review of the resident's progress note, dated 5/3/24 at 10:34 P.M., showed this resident came to this writer, LPN G, accusing another resident of being sexually inappropriate with him/her. Resident was unable to give a date or a time, and states it was before this resident moved over to a hall on a locked unit. Call placed to management, and resident's guardian to make them aware. Physician also made aware. Review of the online reporting shows the allegation was submitted to DHSS on 5/4/24 at 12:59 P.M. -Review of the facility's investigation, received 5/6/24 at 4:30 P.M., showed: -The date/time of the incident was on 5/1/24 at 12:00 A.M. and reported by the Charge Nurse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/24 at 2:52 P.M., the Administrator said all allegations of abuse and neglect should be reported within 2 hours. He said the facility should have notified DHSS on 5/3/24 about the incident involving Resident #109. MO00235393 MO00235415 MO00235645

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44950 Based on interview and record review, the facility failed to follow their policy to report to the Department of Health and Senior Services (DHSS) and investigate physical abuse between two residents which occurred when one resident wandered into another resident's room. The first altercation was not reported to DHSS and investigated. A second altercation occurred the next day, when the resident again wandered into the other resident's room. Both times, the resident hit the other resident in the mouth (Residents #3 and #4). The sample size was 5. The census was 139. Review of the facility's Abuse and Neglect Policy, revised 1/5/23, included: -Purpose: To outline procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/property, and to define terms of types of abuse/neglect and misappropriation of funds and property. To ensure immediate reporting of all abuse allegations to the Administrator or designee and the Director of Nursing (DON) or designee and outside persons or agencies To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed. - Definitions: -Physical Abuse-Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment or management. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Physical abuse also includes corporal punishment, which is physical punishment used as a means to correct or control behavior. -Policy: -III. Mistreatment, Abuse, or Neglect: -Mistreatment, neglect or abuse of residents is prohibited by this Facility. This includes physical abuse, sexual abuse. verbal abuse, mental abuse and involuntary seclusion. -Abuse includes deprivation of goods or services by staff that are necessary to attain or maintain physical, mental, and psychosocial well-being In these cases, staff has the knowledge and ability to provide care and services, but chose not to do it, or acknowledge the request for assistance from a resident, which results in care deficits to a resident. -This Facility is committed to protecting our residents from abuse by anyone including, but not limited to, Facility staff, other residents. consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/11/24 at 4:14 A.M., Resident was sleeping in his/her room. Certified Nursing Assistant (CNA) went to check on the resident and found him/her in another resident's room with the left side of his/her lip swollen and with a small cut, the other resident had his/her hand in a fist. Call place to DON, Assistant Director of Nursing (ADON), and Administrator. Voice message left for each of them. -3/11/24 at 5:37 A.M., Physician notified of resident altercation and Administration aware of resident altercation. -3/11/24 at 5:40 A.M., DON notified of resident altercation. -3/11/24 at 6:23 A.M., Son/Daughter notified of resident's altercation. Review of Resident #4's neurochecks on 3/11/24, included: -3/11/24 at 3:30 A.M.; -3/11/24 at 3:45 A.M.; -3/11/24 at 4:00 A.M.; -3/11/24 at 4:30 A.M.; -3/11/24 at 5:00 A.M.; -3/11/24 at 5:30 A.M.; -3/11/24 at 6:00 A.M.; -3/11/24 at 6:55 A.M. Review of Resident #4's care plan, showed there were no updates to the care plan on 3/11/24. Review of Resident #3's admission MDS, dated [DATE], showed: -Cognitively intact; -Hearing: Adequate; -Vision: Adequate; -Speech: Clear, Resident is understood and understands others; -Mobility: No upper or lower impairment, uses walker for mobility; -Wandering: Blank; -Physical Behavior directed towards others: Behavior not exhibited; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Verbal Behavior directed towards others: Behavior not exhibited; -Other Behavior not exhibited toward others: Behavior not exhibited; -Diagnoses include end stage renal disease (ESRD), arthritis, dementia, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and cataracts. Review of Resident #3's care plan, initiated 1/19/24, showed: -Focus: Resident has potential to be verbally/physically aggressive related to diagnosis of schizoaffective disorder, unspecified dementia, violent behavior, restlessness and agitation; -Goal: Resident will demonstrate effective coping skills through the review date; -Interventions: Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Assess and address for contributing sensory deficits. Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc. Provide physical and verbal cues to alleviate anxiety; give positive feeding, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out staff member when agitated. Give resident as many choices as possible about care and activities. Review of Resident #3's progress notes, showed: -3/11/24 at 4:26 A.M., Another resident was found in this resident's room with his/her left lip swollen and a small cut to it, this resident has his/her hand in a fist; -3/11/24 at 5:35 A.M., Physician notified of resident's altercation and Admin aware of resident altercation; -3/11/24 at 5:43 A.M., DON notified of resident altercation; -3/11/24 at 3:05 P.M., Resident observed on the hall displaying increased agitation towards peers and staff. Code [NAME] (behavioral emergency) called. Staff answered, resident noted to charge at staff and displaying increased physical aggression. Resident then noted to throw things in his/her room. 911 called. Emergency Medical Services (EMS) arrived at 2:50 P.M. Resident refused to speak with EMS. ADON came to unit where he/she was able to vent feelings and concerns. Resident continues to refuse to go to hospital for further treatment. Resident educated and encouraged to allow further treatment. Resident continues to refuse. Upper management and physician made aware. Resident educated that staff will place him/her in a different room. Resident stated understanding. No pain or discomfort noted at this time. New order Haldol (antipsychotic, used to treat nervous, emotional, and mental conditions) 5 milligrams (mg) by mouth (PO)/Intramuscular injection (IM, technique used to deliver a medication deep into the muscles) every 8 hours as needed (PRN). Staff will continue to monitor for protective oversight; -3/11/24 at 7:13 P.M., Resident was calm this evening. Resident was singing with staff and showed no signs of physical aggression. Review of Resident #3's care plan, showed no updates on 3/11/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's electronic progress note, showed: -3/12/24 at 7:54 A.M., Resident remains on 1:1 monitoring. During shift change resident wandered into another resident's room and was hit in the lip. Resident is being sent to the hospital for evaluation. No complaints of pain or discomfort voiced or noted at this time. Management guardian, doctor has been made aware. -3/12/24 at 4:12 P.M., Resident returned to facility per ambulance and 2 attendants. Resident showing no signs of agitation at this time. Resident has no new orders. Resident is voicing no complaints of pain or discomfort at this time. -3/12/24 at 10:42 P.M., Resident remains of 1:1 for protective oversight. Resident rested in his/her room most of the evening. No acute distress noted at this time. Resident ate well this evening and went to sleep. Review of Resident #4's care plan, revised 3/12/24, showed: -Focus: Resident is impulsive and grabs items within his/her reach often, especially food/drink items related to diagnosis of unspecified Dementia and cognition impairment; -Goal: Ensure protective oversight is provided through next review; -Interventions: Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Minimize potential for the resident's disruptive behaviors by ensuring staff is providing intense monitoring. Monitor behavior episodes and attempt to determine underlying cause. Document behavior and potential causes; -Focus: On 3/12/24, Resident wandered into a peer's room and the peer struck him/her in the lip; -Goal: Resident will have no injury through next review; -Interventions: Staff intervened immediately and separated the residents. Staff will continue to monitor the resident for wandering behaviors. Referral is in progress to find a facility that can meet his/her needs. Skin assessment completed and no injures noted. Neurochecks initiated and within normal limits. Resident sent to the emergency room (ER) for a medical evaluation. Review of Resident #3's progress notes, showed: -3/12/24 at 7:02 A.M., Resident observed in his/her room displaying increased agitation toward peers/hitting another resident that had walked into his/her room in the lip. Code green called. Staff answered. Resident noted to charge at staff continuing to display increased physical aggression. Resident then noted refusing to go to the ER. Resident educated and encouraged to allow further treatment. Resident continue to refuse. Upper management and physician made aware. Resident educated that staff will place him/her in a different room if behaviors continue. Resident stated understanding. No pain or discomfort noted at this time. Staff will continue to monitor for protective oversight. Management, doctors made aware. No guardian listed at this time/self; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/12/24 at 11:10 A.M., Resident continued to display progressed signs of agitation. Resident refused medications, refused injections on multiple attempts when asked. 911 called due to aggression which assisted (by) three EMS. Resident continued to be non-compliant, at this point being a threat to him/herself and others. Requiring an injection from EMS after a half an hour trying to convince the resident to go. Resident has been transferred to the hospital for further evaluation. Social service has been made aware that that resident needs to have guardianship. Management and doctors made aware. Vitals refused. Review of Resident #3's care plan, initiated 3/12/24, showed: -Focus: On 3/12/24, peer wandered into resident's room and resident struck his/her peer; -Goal: Resident will have fewer behavioral episodes through next review; -Interventions: Staff intervened immediately and separated the residents. Resident was placed on 1:1 monitoring, and room moves were made. The resident refused assessment or any care. 911 was notified and responded. Resident refused to go to the ER and is his/her own person. EMS made several attempts to get him/her to the ER, but he/she continued to refuse. Room moves made. Resident continued to have codes throughout the shift. He/She became physically aggressive with staff. 911 called again and responded with St. Louis police department. 5 mg Versed (benzodiazepine, sedative) given IM in right gluteal via EMS. Resident was finally calm and able to be transferred to the stretcher. He/She was sent to hospital ER for medical and psych evaluation. Review of Resident #3's Nurse Practitioner (NP) follow up note, electronically signed 3/13/24 at 7:48 P.M., showed: -Chief complaint: Follow up ER -History of Present Illness: 3/11/24, Received call from Licensed Practical Nurse (LPN) A, Resident was involved in a peer-to-peer altercation. The peer came into resident's room. Resident with no injuries. 3/12/24 received a call from LPN B reporting that resident was in a peer-to-peer altercation this A.M. and has continued aggressive behaviors. Resident is his/her own person and does not want to go to the hospital but he/she is a threat to himself/herself and others, 911 was contacted and he/she will be escorted to the hospital. Resident returned from the ER today with a new order for hydroxyzine PRN anxiety. -Plan: Altercation with peer. Evaluated in ER. No acute injury or pain. Reviewed appropriate behaviors with patient. Verbalized understanding. Redirect as possible. Continues on hall restriction if ordered. Ok to continue hydroxyzine for anxiety. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/24 at 1:40 P.M., LPN A said the incident on 3/11/24 happened in the middle of the night around 3:00 A.M. Resident #4 should have been a 1:1 but the resident did not have one due to short staffing. There were two CNAs on the unit. One of the CNAs started to do another set of resident rounds. He/She thought Resident #4 was still asleep. This time Resident #4 was not in his/her room. The CNA found Resident #4 in Resident #3's room. When the CNA walked in Resident #3's room, Resident #4 had a cut to his/her lip which was a little swollen. Resident #3 had his/her fist balled up. There was a little drop of blood on Resident #4's lip which the CNA wiped off. The CNA brought Resident #4 up to the nurses station. The other CNA was in the day room with a different resident. LPN A was not sure what caused the cut on Resident #4's lip but believed when Resident #3 hit Resident #4, his/her lip probably got cut on his/her tooth. LPN A did not send either resident out to the hospital. He/She completed the neurochecks and kept a close eye on Resident #4. Resident #4 was not acting any differently. Resident #3 did not have any unusual behavior the rest of the shift. The incident was reported to management, the DON, the ADON, the physician, and the resident's son/daughter. The son/daughter was not happy. LPN A does not think the incident would have happened if Resident #4 was 1:1 like he/she was supposed to be. This is because Resident #4 would have never gotten to Resident #3's room. When a resident has a 1:1, they have a staff person with them at all time within arm's length. The other nurse who worked that night was on break when the incident occurred. That nurse called the Administrator. Both residents were normal the rest of the night. LPN A thought the CNA kept Resident #4 with him/her the rest of the night. The incident on 3/12/24 must have been a different incident. This incident did not happen at shift change. LPN A said Resident #4 needed to go to facility that could better meet his/her needs. During an interview on 3/19/24 at 2:44 P.M., the Administrator provided a list of residents on 1:1, dated 3/9/24. Resident #4 was not on the list. The Administrator said the list is printed at the beginning of the week and done a week at a time. If an incident occurs after the list is made and a resident needs a 1:1, then that resident is added to the list. Resident #4 was added the day of the 3/12/24 incident. Resident #4 was kept on monitoring for the first 72 hours. He/She was not kept past the 72 hours because the incident was not behavior related. Resident #4 just wanders. During an interview on 3/19/24 at 3:25 P.M., the Administrator and DON said they do not think Resident #4 should have been on a 1:1 after the incident on 3/11/24. Resident #4 was on 1:1 for almost a year. The DON said in the past, their go to was to just place residents on a 1:1. The facility cannot do that with each and every person. They have to look at each incident and check intent and reason. Then try other stuff before they go to the 1:1. The other thing with the 1:1 is that it requires a staff person continuously for 24 hours. The Administrator and DON said the incident on 3/11/24 should have been investigated. They expected staff to report it and then they send to DHSS and do a full investigation. MO00233067