

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26A293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Clara Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3621 Warwick Boulevard Kansas City, MO 64111	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35013</p> <p>Based on observation, interview and record review, the facility failed to protect two sampled residents (Resident #1 and #6) from physical abuse. On 7/3/24 at approximately 8:10 P.M., Resident #2 who smelled strongly of alcohol entered Resident #6's room and hit him/her in the mouth without provocation, causing a small cut on the resident's lower lip. On 7/22/24 at approximately 9:00 A.M., Resident #2, who smelled strongly of alcohol, became agitated and struck Resident #1 with closed fists in both cheeks approximately one inch below each eye, causing four centimeter cuts requiring a hospital emergency room visit to apply two stitches for each cut out of 10 sampled residents. The resident census was 85 residents.</p> <p>Review of the facility's policy for Abuse and Neglect, revised in 2022 showed:</p> <ul style="list-style-type: none"> -The purpose of the policy was to ensure the residents' rights were respected and honored and to provide protection from all forms of abuse and/or neglect. -Each resident had the right to be free from abuse. -The facility was responsible to prevent resident abuse. <p>Residents were not to have been subjected to abuse by anyone, including other residents.</p> <ul style="list-style-type: none"> -Abuse was defined as the willful infliction of injury resulting in physical harm, pain or mental anguish, with physical abuse resulting in bodily injury, physical pain, or impairment. -Physical abuse included hitting, slapping, punching and kicking. -Some examples of physical abuse were bruises, black eyes, lacerations/cuts and broken bones. <p>1. Review of Resident #2's Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually certified beds both Medicare and Medicaid), dated 10/25/23, showed he/she had the following diagnoses:</p> <ul style="list-style-type: none"> -Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 26A293
		If continuation sheet Page 1 of 22

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Alcohol abuse.</p> <p>-Psychoactive substance abuse-(use of a variety of drugs or other agent that affects normal mental functioning as mood, behavior, or thinking processes).</p> <p>Review of Resident #2's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning) dated 6/27/24 showed he/she:</p> <p>-Was cognitively intact.</p> <p>-Showed no issues with mood or negative behaviors.</p> <p>Review of Resident #6's facility Admission Record showed he/she was admitted on [DATE] with the following diagnoses:</p> <p>-Stress fracture of his/her left ankle.</p> <p>-Anxiety.</p> <p>-Alcohol abuse.</p> <p>Review Resident #6's quarterly MDS dated [DATE] showed he/she:</p> <p>-Was cognitively intact.</p> <p>-Was unable to walk and used a wheelchair to ambulate and perform his/her daily activities.</p> <p>During an interview on 7/26/24 at 11:00 A.M., Licensed Practical Nurse (LPN) A said:</p> <p>-On 7/3/24 Resident #2 had smelled strongly of alcohol and stating his/her cell phone had been stolen.</p> <p>-The resident was getting angry and jumped off his/her bed and lunged at him/her as if he/she was going to hit him/her.</p> <p>-He/she called 911.</p> <p>-LPN C reported that Resident #2 went into Resident #6's room and hit him/her in the mouth, splitting open the resident's lower lip.</p> <p>-The police came but stated there was no room in the jail so Resident #2 went to the hospital.</p> <p>During an interview on 7/26/24 at 12:42 P.M., Resident #6 said:</p> <p>-He/she was sitting in his/her room watching television when Resident #2 just walked in and hit him/her in the mouth stating, you killed your roommate!</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The police came and put Resident #2 in hand cuffs, but the police said they had not room in the jail so the resident would have to go to the hospital.</p> <p>-He/she asked to press assault charges, but no police ever came to take his/her statement.</p> <p>-He/she just stayed away and stopped hanging out with Resident #2.</p> <p>During an interview on 7/26/24, at 3:30 P.M., LPN C said on 7/3/24 between 8:00 P.M. and 9:00 P.M. Resident #2 punched Resident #6 and cut open his/her bottom lip.</p> <p>2. Review of Resident #1's facility Admission Record showed he/she was admitted on [DATE] with the following diagnoses:</p> <p>-Spinal stenosis-(narrowing of the spinal canal).</p> <p>-Heart disease.</p> <p>-Alcohol abuse.</p> <p>Review of Resident 1's quarterly MDS dated [DATE] showed he/she:</p> <p>-Was cognitively intact.</p> <p>-Was unable to walk and used a wheelchair to ambulate and perform his/her daily activities.</p> <p>Review of Resident #2's Nurse's Notes dated 7/22/24 at 9:10 A.M., showed:</p> <p>-The resident came to LPN B asking for a cup of water.</p> <p>-LPN B told him/her that the water on his/her medication cart was not cold and the resident might want to check on the other medication cart.</p> <p>-The resident acted angry so he/she got a cup of cold water and took it to him in his/her room.</p> <p>-He/she became angry telling him/her that the cup was too small.</p> <p>-A couple of minutes later, he/she heard loud banging and a thud coming from the resident's room as if the resident was kicking his/her room door.</p> <p>-A minute later, Resident #1 came out of the room blood dripping down his/her cheeks stating his/her roommate, Resident #2 had beat him/her up.</p> <p>-Resident #2 was taken away to calm down while Resident #1's injuries were attended to.</p> <p>Review of Resident 1's Nurse's Notes dated 7/22/24 at 9:30 A.M., showed:</p> <p>-The resident came into the hallway with blood on his/her face, both the left and right sides.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she stated that Resident #2 hit him/her several times.</p> <p>-The resident showed he/she had lacerations to both his/her upper right cheeks.</p> <p>-The lacerations were cleaned but the bleeding continued so emergency medical services (EMS) were called to examine the residents.</p> <p>Review of Resident 1's Nurse's Notes dated 7/22/24 at 12:25 P.M., showed:</p> <p>-The resident's physician saw the resident and encouraged him/her to go to the emergency room for stitches to his/her cheeks.</p> <p>-The resident agreed to go to the hospital and was transported by EMS for evaluation and treatment.</p> <p>Review of Resident 1's Nurse's Notes dated 7/22/24 at 6:45 P.M., showed:</p> <p>-He/she returned from the emergency room with stitches to each laceration covered by steri-strips (a thin, adhesive bandage used to assist with keeping lacerated skin together and protect a wound).</p> <p>-His/her right eye was swollen and discolored.</p> <p>During an interview on 7/25/24 at 12:30 P.M., LPN B said:</p> <p>-He/she had heard a commotion coming from Resident #2 and Resident #1's room which sounded like banging or someone kicking the door.</p> <p>-He/she walked down to the room and the door was closed as the banging continued.</p> <p>-He/she did not hear anyone yelling and thought that Resident #2 was just kicking the door to his/her room since he/she was angry. He/she did not enter the room.</p> <p>-A minute later, Resident #1 came out of the room with blood coming from both of his/her cheeks, stating that Resident #2 had beat him/her up.</p> <p>-Resident #2 was taken from the room to calm down.</p> <p>-Resident #1 after contact with the physician was transported to the ER for stitches.</p> <p>During an interview on 7/25/24 at 1:40 P.M., Certified Nursing Assistant (CNA) A said he/she was in the shower room nearby when the incident occurred and heard the banging, but no yelling, so had no idea what was going on.</p> <p>Observation and interview on 7/25/24 at 2:00 P.M., with Resident #1 showed:</p> <p>-He/she was in the bathroom when Resident #2 came in asking for water.</p> <p>-He/she told Resident #2 to hold on a second and Resident #2 just started pounding on me!</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she did not yell for help as he/she thought it could make things worse.</p> <p>-Resident #2 hit him/her in both cheeks with both fists.</p> <p>-Resident #2 had never been physically aggressive with him/her but he/she had yelled and called him/her names including the N word.</p> <p>-He/she was never afraid of Resident #2 and wasn't afraid of him/her if he/she returned to the facility.</p> <p>-He/she knew the resident drank too much and blamed it all on the alcohol.</p> <p>-The resident was up in his/her wheelchair.</p> <p>-He/she had two steri-strips covering each laceration on his/her cheeks.</p> <p>-Two approximately four-centimeter (cm) lacerations were noted below each eye.</p> <p>-Both lacerations appeared to have two stitches each.</p> <p>-Slight bruising was noted around the left laceration.</p> <p>-No swelling was noted on either cheek.</p> <p>3. During an interview on 7/29/24 at 3:15 P.M., Nurse Practitioner (NP) A said:</p> <p>-He/she was responsible for the resident' medical care.</p> <p>-He/she was not aware that Resident #2 was becoming violent or that he/she was leaving the facility, drinking and then harming other residents.</p> <p>-He/she would have made sure the psychiatric NP knew and possible changed up his/her treatment plan and/or medications.</p> <p>-He/she would have expected the facility to notify him/her of all changes in resident's conditions.</p> <p>-He/she was not aware Resident #2 hit any residents.</p> <p>-He/she would have expected a staff member notify him/her.</p> <p>-It was not appropriate for Resident #2 to hit another resident</p> <p>During an interview on 7/31/24 at 1:30 P.M., the Director of Nursing (DON) said:</p> <p>-He/she would have expected the facility staff to keep all residents safe from abuse.</p> <p>-When Resident #2 injured and hit Resident #6 and #1 it was considered abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/31/24 at 1:55 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -He/she would have expected the staff to intervene when Resident #2 became agitated in order to prevent any violent behaviors. -He/she would have expected the staff remove the vulnerable resident from the agitated resident. -He/she did not feel abuse could be concluded as per his/her investigation he/she found the event was not witnessed. -Resident #2 did not have blood on his/her knuckles. -Resident #1 could have accidentally hit his/her own face on something as both the lacerations were equal in size and in the same place bilaterally. -He/she did not necessarily feel it was abuse without a witness and both residents smelled of alcohol. <p>MO00239366</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35013</p> <p>Based on interview and record review, the facility failed to report two allegations of resident to resident abuse for two sampled residents (Resident #1 and Resident #6) when on 7/3/24 Resident #2 hit Resident #6 in the mouth causing a small cut on the resident's lower lip and on 7/22/24 Resident #2 hit Resident #6 causing laceration to both sides of his/her cheeks out of 10 sampled residents. The facility census was 85 residents.</p> <p>Record review of the facility's policy for Abuse and Neglect, revised in 2022 showed:</p> <ul style="list-style-type: none"> -Each resident had the right to be free from abuse. -Abuse was defined as the willful infliction of injury resulting in physical harm, pain or mental anguish, with physical abuse resulting in bodily injury, physical pain, or impairment. Physical abuse included hitting, slapping, punching and kicking. -All incidents of abuse were to have been reported immediately to the charge nurse on duty who was to in turn, report to the Director of Nursing (DON) and/or the Administrator. -All staff were to have been educated on reporting requirements and procedures for reporting incidents of abuse as it was the responsibility of every employee to immediately report incidents of resident abuse to their immediate supervisor. -Any abuse resulting in serious bodily injury requiring medical intervention should have been reported to all required entities within two hours. <p>1. Review of Resident #2's Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually certified beds both Medicare and Medicaid), dated 10/25/23, showed he/she had the following diagnoses:</p> <ul style="list-style-type: none"> -Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). -Alcohol abuse. -Psychoactive substance abuse (use of a variety of drugs or other agent that affects normal mental functioning as mood, behavior, or thinking processes). <p>Record review of Resident #6's facility Admission Record showed he/she was admitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Anxiety. -Alcohol abuse. <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's facility Admission Record showed he/she was admitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Spinal stenosis (narrowing of the spinal canal). -Heart disease. -Alcohol abuse. <p>During an interview on 7/26/24 at 11:00 A.M., Licensed Practical Nurse (LPN) A said:</p> <ul style="list-style-type: none"> -On 7/3/24, LPN C had reported Resident #2 went into Resident #6's room and hit him/her in the mouth, splitting open Resident #6's lower lip. -He/she did not recall notifying anyone of the incident on 7/3/24 as the resident who was hit was the responsibility of a different nurse who would have notified all required parties. <p>During an interview on 7/26/24 at 12:42 P.M., Resident #6 said on 7/3/24 between 8:00 P.M. and 9:00 P.M., he/she was sitting in his/her room watching television when Resident #2 just walked in and hit him/her in the mouth stating, you killed your roommate!</p> <p>During an interview on 7/26/24, at 3:30 P.M., LPN C said:</p> <ul style="list-style-type: none"> -On 7/3/24 between 8:00 P.M. and 9:00 P.M. Resident #2 punched Resident #6 and cut open Resident #6's bottom lip. -He/she had documented something in Resident #6's chart and wasn't sure why the chart showed no documentation. -He/she passed the incident along to the on-coming nurse and documented it on the communication sheet. -He/she notified the Director of Nursing (DON), Administrator and physician of the incident on 7/3/24. <p>Review of Resident 1's Nurse's Notes dated 7/22/24 at 9:30 A.M., showed:</p> <ul style="list-style-type: none"> -Resident #1 had came into the hallway with blood on his/her face, both the left and right sides and showed a laceration to both upper right cheeks. -Resident #1 stated Resident #2 had hit him/her several times. <p>During an interview on 7/25/24 at 12:30 P.M., LPN B said:</p> <ul style="list-style-type: none"> -Resident #1 had come out of the room with blood coming from both cheeks, stating Resident #2 had beat him/her up. -He/she reported the incident to the DON and Administrator right after the incident occurred. <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/25/24 at 2:00 P.M., Resident #1 said:</p> <ul style="list-style-type: none"> -Resident #2 hit him/her in both cheeks with both fists. -He/she reported it to LPN B. <p>During an interview on 7/25/24 at 2:30 P.M., CNA B said:</p> <ul style="list-style-type: none"> -Resident #1 had come out of the room bleeding from his/her face and said Resident #2 had hit/her. -LPN B was in the hall when the resident reported the incident, so CNA B didn't report the incident to anyone else. <p>During an interview on 7/29/24 at 3:15 P.M., Nurse Practitioner (NP) A said:</p> <ul style="list-style-type: none"> -He/she was not aware Resident #2 had hit Resident #1 and Resident #6. -He/she would have expected notification from a staff member. <p>During an interview on 7/31/24 at 1:30 P.M., the DON said:</p> <ul style="list-style-type: none"> -He/she was never notified Resident #2 had hit Resident #6 on 7/3/24 and he/she was out of town. -He/she would have expected the staff to notify him/her of all incidents where residents were injured. -He/she had not made a report to the state agency, his/her understanding was the Administrator would report. <p>During an interview on 7/31/24 at 1:55 P.M., the Administrator said:</p> <ul style="list-style-type: none"> -He/she would have expected the staff to notify him/her of all resident to resident incidents so he/she could determine what needed to be done next. -He/she did not know Resident #2 had hit Resident #6 on 7/3/24. The staff should have notified both the DON and him/her. -He/she was notified 7/22/24 that Resident #2 had hit Resident #1. -He/she had not made a report to the state agency. -He/she felt since her investigation did not show the incident was abuse he/she questioned whether or not the incident should have been reported. -The event was not witnessed and Resident #2 did not have blood on his/her knuckles. Resident #1 could have accidentally hit his/her face on something as both the lacerations were equal in size and in the same place bilaterally. He/she did not necessarily feel it was abuse without a witness and both residents smelled of alcohol. <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35013</p> <p>Based on interview and record review, the facility failed to investigate an allegation of resident to resident abuse for one sampled resident (Resident #6) when on 7/3/24 Resident #2 entered Resident #6's room and hit him/her in the mouth and cut his/her lip out of 10 sampled residents. The census was 85 residents.</p> <p>Record review of the facility's policy for Abuse and Neglect, revised in 2022 showed:</p> <ul style="list-style-type: none"> -All allegations of abuse were to have been investigated immediately by facility administrative staff. -The facility was to have investigated who was involved, any injuries sustained, and if the residents needed hospital care. <p>1. Review of Resident #2's Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually certified beds both Medicare and Medicaid), dated 10/25/23, showed he/she had the following diagnoses:</p> <ul style="list-style-type: none"> -Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). -Alcohol abuse. -Psychoactive substance abuse (use of a variety of drugs or other agent that affects normal mental functioning as mood, behavior, or thinking processes). <p>Record review of Resident #6's facility Admission Record showed he/she was admitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Anxiety. -Alcohol abuse. <p>During an interview on 7/26/24 at 11:00 A.M., Licensed Practical Nurse (LPN) A said:</p> <ul style="list-style-type: none"> -On 7/3/24 LPN C had reported to him/her that Resident #2 went into Resident #6's room, hit Resident #6 in the mouth, and split Resident #6's lower lip. -The police came but stated there was no room in the jail so Resident #2 went to the hospital. -He/she did not recall notifying anyone of the incident on 7/3/24 as the resident who was hit was the responsibility of a different nurse who would have notified all required parties. -He/she was not responsible for the investigation, only the documentation in the nurse's notes. <p>(continued on next page)</p>		

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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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she should have made sure the 1st floor nurse notified the Director of Nursing (DON) and/or the Administrator.</p> <p>During an interview on 7/26/24 at 12:42 P.M., Resident #6 said:</p> <p>-Resident #2 just walked in and hit him/her in the mouth stating, you killed your roommate!</p> <p>-The police came and put Resident #2 in hand cuffs, but the police said they had not room in the jail so the resident would have to go to the hospital.</p> <p>-He/she asked to press assault charges, but no police never came back to take his/her statement.</p> <p>During an interview on 7/26/24, at 3:30 P.M., LPN C said:</p> <p>-On 7/3/24, Resident #2 punched Resident #6 and cut open Resident #6's bottom lip.</p> <p>-He/she thought he/she had documented something in Resident #6's chart and wasn't sure why it wasn't there.</p> <p>-He/she had passed the incident along to the on-coming nurse and documented it on the communication sheet.</p> <p>-He/she was sure he/she notified the DON, Administrator and physician of the incident on 7/3/24.</p> <p>-He/she was not responsible for the investigation but would have notified the DON and/or the Administrator or ensure that LPN A had notified the necessary people that the incident had occurred.</p> <p>During an interview on 7/29/24 at 3:15 P.M., Nurse Practitioner (NP) A said:</p> <p>-He/she was not aware Resident #2 had become violent or that he/she was leaving the facility, drinking and on return had harmed other residents.</p> <p>-He/she would have made sure the psychiatric NP knew and possible changed up his/her treatment plan and/or medications.</p> <p>-He/she would have expected they notify him/her of all changes in the resident's conditions.</p> <p>During an interview on 7/29/24 at 3:50 P.M., NP B said he/she knew nothing of any incidents where Resident #2 had injured other residents.</p> <p>During an interview on 7/31/24 at 1:30 P.M., the DON said:</p> <p>-He/she would have expected the facility staff to keep all residents safe from abuse.</p> <p>-He/she would have expected the staff to notify the physician or NP of any resident behavior that might pose a risk to other residents.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she would have expected the staff to remove Resident #1 from the room as soon as staff was aware that Resident #2 was becoming agitated in attempt to prevent any residents being injured.</p> <p>-He/she was never notified of the 7/3/24 incident.</p> <p>-He/she was out of town when that incident occurred.</p> <p>-He/she would have expected the staff to notify him/her of all resident to resident altercations so an investigation could have been initiated.</p> <p>-He/she was responsible to begin the investigation for abuse and it was to be finished by the Administrator but if he/she were unavailable the Administrator would complete the entire investigation.</p> <p>During an interview on 7/31/24 at 1:55 P.M., the Administrator said:</p> <p>-He/she would have expected the staff to notify him/her of all resident to resident incidents so he/she could determine what needed to be done next.</p> <p>-He/she was not notified of the 7/3/24 incident and did not do an investigation.</p> <p>-He/she could not investigate what he/she was not aware of.</p>

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35013</p> <p>Based on interview and record review, the facility failed to provide appropriate treatment and services to deescalate one sampled resident (Resident #2) out of 10 sampled residents, who was displaying emotional and behavioral adjustment difficulty. The facility census was 85 residents.</p> <p>Record review of the facility's policy for Behavior Management, revised in 2022 showed:</p> <ul style="list-style-type: none"> -The purpose of the policy was to maintain and promote a healthy environment that provided comfort to the residents. -The policy was also to help the facility staff detect early on, any changes in psychosocial status and appropriate interventions. -The facility staff was to monitor residents with fluctuated behaviors or new behavior symptoms for any underlying medical conditions. -The facility staff was to observe the residents daily and document on the behavioral flow sheet any intensity of behaviors. -The observations can be increased to every shift as needed. -The Director of Nursing (DON) was to review and determine the time frame for monitoring the behavior indicators. -All staff were responsible to communicate and recommend what behavior needed to be monitored more closely by using the special care plan for daily/changed approaches. -The DON was to review the medication effectiveness and report to the physician for alternative treatments or changes in dosage, frequency, or time of administration if needed. -The DON was to review the resident's care plan to identify causative factors and develop appropriate interventions. -The Care Team was to assist with reviews of psychosocial and activity needs to develop appropriate interventions. -All staff were required to attend the in-service, Tips On How to Deal With Behaviors at least twice a year. -Safety was the key so approaches were individualized depending on the resident, circumstances, incidents, situations and conclusions of investigations. -The plan was to have been communicated via the resident's care plan. <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Facility assessment dated [DATE] showed:</p> <ul style="list-style-type: none"> -The facility staff was to have education every six months on Tips On How to Deal With Behaviors. -75 out of 85 residents residing in the building showed psychosocial needs. -Non-pharmological interventions were to have been individualized per the resident's needs. <p>1. Review of Resident #2's Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually certified beds both Medicare and Medicaid), dated 10/25/23, showed:</p> <ul style="list-style-type: none"> -He/she had, Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety), Depression complicated by alcohol abuse, and Psychoactive substance abuse-(use of a variety of drugs or other agent that affects normal mental functioning as mood, behavior, or thinking processes). -The resident had been homeless, living on the streets for approximately two years off and on. -He/she had stated his/her reason for homelessness was due to an inability to maintain a job because he/she was drinking too much. -He/she had a lack of community or family support to maintain functioning at home. -Per the psychiatric evaluation dated 9/8/23, the resident had presented to the emergency room (ER) on 9/7/23 for evaluation of intoxication. -The hospital staff knew him/her well from past ER visits. -He/she had smoked bad methamphetamine prior to coming to the ER, smoked marijuana and drank one-fifth of whiskey and some beer. -While in the ER, he/she stated he/she wanted to kill himself/herself with a plan to do a mass shooting or a mass bombing. -The following day while still in the ER, he/she stated he/she no longer felt suicidal or homicidal and he/she no longer had a plan. -He/she told the ER staff the last time he/she had a plan of suicide was a couple of years ago and he/she had never attempted suicide. -He/she did not know why he/she suddenly took so many drugs. -His/her past psychiatric history included chronic polysubstance abuse, mostly alcohol, methamphetamine. -He/she had a moderate risk of suicide with no prior attempts. <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she stated that his/her symptoms became more severe in the context of alcohol intoxication, stating he/she got over-anxious and drank heavily causing him/her to get days mixed up, making him/her even more anxious.</p> <p>-He/she endorsed visual hallucinations saw ghosts once he/she got to the long-term care facility.</p> <p>-He/she drank a fifth of whisky beginning around the age of [AGE] years old and four to five marijuana joints per week.</p> <p>-His/her history of mental health care began back in 1995 with the most recent encounter in 2021.</p> <p>-He/she admitted to a history of aggressive and assaultive behavior a whole bunch of different times.</p> <p>-He/she showed worse aggression when he/she was under the influence of drugs and alcohol.</p> <p>-He/she had asked for Naltrexone (a medication to help prevent relapses into alcohol and drug abuse) to help with the urges and impulsive behaviors.</p> <p>-He/she had two previous inpatient psychiatric hospitalizations due to suicidal ideation's with a plan as well as homicidal ideation's.</p> <p>-He/she had a history of aggressive/assaultive behavior, restlessness, irritability, , feeling confused and mixed up, visual hallucinations, and treatment/medication non-compliance.</p> <p>-Given the resident's current difficulty with sobriety, limited insight/judgement, history of non-compliance and risk for decompensation, the resident would have benefited from a structured environment with 24/hour a day oversight and supervision, including a nursing facility to promote medication/treatment compliance, assistance with daily tasks, consistent access to medical/psychiatric care, sobriety and safety.</p> <p>-A behavioral support plan was indicated for the resident due to his/her history of unsafe/risk-taking behavior, homicidal ideation's and aggressive/assaultive behavior.</p> <p>-The resident needed mental and behavioral health support, monitoring of behavioral symptoms, trauma informed services and well as other positive behavioral support services.</p> <p>-He/she also need psychiatric follow-up to prescribe and manage his/her medications.</p> <p>-He/she needed medication set-up/administration by facility staff and monitoring for compliance with his/her prescribed medications.</p> <p>-The facility was to address, report, and implement a plan to manage resident refusals and non-compliance.</p> <p>-The resident was to be provided with education and training in drug therapy management.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-There was no documentation of any interventions completed to discourage the resident from drinking or to de-escalate the aggressive behaviors the resident displayed.</p> <p>-There was no documentation the staff had been trained on de-escalation techniques or diffusing argumentative situations.</p> <p>Review of the resident's Nurse's Notes dated 10/21/23 at 11:00 P.M., showed:</p> <p>-He/she walked up the street and when he/she returned to the facility, he/she was very intoxicated.</p> <p>-He/she was verbally aggressive with staff and other residents.</p> <p>-Several residents including Resident #1 complained about the resident screaming and cursing, calling other residents names.</p> <p>-Prior to the incidents on the porch and on the unit, he/she was in the parking garage and was verbally abusive to an older resident, physically violating of resident's space and showing increased aggression.</p> <p>-The resident went from zero to 10 very quickly and was somewhat unpredictable.</p> <p>-No interventions were documented in the nurse's notes.</p> <p>Review of the resident's Nursing Care Plan dated/revised 7/23/24 showed:</p> <p>-He/she had a potential for injury related to his/her alcohol abuse.</p> <p>-He/she was to verbally express his/her needs, share his/her concerns and have no injuries related to his/her alcohol abuse.</p> <p>-The facility staff was to encourage his/her to talk about his/her past and make decisions and goals for his/her care.</p> <p>-The facility staff was to encourage him/her to ventilate his/her feelings about concerns and wishes.</p> <p>-The facility staff was to monitor for safety and if there was a sign or symptom of alcohol consumption or other suspected use of substance abuse.</p> <p>-The facility was to provide counseling services, explaining the option of Alcoholics Anonymous if needed.</p> <p>-The facility staff was to remind the resident to sign out on passes and be safe.</p> <p>-He/she had episodes of being verbally aggressive to staff and other residents.</p> <p>-He/she was to demonstrate effective coping skills through the review date.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The facility staff was to administer medications as ordered and monitor for their effectiveness/side effects.</p> <p>-The facility staff was to monitor his/her behaviors throughout the day and night and document observed behaviors and attempted interventions.</p> <p>-The facility staff was to teach the resident to avoid alcohol consumption.</p> <p>-The facility staff was to report to the physician the risk for harming others, increased anger, labile mood, agitation or thoughts of harming others.</p> <p>-The facility staff were to have used the resident's individualized care plan as a reference for providing the resident's care including psychosocial care.</p> <p>-There was no indication the facility staff members followed the care plan recommendations, knew resident triggers or resident coping skills.</p> <p>During an interview on 7/25/24 at 12:30 P.M., Licensed Practical Nurse (LPN) B said:</p> <p>-He/she was not familiar with what a PASRR was.</p> <p>-He/she had some previous mental health education at another facility where he/she used to work.</p> <p>-He/she had not had any education since working at this facility.</p> <p>-He/she did not like working with residents with mental illness.</p> <p>-He/she did not ever look at the PASRR or pre-admission paperwork on residents and had not looked at said paperwork for the resident.</p> <p>-When the resident became agitated on 7/22/24 and assaulted his/her roommate, he/she heard a commotion coming from the residents' room, however he/she did not go in there as he/she knew the resident was upset and thought he/she was just kicking the door and wall.</p> <p>-He/she did not want the resident to turn on him/her, he/she had no training to deal with the resident's behavior.</p> <p>-He/she did not know the resident had a history or homicidal ideation's in the past or that the resident had a history of being aggressive and assaulting others.</p> <p>-Had he/she been more aware of the resident's history, he/she would have been more in tune with his/her drinking and potential behaviors of aggression associated with drinking too much in order to better protect the other residents from getting hurt.</p> <p>-He/she had not gotten any history on the resident prior to the resident's admission.</p> <p>During an interview on 7/25/24 at 1:40 P.M., Certified Nursing Assistant (CNA) A said:</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she had not had any mental health education at the facility.</p> <p>-He/she did not look at any resident paperwork, nor did he/she know that the resident had a history of violence.</p> <p>-He/she had never observed the resident being violent.</p> <p>During an interview on 7/25/24 at 2:30 P.M., CNA B said:</p> <p>-He/she had not had any mental health education at this facility.</p> <p>-He/she had asked if the staff could get some mental health education, but it had not yet happened.</p> <p>-He/she felt the staff really needed education as the residents' behaviors in the facility had gotten so much worse and the staff really did not know how to handle them.</p> <p>-The charge nurses told the CNA's they could not look at resident charts so he/she relied on report from the nurses and other CNA's to care for the residents' needs.</p> <p>-He/she was not aware of what should have been done to de-escalate the resident when he/she became.</p> <p>During an interview on 7/26/24 at 11:00 A.M., LPN A said:</p> <p>-He/she believed they gave the staff some modules to watch, regarding mental health but he/she couldn't remember for sure.</p> <p>-He/she did not look at the residents' PASRR's as the Social Worker usually did all of that.</p> <p>-He/she was aware of an incident that occurred on 7/3/24 where the resident went down to the first floor into Resident #6's room and hit the resident in the mouth unprovoked.</p> <p>-He/she was not aware the resident had a history of aggressive behaviors and assault.</p> <p>-He/she knew the resident drank from time to time and left the facility on occasion, but had no idea the resident could be violent.</p> <p>-Had he/she known this about the resident, he/she would have monitored the resident more closely when he/she came to visit the first floor residents to ensure their safety.</p> <p>During an interview on 7/29/24 at 3:15 P.M., NP A said:</p> <p>-He/she was not aware the resident was becoming violent or he/she had been leaving the facility, drinking and then harming other residents.</p> <p>-He/she would have made sure the psychiatric NP knew and possible changed up his/her treatment plan and/or medications.</p> <p>(continued on next page)</p>

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-They had just begun holding Alcohol Anonymous (AA) meetings at the facility one time per month.</p> <p>-He/she did not remember seeing the resident at any of the AA meetings.</p> <p>-He/she did remember speaking with the resident about the meetings, however she did not recall seeing the resident there.</p> <p>-He/she had not shared with the physician or psychiatrist that the resident had not attended.</p> <p>-He/she was new to his/her role and still trying to learn how to deal with residents with mental illness.</p> <p>-There were notes the resident was encouraged to attend AA.</p> <p>During an on 7/31/24 at 1:55 P.M., the Administrator said:</p> <p>-He/she was the one in charge of all facility Admissions.</p> <p>-He/she liked to see a completed PASRR on a resident if there was one, however many of their residents had been homeless so there was not such paperwork prior to the admission.</p> <p>-He/she was the one who provided all the information to the staff for each new resident.</p> <p>-He/she would pass on the education regarding individual residents, to the charge nurses and it was their responsibility to provide that education to their staff members.</p> <p>-There was not really a formal education process when it came to educating staff on mental illness or behaviors.</p> <p>-He/she knew they needed to add that into their staff training plan.</p> <p>-He/she expected the charge nurses communicate all information necessary to provide</p> <p>-He/she would have expected all staff to know their residents well enough to know what escalated them and what de-escalated them.</p> <p>-He/she would have expected the staff keep the residents de-escalated and safe.</p> <p>-All staff had access to the residents' charts and could read them at any time they weren't busy providing resident care.</p>		