

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 01/14/2025
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** 42955</p> <p>Refer to F600 Event ID 66SW12</p> <p>Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #69) was free from physical abuse, when on 1/10/25 at approximately 10:00 P.M., Resident #76 willfully hit Resident #69 on his/her face, resulting in swelling and pain. Resident #72 stated Resident #76 had threatened to beat up people and was violent. The facility census was 86 residents.</p> <p>An Abuse/Neglect policy was requested from the facility, but was not provided.</p> <p>Review of the facility's Abuse and Neglect Educational Material; Policy Regarding Abuse and Neglect of Facility Residents, undated showed:</p> <ul style="list-style-type: none"> -Resident rights protected them from physical and mental abuse. -Abuse was defined as a willful infliction of injury. -Physical force that may result in physical pain or impairment included: <ul style="list-style-type: none"> --Pushing, slapping, hitting, shoving, striking with or without an object, pinching kicking or burning. <p>1. Review of Resident #76's Face Sheet, undated, showed:</p> <ul style="list-style-type: none"> -The resident admitted to the facility on [DATE]. -His/Her diagnoses included: <ul style="list-style-type: none"> --Major Depressive Disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest), single episode. --Other psychoactive substance abuse (a strong desire or sense of compulsion to take the substance) --Generalized anxiety disorder (a constant about everyday issues and situations). <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
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's care plan dated 1/13/25 showed:</p> <ul style="list-style-type: none"> -The resident had potential for sad mood related to depression. -The resident was at risk for increased behaviors. --Monitor behavior episodes and attempt to determine underlying cause. <p>Review of the resident's Physician Orders, dated January 2025, showed:</p> <ul style="list-style-type: none"> -Buspirone (medication used to treat anxiety disorders); 5 mg twice a day. -Quetiapine (medication used to treat hallucinations) 25 mg twice a day. -Hydroxyzine (medication used to treat agitation) 50 mg three times a day. <p>During an interview on 1/13/25 at 3:19 P.M., Resident #76 said:</p> <ul style="list-style-type: none"> -He/She thought Resident #69 was going through his/her belongings. -He/She hit Resident #69 in the face. -He/She was unsure if anyone else was around when it happened. -The police came and arrested him/her and took him/her to the hospital. <p>2. Review of Resident #69's Face Sheet, undated, showed:</p> <ul style="list-style-type: none"> -The resident admitted on [DATE]. -The resident's diagnoses included: <ul style="list-style-type: none"> --Schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and actions). --Major Depressive Disorder --Persistent Mood Disorder (a continuous, long-term form of depression). <p>Review of the resident's Care Plan, dated 11/21/24, showed:</p> <ul style="list-style-type: none"> -The resident was resistant to cares. -The resident received antidepressant medication. -The resident had chronic pain in the lower back. <p>During an interview on 1/13/25 at 8:45 A.M., the resident said:</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>-Resident #76 said he/she kidnapped his/her children.</p> <p>-He/She was sleeping when Resident #76 came in his/her room and hit him/her in the face.</p> <p>-He/She had swelling and pain on the left side of his/her face.</p> <p>-He/She asked for pain medication and an ice pack and received it.</p> <p>-He/She did not want to go to the hospital.</p> <p>-Resident #76 harassed him/her every day about going into Resident #76's room and taking his/her belongings, which never happened.</p> <p>-He/She talked to staff about Resident #76's behavior and they told him/her to stay away from Resident #76.</p> <p>-Resident #76 also bothered other resident's, saying they went into his/her room and took belongings.</p> <p>-He/She felt safe now that Resident #76 was gone.</p> <p>Observation on 1/13/25 at 8:45 A.M. showed:</p> <p>-A small amount of swelling in Resident #69's left cheek.</p> <p>3. During an interview on 1/13/25 at 9:00 A.M., Resident #59 (roommate of Resident #69) said:</p> <p>-Resident #76 was in their room.</p> <p>-He/She saw Resident #76 go over to the other side of the room, but the curtain was drawn and did not see what happened.</p> <p>During an interview on 1/13/25 at 9:15 A.M., Resident #72 said:</p> <p>-Resident #76 yelled a lot at the residents and had paranoid episodes, saying people were in his/her room taking his/her items.</p> <p>-Resident #76 threatened to beat up people.</p> <p>-Resident #76 was violent. Staff told Resident #76 to stay in his/her room.</p> <p>-He/She heard Resident#69 and #76 argue on Friday night (1/10/25), but did not see anything.</p> <p>-He/she felt safe without Resident #76 around.</p> <p>During an interview on 1/13/25 at 9:25 A.M., Resident #37 said:</p> <p>-Resident #76 was unruly in the evenings.</p> <p>(continued on next page)</p>

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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955</p> <p>Refer to F740 Event ID 66SW12</p> <p>Based on observation, interview and record review, the facility failed to effectively manage behaviors by not providing appropriate behavior interventions for one sampled resident (Resident #76) when the resident physically assaulted and injured Resident #69 by hitting him/her in the face causing pain, swelling, and redness. The facility census was 86 residents.</p> <p>Review of the facility's Behavior Management Program, undated, showed:</p> <ul style="list-style-type: none"> -A behavior symptom was defined as an indication or characteristic of a negative physical or psychosocial outcome which may have resulted in disturbing of others. -A behavior could also inhibit the resident in attaining or maintaining his/her highest practical well-being. -The purpose of the policy was to promote a healthy environment that provided comfort to all residents. -The staff may detect early changes in mental or psychosocial status for appropriate interventions, which included: medication regimen, activities, counseling, visits (not specified) or social therapy. -Residents who exhibit behavior symptom concerns were monitored and/or treated to prevent incident. -Monitoring included checking for patterns and occurrence. -Residents who exhibited behavior concerns that fluctuated should be observed or monitored for increased/decreased and factors that contribute to elevate behavior symptoms. -Residents who often exhibited outburst behaviors, aggression, verbal and/or physical abusive behavior were monitored for safety, based on each individual and decided by the safety committee or Quality Assurance (QA) team. -Residents who exhibit fluctuated behavior or new behavior symptoms or indicators: <ul style="list-style-type: none"> --Monitor for underlying medical conditions and notify the Director of Nursing (DON) to revise the care plan. --Daily observation and documentation on each resident's behavior flow sheet determined by the charge nurse. --All staff were responsible to communicate and recommend what behavior needs to be monitored. <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>1. Review of Resident #76's Face Sheet, undated, showed:</p> <ul style="list-style-type: none"> -The resident was admitted to the facility on [DATE]. -His/Her diagnoses included: <ul style="list-style-type: none"> --Major Depressive Disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest), single episode. --Other psychoactive substance abuse (a strong desire or sense of compulsion to take the substance). --Generalized anxiety disorder (a constant about everyday issues and situations). <p>Review of the resident's initial care plan dated 1/10/24 showed the resident:</p> <ul style="list-style-type: none"> -Had a history of drug use/abuse. --The goal was the resident would understand the expectations of the facility, no drug use, and sign a contract. --The only intervention was the resident would understand that breaking the contract would result in discharge. ---NOTE: This care plan was not updated or revised. <p>Review of the resident's Pre-Admission Screening/Resident Review (PASRR- a federally mandated screening process for individuals with serious mental illness, intellectual disability/developmental disability, and/or related condition who reside in a Medicaid Certified nursing facility), dated 6/13/24, showed:</p> <ul style="list-style-type: none"> -The resident qualified for care. -The resident had a serious mental illness. -The resident had a history of Schizophrenia (a serious mental illness that affected how a person thought, felt and behaved). -The resident needed continued support and services. --Monitoring of behavioral symptoms. --Tools of choice or other positive behavioral support services. --Mental status to be monitored for signs/symptoms of depression, changes in mood, agitation and aggression. <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>--Anger management may be helpful by teaching coping skills to deal with his/her emotions appropriately.</p> <p>--Staff to provide support and redirection as needed.</p> <p>-Resident would like to see a psychologist.</p> <p>Review of the resident's care plan showed:</p> <p>-There were no updates to the initial care plan of any new focus areas or interventions that addressed the resident's mood, mental status, and anger management.</p> <p>-There were no interventions that showed how to provide support and redirection to the resident.</p> <p>Review of the resident's Psychiatric Periodic Evaluation dated 10/3/24 showed:</p> <p>-The form was completed by an outside Psychiatric provider.</p> <p>-Was a psychiatry evaluation and medication management at the facility.</p> <p>-The resident denied feeling depressed or anxious.</p> <p>-The resident said the recent medication changes had helped his/her anxiety.</p> <p>-Staff noted no concerns, no new psychiatric issues or complaints.</p> <p>-Labs and medications list were reviewed, continue to monitor for changes and medication adjustment as needed.</p> <p>-Monitor for depression symptoms and document.</p> <p>-Psychological service to improve coping skills.</p> <p>-Safety concerns were addressed, staff were instructed regarding communication and redirection needed in caring for psychiatric and mental health residents.</p> <p>-Continue to monitor closely, redirect to promote safety, and utilize nursing intervention and behavioral modification.</p> <p>-Continue to offer activities, social events, group initiating, and resident one-on-one when needed.</p> <p>-Encourage sleep-wake cycle.</p> <p>-Monitor for changes in mood or behaviors and notify psychiatry if agitation or resident symptoms worsen.</p> <p>Review of the resident's care plan showed:</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-There were no updates, new focus areas, or new interventions that addressed safety concerns, communication, redirection, behavior modification, or placing the resident on 1:1 monitoring.</p> <p>Review of the resident's progress notes dated 10/24/24 showed:</p> <p>-The resident was agitated, kicking and screaming.</p> <p>-The resident was taken to the hospital for evaluation and treatment of increased agitation and aggressiveness.</p> <p>-The social worker notified the Administrator and Director of Nursing (DON) of the resident's behaviors and being admitted to the hospital.</p> <p>Review of the resident's care plan showed:</p> <p>-There were no updates or new focus areas initiated following the resident's hospitalization for behaviors.</p> <p>-There were no updates or new focus areas that addressed the resident's behaviors and interventions including 1:1 monitoring.</p> <p>Review of the resident's Psychiatric Periodic Evaluation dated 10/31/24 showed:</p> <p>-Psychiatric medication regimen was reviewed.</p> <p>-Continue current psychiatric medications.</p> <p>-Continue to monitor response and make adjustments as needed.</p> <p>-Resident could benefit from psychological services to enhance coping skills.</p> <p>-Monitor for changes in mood or behaviors.</p> <p>-No new psychiatric concerns/complaints noted.</p> <p>Review of the resident's Psychotherapy Progress Note dated 10/31/24 showed:</p> <p>-Was completed by an outside psychological provider.</p> <p>-Staff reported resident behaviors of fighting with others, emotionally labile, fighting with staff.</p> <p>-Therapist focused on the resident's current mental health status and progress towards management of mood and anxiety symptoms.</p> <p>-Therapist encouraged the resident to set short-term goals that involved only him/her and did not depend on anyone else's involvement in his/her life.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The social worker and the DON talked with the resident.</p> <p>-The DON notified the psychiatrist of the resident's increased behaviors and asked for medication management and adjustment as needed.</p> <p>Review of the resident's Psychotherapy Progress Note dated 11/21/24 showed:</p> <p>-The resident refused psychotherapy services and said his/her mind was all crazy and he/she couldn't think.</p> <p>-The therapist will follow up in one to three weeks.</p> <p>Review of the resident's Psychotherapy Progress Note dated 11/27/24 showed:</p> <p>-The resident was extremely agitated and unreasonable.</p> <p>-The resident expressed distrust with residents and staff.</p> <p>-The resident expressed significant agitation and frustration.</p> <p>-The resident expressed thoughts of suicide, but did not report a plan.</p> <p>-Therapist attempted to reduce the resident's emotional distress and to problem solve around the crisis.</p> <p>-The resident reported disinterest in hospitalization .</p> <p>-The resident's distress and agitation were lessened with the opportunity to express difficult emotion with the therapist.</p> <p>-At the end of the session, the resident denied thoughts of suicide.</p> <p>-The therapist reported to the resident that his/her original expression of suicide would be shared with the staff.</p> <p>-The therapist discussed the resident's presentation and safety planning with the Administrator, DON, charge nurse, and floor nurses.</p> <p>--Issues of safety were discussed with all.</p> <p>Review of the resident's care plan showed:</p> <p>-There were no updates or new focus areas that addressed the safety of the resident or others.</p> <p>-There were no updates or new focus areas that addressed the resident's aggression,</p> <p>-There were no updates or new focus areas that addressed the resident's behaviors.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Clara Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3621 Warwick Boulevard Kansas City, MO 64111	
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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-There were no new interventions that addressed behavior modification when the resident became aggressive.</p> <p>-There were no updates or new focus areas that addressed the resident's behaviors and interventions including 1:1 monitoring.</p> <p>Review of the resident's progress notes showed there was no documentation that mentioned changes in care needed following episodes of increased aggression and increased behaviors.</p> <p>Review of the resident's Psychiatric Periodic Evaluation, dated 11/28/24, showed:</p> <p>-Psychiatric medication regimen was reviewed.</p> <p>-Staff noted increased behavioral concerns as others were afraid of the resident because of his/her aggressive posture on the unit.</p> <p>-No new psychiatric issues or complaints were observed during the visit.</p> <p>-Mental status examination included:</p> <p>--Perseveration, pressured speech, coherent with loud tone and value speech.</p> <p>--Mood was noted to be irritable.</p> <p>--Affect was suspicious and irritable.</p> <p>--No response to hallucinations.</p> <p>--Poor concentration, insight, and judgement.</p> <p>-Start Seroquel (an antipsychotic used to treat hallucinations) 25 milligrams (mg) twice a day.</p> <p>Review of the resident's Psychiatric Periodic Evaluation, dated 12/19/24, showed:</p> <p>-Psychiatric medication regimen was reviewed.</p> <p>-The resident reported auditory hallucinations.</p> <p>-Staff noted increased behavioral concerns with anxiety and agitation.</p> <p>-No new psychiatric issues or complaints were observed during the visit.</p> <p>-Mental status examination included:</p> <p>--Perseveration, pressured speech, coherent with loud tone and value speech.</p> <p>--Mood was noted to be irritable.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>--Affect was suspicious and irritable.</p> <p>-Start Hydroxyzine (an antihistamine used to treat anxiety and agitation) 50 mg three times a day.</p> <p>Review of the resident's care plan showed:</p> <p>-There were no updates or new focus areas that addressed the safety of the resident or others.</p> <p>-There were no updates or new focus areas that addressed the resident's hallucinations.</p> <p>-There were no new interventions that addressed behavior modification when the resident became aggressive.</p> <p>Review of the resident's progress notes showed there was no documentation that mentioned changes in care needed with episodes of hallucinations and increased aggression.</p> <p>Review of the resident's Physician Orders, dated January 2025, showed the resident was ordered:</p> <p>-Sertraline (medication used to treat depression); 150 mg daily (order updated on 11/7/24).</p> <p>-Buspirone (medication used to treat anxiety disorders); 5 mg twice a day (order updated on 11/7/24).</p> <p>-Quetiapine (medication used to treat hallucinations) 25 mg twice a day (order started on 11/29/24).</p> <p>-Hydroxyzine (medication used to treat agitation) 50 mg three times a day (order started on 12/19/24).</p> <p>Review of the resident's Psychotherapy Progress Note dated 1/3/25 showed:</p> <p>-The resident reported significant distress over current level of functioning.</p> <p>-The resident expressed his/her mind was racing.</p> <p>-The resident reported auditory hallucinations and explained them as hearing voices of people he/she knew just talking, both day and night all the time.</p> <p>-The resident reported poor sleep with difficulty falling and staying asleep.</p> <p>-The therapist encouraged the resident to let staff know of needs as needed and appropriate.</p> <p>-The resident would benefit from continued psychotherapeutic support maintain current level of progress and stability.</p> <p>-The therapist discussed the resident's presentation and plan of care with the unit nurse, nurse manager, and the social worker.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's care plan showed:</p> <ul style="list-style-type: none"> -There were no new focus areas or interventions that addressed the resident's increased behaviors. -There were no new focus areas or interventions that addressed the resident's increased aggression towards other resident's and staff. <p>Review of the resident's progress notes showed:</p> <ul style="list-style-type: none"> -There was no documentation that addressed if changes in care were needed following episodes of increased aggression, hallucinations, and increased behaviors. -There was no documentation that addressed psychology or psychiatry was notified of the resident's increased behaviors, hallucinations, and increased aggression. <p>Review of the resident's Psychotherapy Progress Note dated 1/9/25 showed:</p> <ul style="list-style-type: none"> -The resident initially presented with agitation and anxiety. -The resident described his/her disappointment with his/her current family situation. -The resident had feelings of isolation and resentment. -The therapist helped the resident problem solve around preparing broken relationships. -The therapist determined the resident had periodic intermittent drops in mood and increased anxiety due to various personal issues, acute and chronic health conditions, strained family relationship dynamics, and ongoing situational stressors and challenges. -The therapist discussed the resident's recent presentation and plan of care with unit nurse, nurse manager, and the facility social worker. <p>Review of the resident's care plan dated 1/13/25, showed:</p> <ul style="list-style-type: none"> -The resident had a history of drug use/abuse. -The resident had potential for sad mood related to depression. --Administer medications as ordered. --Allow the resident to express feelings. --Behavioral health consults as needed. --Encourage the resident to attend activities of his/her choice. --Psychiatry consultation as needed. <p>(continued on next page)</p>

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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident was at risk for increased behaviors related to a history of auditory hallucinations.</p> <p>--Administer medications as ordered.</p> <p>--Assist the resident to develop more appropriate methods of coping and interacting.</p> <p>--Encourage the resident to express feelings appropriately.</p> <p>--Caregivers were to provide opportunity for positive interactions, attention.</p> <p>--Stop and talk with him/her as passing by.</p> <p>--Monitor behavior episodes and attempt to determine underlying cause.</p> <p>--Consider location, time of day, persons involved, and situations.</p> <p>--Document behavior and potential causes.</p> <p>--Monitor behavior episodes and attempt to determine underlying cause.</p> <p>-The interventions / recommendations from the psychologist and psychiatrist were not added to the care plan.</p> <p>During an interview on 1/13/25 at 3:19 P.M., Resident #76 said:</p> <p>-He/She thought Resident #69 was going through his/her belongings.</p> <p>-He/She hit Resident #69 in the face.</p> <p>During an interview on 1/13/25 at 8:45 A.M., Resident #69 said:</p> <p>-Resident #76 said he/she kidnapped his/her children.</p> <p>-He/She was sleeping when Resident #76 came in his/her room and hit him/her in the face.</p> <p>-Resident #76 harassed him/her every day about going into Resident #76's room and taking his/her belongings, which never happened.</p> <p>-He/She talked to staff about Resident #76's behavior and they told him/her to stay away from Resident #76.</p> <p>-Resident #76 also bothered other residents, saying they went into his/her room and took belongings.</p> <p>-He/She felt safe now that Resident #76 was gone.</p> <p>During an interview on 1/13/25 at 9:15 A.M., Resident #72 said:</p> <p>(continued on next page)</p>

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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #76 yelled a lot at the residents and had paranoid episodes, saying people were in his/her room taking his/her items.</p> <p>-Resident #76 was crazy, he/she threatened to beat up people.</p> <p>-Resident #76 was violent. Staff told him to stay in his/her room.</p> <p>-He/She heard Residents #69 and Resident #76 argue on Friday night (1/10/25), but did not see anything.</p> <p>-He/she felt safe without Resident #76 around.</p> <p>During an interview on 1/13/25 at 9:25 A.M., Resident #37 said:</p> <p>-Resident #76 was unruly in the evenings.</p> <p>-Staff told Resident #76 to return to his/her room when he/she acted up.</p> <p>-On Friday he/she saw Resident #76 go into Resident #69's room.</p> <p>-He/She could not see the head of the bed behind the curtain, but he/she saw the motion of Resident #76 swing his/her arms as if he/she had hit Resident #69.</p> <p>-He/She felt safe now that Resident #76 was gone.</p> <p>-Staff tried to stop Resident #76 from hitting Resident #69.</p> <p>-He/She thought Resident #76 was going to hit the staff.</p> <p>-The staff ended up calling the police.</p> <p>During an interview on 1/13/25 at 9:35 A.M., Resident #11 (Resident #76's roommate) said:</p> <p>-Resident #76 was paranoid a lot.</p> <p>-He/She never saw anyone in their room.</p> <p>-He/She did not see what happened on Friday.</p> <p>During an interview on 1/14/25 at 11:16 A.M., Resident #29 said:</p> <p>-He/She had seen Resident #76's explosive behaviors before Friday.</p> <p>-He/She was afraid of the resident and felt safer now that Resident #76 was gone.</p> <p>-He/She noticed that staff stayed with Resident #76 during his/her explosive behaviors and tried to keep him/her busy.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She separated the resident from other residents when he/she started to act up.</p> <p>-He/She did not report the behaviors because he/she was able to handle them.</p> <p>During an interview on 1/14/25 at 10:24 A.M., LPN B said:</p> <p>-Residents #76 and Resident #69 exhibited several hours of verbal altercations, including cussing at each other.</p> <p>-Resident #76 said he/she was going to kill Resident #69 while pacing in the hall.</p> <p>-He/She separated the residents, directing them to remain on separate sides of the hall.</p> <p>-Resident #76 was sweating and acting paranoid.</p> <p>-Resident #76 believed people were tapping into his/her phone.</p> <p>-Resident #76 believed Resident #69 was in his/her room.</p> <p>-Twice Resident #76 tried to enter Resident #69's room, accusing Resident #69 of taking things from his/her room.</p> <p>-Resident #76 threatened LPN B at which time LPN B called the police.</p> <p>-When police arrived Resident #76 physically assaulted the police as well as the paramedics.</p> <p>-Paramedics administered a sedative and the resident was removed in handcuffs.</p> <p>During an interview on 1/14/25 at 10:59 A.M., Certified Medication Technician (CMT) A said:</p> <p>-He/She was working Friday night during the incident.</p> <p>-The charge nurse told him/her that Resident #76 was being volatile.</p> <p>-He/She did not see anything that happened until the police arrived.</p> <p>-There were 11 officers and paramedics who responded to the 911 call.</p> <p>-Resident #76 had to be put in restraints.</p> <p>-Several residents told him/her they were afraid of Resident #76.</p> <p>-Resident #76 was usually easily redirected.</p> <p>-Resident #76 tended to be more aggressive toward people he/she believed to be more vulnerable.</p> <p>During an interview on 1/14/25 at 1:20 P.M., the DON said:</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-No residents or staff reported anything to him/her about Resident #76's behaviors.</p> <p>-Resident #76 went to the hospital last month, but that was the first time Resident #76 ever exhibited behaviors, that he/she was aware of.</p> <p>During an interview on 1/14/25 at 1:20 P.M. the Administrator said:</p> <p>-He/She was not made aware of any previous behaviors by Resident #76.</p> <p>-Resident #76 was sent out to the hospital last month for behaviors, but to his/her knowledge that was the only previous issue with his/her behaviors.</p> <p>-He/She would expect staff to separate the resident from other residents, place on one on one observation, someone should have been watching the resident, and call the police as the resident was very intimidating.</p> <p>MO00247856</p>		