STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265437	A. Building B. Wing	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon View Health and Wellness	1200 West College Street Liberty, MO 64068

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31100 Based on interview and record review, the facility failed to notify one resident's (Resident #1) guardian, when the resident was physically aggressive and was transferred to a local hospital for evaluation. The facility also failed to notify one resident's (Resident #2) guardian when the resident was in an altercation out of three sampled residents. The facility census was 103. Review of the facility staffing inservice, dated 7/19/21, on resident to resident altercation showed the aggressor must be sent out to the hospital for evaluation. The facility did not provide a policy on when to notify a resident's responsible party. 1. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 8/3/21, showed: - Severe cognitive impairment; - Behaviors included delusions; - Required supervision for cares; - Diagnoses included dementia and depression; - Received antipsychotic and antidepressant medications. Review of the resident's care plan, dated 8/6/21, showed: - The resident was dependant upon staff for meeting needs due to required to use a walker. - The resident had the potential to be physically aggressive with staff and residents. - Staff to analyze behavioral triggers and provided strategies to improve behavior. Review of the resident's nurses notes by Registered Nurse (RN) D, dated 10/9/21 at 6:25 A.M., showed: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #1 entered Resident #2's room without asking permission. - Resident #2 yelled and cursed at Resident #1 while telling Resident #1 to leave his/her room. - Staff separated both residents and instructed the residents to stop. - Staff did not document they notified either residents' guardians. During an interview on 10/28/21 at 1:12 P.M. Public Administrator (PA) B said: - He/she was Resident #1's PA. - The facility did not notify him/her when the incident occurred. 2. Review of Resident #2's admission MDS, dated [DATE], showed: - Memory problem with moderate cognitive impairment; - Required supervision for cares; - Behaviors included verbal and physical aggression towards others. - Diagnoses included a urinary tract infection and dementia; - Medications included antipsychotic and antidepressant medications. Review of the resident's nurses notes by RN D, dated 10/9/21 at 6:19 A.M.,. showed: - Resident #1 entered Resident #2's room without asking permission. - Resident #2 yelled and cursed at Resident #1 while telling Resident #1 to leave his/her room. - Staff separated both residents and instructed the residents to stop. - Staff did not document they notified either residents' guardians. Review of the resident's care plan, dated 10/17/21, showed: - Staff discuss behavior and protect the safety of others. - Cognitive impairment due to dementia. - Diagnoses included alcohol dependence, dementia with behavioral disturbance, bipolar disorder (severe mood swings), major depressive disorder, alcohol induced psychotic disorder with hallucinations. During an interview on 10/28/21 at 11:50 A.M., the resident said: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #1 came into his/her room without permission. - He/she requested the resident leave. - Resident #1 refused to leave. - They started yelling. - Resident #1 slapped Resident #2 multiple times. - He/She did not slap Resident #1, but simply blocked the slaps. During an interview on 10/27/21 at 1:20 P.M., the Administrator (ADM) said: - Staff should have notified both residents' guardians and physicians after the altercation. - Staff should have assessed both residents after the altercation. MO192629

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(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** 31100 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse when the facility failed to protect residents who reside on a Special Care Unit (SCU), when one resident (Resident#1) who had a history of physical aggression, physically abused a resident (Resident #2) on 10/15/21. The facility failed to implement interventions after the incident on 10/15/21 to protect other residents. On 10/23/21 Resident #1 abused another resident (Resident #3) causing injury to the resident. The facility failed to ensure staff were aware of Resident #1's aggression and failed to ensure staff had access and knowledge of the resident's plan of care. The facility census was 103. The Administrator was notified on 10/26/21 at 4:30 P.M. of an Immediate Jeopardy (IJ) which began on 10/15/21. The IJ was removed on 10/27/21 as confirmed by surveyor onsite verification. Review of the facility policy, dated 2021, on Abuse, Neglect, and Exploitation showed: - The facility would provide protection for the health, welfare, and rights of each resident; - Abuse was defined as willful infliction of injury resulting in physical harm, pain, or mental anguish; - All staff will be educated on prevention of abuse; - The facility must provide a safe environment; - The facility must report and investigate all possible abuse; - The facility must protect residents from harm; - The facility must promptly respond to allegations of abuse; - The facility may require increased supervision of residents. Review of the facility staffing inservice, dated 7/19/21, on resident to resident altercation showed: - In the event of a resident to resident altercation staff must immediately separate the residents; - The aggressor must be placed on 1:1 supervision; - Staff must immediately report the issue to the Administrator (ADM) and the Director of Nursing (DON); - The aggressor must be sent out to the hospital for evaluation; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The aggressor must remain upon 1:1 supervision until a medication change has been performed and the first dose of medication; - If the hospital did not make any medication changes, the aggressor must remain on 1:1 until the facility psychiatrist made a medication change. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/3/21, showed: - Severe cognitive impairment; - Behaviors included delusions; - No physical behaviors; - Required supervision for cares; - Diagnoses included dementia and depression; - Received antipsychotic and antidepressant medications. Review of Resident #1's care plan, dated 8/6/21, showed: - The resident was dependant upon staff for meeting needs due to required use of a walker; - The resident had the potential to be physically aggressive with staff and residents; - Staff are directed to analyze behavioral triggers and provided strategies to improve behavior. - No interventions for the aggressive behaviors. Review of Resident #2's admission MDS, dated [DATE], showed: - Memory problem with moderate cognitive impairment; - Required supervision for cares; - Behaviors included verbal and physical aggression towards others. - Diagnoses included a dementia; - Medications included antipsychotic and antidepressant medications. Review of Resident#2's care plan, dated 10/17/21, showed: - Staff discuss behavior and protect the safety of others. - Cognitive impairment due to dementia. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Diagnoses included alcohol dependence, dementia with behavioral disturbance, bipolar disorder (severe mood swings), major depressive disorder, alcohol induced psychotic disorder with hallucinations. Review of Resident #3's quarterly MDS, dated [DATE], showed: - Mild cognitive impairment; - No behaviors noted; - Diagnoses included heart disease, Alzheimer's disease, and dementia; - Received antidepressant medications. Review of Resident#3's care plan, dated 8/3/21, showed: - The resident had the potential for behaviors due to history of aggression. - The resident had the right be treated with dignity and respect. - The resident's diagnoses included dementia with behavioral disturbance, major depression, systemic lupus (an inflammatory disease characterized by the body attacking it's own tissues), and heart disease. Review of Resident #1's nurses notes, dated 10/9/21 at 6:25 A.M., by Registered Nurse (RN) D showed: - Resident #1 got into an altercation with Resident #2. - Resident #1 was going into other resident's rooms. - Resident #2 told Resident #1 to leave his/her room. - Both residents hit each other with open hands on the face, arms, and head. - Staff instructed both residents to stop hitting each other and separated. - No interventions were noted. Review of Resident #1's nurses notes by Licensed Practical Nurse (LPN) A, dated 10/15/21 at 2:55 P.M., showed: - Resident #1 and Resident #2 were hitting each other. - Resident #2 was yelling at Resident #1 to get out of his/her room. - Staff separated both residents and assessed the residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- LPN A notified the DON. - The DON immediately called the resident's physician A who requested that staff transport the resident to the emergency department (ED) for evaluation and admission. - Resident #1 was transported to the ED by emergency medical services (EMS). Review of Resident #1's nurses notes, dated 10/15/21 at 6:51 P.M. by RN A showed: - ED nurse called and said Resident #1 was being returned to the facility. - RN A told the ED that physician A said the resident was to be admitted . - Resident #1 returned to the facility by EMS at 5:20 P.M. - Approximately 15 minutes after Resident #1 returned to the facility, Resident #1 was arguing with an unnamed resident (later identified as Resident #2). - Staff separated the residents. - RN A notified the DON who said to place Resident #1 on 1:1 supervision due to the resident's behavior. Review of Resident #1's medical record showed the following: - Staff did not complete one on one monitoring of the resident and instead completed 15 minute checks. - A check list for monitoring, dated 10/15/21 showing 15 minute checks were completed from 5:45 P.M. to 10:30 P.M. - Staff did not document checks past 10:30 P.M. on 10/15/21. - Staff did not notify the facility psychiatrist B. Review of Resident#1's care plan, updated on 10/15/21 showed: - The resident was transferred to the hospital for evaluation. - Resident was placed on Depakote (medication used to treat psychiatric disorders) to treat impulse control. - No other interventions put in place for the resident's aggressive behaviors after the resident's resident to resident altercation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on 10/16/21 at 2:15 P.M., showed RN E on the locked unit, standing in the hall way. Resident #1 wandered back and forth through the halls, pressing on the panic bars on the three exit doors, and wandering into three different resident rooms. Two other residents redirected him/her from the resident rooms he/she attempted to enter. RN E said the resident had been aggressive and had hit another resident on the unit the previous day. RN E said he/she had come to the facility from a sister facility and he/she did not know where the Certified Nursing Assistant (CNA) who worked on the unit was; he/she was just trying to keep track of all the residents. As RN E stood in the hallway with two other residents close by, Resident #1 forcefully moved between the residents and surveyor. Review of Resident #1's medical records, dated 10/16/21 at 3:01 P.M. by RN A, showed: - The resident wandering the hall. - Two unnamed CNAs tried to change the resident. - The resident pulled one of the CNA's hair and slapped the CNA. - The resident tried to bite the CNA. - Did not document any behavioral interventions. Review of Resident #3's nurses notes, dated 10/23/21 at 6:15 P.M. by LPN D, showed: - Resident #3 told LPN A that Resident #1 struck him/her in the face three times with his/her wrist after Resident #1 entered his/her room. - Resident #3 had bruising and a hematoma on the left outer eye. - Resident #3 requested to file a police report and then go to the ED. Review of nurses notes, dated 10/23/21 at 7:19 P.M., by the DON showed: - Resident #1 allegedly struck another resident in the resident's room. - Apparently Resident #1 sought out the resident. - The DON sent Resident #1 to the ED for evaluation and emergency discharge. During an interview on 10/25/21 at 3:35 P.M., Certified Medication Technician (CMT) B said the following: - He/she was working the SCU on 10/23/21. - Resident #1 came out of Resident #3's room. - Resident #3 said the fucking bitch hit him/her in the eye. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Resident #1 went into everyone's room. - Some residents got angry when another resident went into his/her room. - The facility did not have any interventions in place to encourage Resident #1 not to go into other residents' rooms. - One CNA sat with Resident #1 until EMS arrived. - He/she tried to redirect Resident #1 as often as possible. - Resident #1 did not always know the location of his/her room. Observation on 10/26/21 at 8:35 A.M., of Resident #3 showed the resident with an approximately 2 centimeter (cm) purple area around the left eye. During an interview on 10/26/21 at 8:35 A.M., Resident #3 said: - Staff did not keep Resident #1 from frequently wandering in residents' rooms. - Resident #1 would get in his/her bed and be aggressive when asked to leave. - Resident #1 hit him/her in the left eye three times on 10/23/21. Review of Resident #1's medical records from a local hospital, dated 10/23/21 at 7:25 P.M., showed: - The resident was brought to the ED for a mental health evaluation. - The ED attempted to return the resident to the facility after finding no acute illness. During an interview on 10/25/21 at 11:26 A.M., LPN B said: - He/she was assigned to provide care to residents on the SCU, including Resident #1 the week before the 10/23/21 incident occurred. - He/she just started working for the facility. - He/she was not trained in dealing with aggressive residents and was not told the resident had aggressive behaviors During an interview on 10/25/21 at 11:27 A.M., CMT said: - He/she was assigned to provide care to residents on the SCU, including Resident #1. - He/she starting working at the facility on 10/24/21. - He/she did not receive any orientation before caring for residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- He/she did not know the resident had aggressive behaviors. During an interview on 10/25/21 at 11:28 A.M., CNA A said: - He/she was assigned to provide care to residents on the SCU, including Resident #1 on 10/23/21. - He/she worked for an agency. - Staff gave a change of shift report, but did not discuss change of behaviors in the shift report. - He/she did not know how to access the residents' care plans. - He/She did not receive any orientation to the facility or the SCU and was not informed that Resident #1 had aggressive behaviors. During an interview on 10/25/21 at 11:30 A.M. CNA B said: - He/she was assigned to provide care to residents on the SCU, including Resident #1. - He/she occasionally worked on the SCU. - He/she did not know how to access the residents' care plans. During an interview on 10/25/21 at 11:50 A.M., LPN C said: - He/she normally worked on the SCU. - Resident #1 often wandered into other resident's rooms and upset the other residents. - He/she redirected the resident when the resident wandered into other resident's rooms. - The only intervention was redirecting. - The resident's behaviors were not discussed in report. During an interview on 10/25/21 at 3:30 P.M., CNA I said: - He/she worked on the SCU. - Resident #1 often got into other residents' beds. - Other resident frequently became angry when Resident #1 got in their beds. - The facility staff did not have any strategies to prevent Resident #1 from going into other resident's rooms. - He/She did not know about the resident to resident incidents. (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 10/25/21 at 3:58 P.M., CNA D said: - He/she started working at the facility several months ago. - At times, he/she worked on all the units in the facility. - He/she did not know where to find residents' care plans. - He/She received no training on what interventions the resident had in place for aggressive behaviors. During an interview on 10/26/21 at 6:26 A.M., RN B said: - He/she worked on the SCU. - He/she did not receive any orientation when he/she started working at the facility - He/she did not know where to find residents' care plans. - He/She did not know the resident had aggressive behaviors or what to do if the residents had aggressive behaviors. During an interview on 10/26/21 at 6:29 A.M., CNA E said: - He/she worked for the facility. - He/she frequently worked on the SCU. - He/she did not know how to access resident's care plans. - Resident #1 frequently went into other residents' rooms. - He/she tried to redirect Resident #1. - The facility did not change anything after the resident to resident altercation. During an interview on 10/26/21 at 8:00 A.M., CNA G said: - He/she frequently worked on the SCU. - Resident #1 was very aggressive with other residents. - He/she redirected Resident #1 frequently. During an interview on 10/26/21 at 8:25 A.M., CMT C said: - He/she worked for an agency. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- He/she had worked on the SCU. - There had been several incidents of aggression with Resident #1. - He/she was afraid of Resident #1 due to the resident's aggressive behavior. - Resident #1 often refused to take his/her medications. - He/she received no training when he/she started at the facility. - He/she did not know how to access residents' care plans. During an interview on 10/26/21 at 8:50 A.M., LPN C said: - Resident #1 was frequently aggressive. - Resident #1 walked a lot and swung his/arms while walking. - There were frequent resident to resident altercations due to Resident #1's swinging arms. - He/she redirected the resident, but frequently that did not work. During an interview on 10/26/21 at 8:55 A.M., CNA H said: - He/she worked all over the facility including the SCU. - Resident #1 frequently was agitated. During an interview on 10/27/21 at 5:40 A.M., LPN H said: - He/she worked for a staffing agency. - He/she did not receive any orientation when working at the facility or the SCU. - He/she was not told in report that Resident #1 was aggressive. During an interview on 10/26/21 at 12:15 P.M. physician A said: - Resident #1 had increasing agitation. - He/she increased his/her medications. - He/she discussed with the facility the use of nonmedication behavior interventions. - He/she sent Resident #1 to the ED on 10/15/21 and requested that the resident be admitted for behavior management. - Instead the ED sent the resident back to the facility with no interventions. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Resident #1 was tranquil in the ED, but was aggressive and yelling as soon as the resident arrived back at the facility. During an interview on 10/26/21 at 2:15 P.M., physician B said: - Staff did not inform him/her that Resident #1 was aggressive. - He/she evaluated for the behavioral issues on 10/17/21 and did not find the resident aggressive at that time. During an interview on 10/26/21 at 1:05 P.M., MDS Coordinator said: - He/she updated resident care plans after discussing new resident issues. - He/she made care plan updates and notified the resident's charge nurse. - The charge nurse should notify the oncoming nurse of care plan changes. - Care plan updates trigger and update the CNA care plans. - He/she said he/she should have added interventions after the first resident to resident's altercation. During an interview on 10/25/21 at 2:05 P.M., the DON said: - Resident #1 assaulted Resident #3 on 10/23/21. - He/she told the staff to contact EMS. - He/she thought staff communicated with the on coming staff with a written sheet. - He/she did not know how agency staff received orientation to the facility. During interviews on 10/25/21 at 2:25 P.M. and 10/26/2021 at 1:20 P.M., the ADM said: - Resident #1 was placed on 15 minute checks some time by the charge nurse, but not on 10/15/21. - Staff should have provided one on one monitoring until the next day. - The ADM said staff did not put any interventions into place to prevent Resident #1 attacking other residents. - Resident #1 should have been placed on 1:1 supervision due to his/her behaviors. - Care plan updates should be reviewed during change of shift report. - The ADM expected all licensed staff to update the care plan. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visits, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s).

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	265437	A. Building B. Wing	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon View Health and Wellness	1200 West College Street Liberty, MO 64068

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 31100 Based on interview and record review, the facility staff failed to follow the proper procedure when the facility discharged a resident (Resident #1) without giving a discharge notice to the resident's Public Administrator (PA) prior to discharging the resident, not allowing time to contest the discharge, and not notifying the resident's PA the resident was being discharged . The facility census was 103. Review of the facility policy, dated 2021, on discharges showed: - The facility would only transfer residents when the health and safety of the resident or other residents was endangered. - Discharge referred to the movement of a resident from a bed in one facility to a bed in another facility. - Facility initiated discharge is a discharge which the resident objects. - The facility must evaluate and determine the level of care required for the resident. - The resident has a right to appeal the transfer. - The facility can not discharge a resident during the appeal process. - If a resident must be discharged emergently, staff must notify the resident's physician. - If a resident must be discharged emergently, staff must notify the resident's representative. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 8/3/21, showed: - Severe cognitive impairment; - Behaviors included delusions; - Required supervision for cares; - Diagnoses included dementia and depression. Review of the resident's care plan, dated 8/6/21, showed: - The resident was dependant upon staff for meeting needs due to required to use a walker. - The resident had the potential to be physically aggressive with staff and residents. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Staff to analyze behavioral triggers and provided strategies to improve behavior. Review of the resident's care plan, updated on 10/15/21 showed: - The resident transferred to the hospital for evaluation. - Resident placed on Depakote (used to treat psychiatric disorders) to treat impulse control. Review of the resident's care plan, dated 10/17/21, showed a consult with the facility psychiatrist. Review of the resident's nurses notes, dated 10/23/21 at 11:41 P.M., by Licensed Piratical Nurse (LPN) D showed: - The Resident #1 struck and injured Resident #3 in Resident #3's room. - The resident sought out Resident #3. - The resident was sent to the local hospital. - The resident's PA was notified by voicemail. - The emergency discharge was delivered to the local hospital. Review of the resident's discharge notice, dated 10/23/21 (no time given) showed: - Staff issued the discharge notice to the Emergency Department. - The notice did not give the PA time to contest the discharge. During an interview on 10/28/21 at 2:40 P.M., LPN D said: - The Administrator (ADM) told him/her to send the resident to a local hospital. - The ADM said that the SSD would deliver an emergency discharge notice. - He/she did not notify the resident's PA on call or physician. During an interview on 10/25/21 at 11:55 A.M., the Social Services Designee (SSD) said: - He/she was on call on 10/23/21. - The ADM told him/her to deliver an emergency discharge notice to the hospital. - He/she called the PA and left a message. - He/she handed the emergency discharge notice to someone in the hospital, but did not give the notice to the resident. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- He/she should have spoken with the resident's PA, but just left a voice mail. - He/she did not know that he/she had to deliver the notice of discharge to the resident's PA. - He/she did not know that he/she had to give the resident's PA a signed notice of discharge that allowed the PA to contest the discharge. During an interview on 10/25/21 at 12:58 P.M., PA A said: - He/she was the PA on call. - The PA's office had a PA on call 24/7 for emergencies. - He/she was called and was notified of the discharge to the hospital. During an interview on 10/25/21 at 1:12 P.M., PA B said: - He/she was the resident's PA. - Facility staff did not notify the PA on call that the resident was transferred to the hospital due to behavioral issues. - Facility staff did not notify the PA on call that the resident was emergently discharged with no accepting facility. - Facility staff notified him/her on 10/18/21 that the resident had behavior issues and the SSD was looking for another facility. - The resident was still in the local hospital awaiting placement. During an interview on 10/25/21 at 2:25 P.M., the ADM said: - He/she felt the resident was a danger to other residents. - He/she told the SSD to issue an emergency discharge notice to be delivered to the hospital. - He/she should have ensured the SSD spoke with the PA on call. - He/she should have taken the resident back to the facility and placed the resident on 1:1 supervision while obtaining a new facility. - He/she refused to take the resident back to the facility. MO192597

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 31100 Based on interview and record review, the facility failed to provide behavioral interventions for one resident's wandering behavior and after one resident (Resident #1) hit two residents (Residents #2 and #3). The facility census was 103. Review of the facility policy on behavioral management, dated 2020, showed: - Residents that exhibited behavioral concerns might require a behavior management plan to ensure the resident received appropriate services and interventions to meet the resident's needs. - The behavioral plan should include a daily schedule including recreational schedule, non-pharmacological interventions, and environmental adjustments. - Upon admission staff should determine if a resident required a behavior management plan. - Behaviors should be documented and include triggers and interventions. Review of the facility policy on orientation, dated 2021, showed: - The purpose of the policy was to develop, implement, and maintain an effective orientation process for all new staff providing services under a contractual agreement (agency staff). - Orientation referred to the process of orientating staff to the facility. Review of the facility agency staff check list, dated 2021, showed: - A facility staff member must review the check list with agency personnel prior to agency staff proving care to residents. - The check list must be returned to the staffing coordinator. - The check list included items such as how staff used the electronic medical records to assess residents' care plans. Review of the facility staffing inservice, dated 7/19/21, on resident to resident altercation showed: - In the event of a resident to resident altercation staff must immediately separate the residents. - The aggressor must be placed on 1:1 supervision - Staff must immediately report the issue to the Administrator (ADM) and the Director of Nursing (DON). (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The aggressor must be sent out to the hospital for evaluation. - The aggressor must remain upon 1:1 supervision until a medication change has been performed and the first dose of medication. - If the hospital did not make any medication changes, the aggressor must remain on 1:1 until the facility psychiatrist made a medication change. 1. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 8/3/21, showed: - Severe cognitive impairment; - Behaviors included delusions; - Required supervision for cares; - Diagnoses included dementia and depression; - Received antipsychotic and antidepressant medications. Review of the resident's care plan, dated 8/6/21, showed: - The resident was dependant upon staff for meeting needs due to required use of a walker. - The resident had the potential to be physically aggressive with staff and residents. - Staff are directed to analyze behavioral triggers and provided strategies to improve behavior. -No other interventions for aggressive behaviors. Review of the resident's nurses notes, dated 9/27/21 at 8:31 A.M., by Licensed Practical Nurse (LPN) A showed: - Behaviors of going in other rooms, sleeping in other beds, and swinging arms back and forth when walking. - No interventions were noted for the resident's behaviors. Review of the resident's nurses notes, dated 9/30/21 at 11:41 A.M., by LPN A showed: - The resident exhibited behavior of swinging arms when walking. - No interventions were noted for the resident's behaviors. Review of the resident's nurses notes, dated 10/5/21 at 3:45 P.M., by LPN I showed: - Resident walked the halls swinging both arms as he/she walked. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident seemed anxious and unable to sit still. - No interventions were noted for the resident's behaviors. Review of the resident's nurses notes, dated 10/8/21 at 10:16 A.M., by LPN C showed: - Behaviors included going in other residents' rooms, sleeping in other resident's beds, and swinging arms when walking and sitting. - No interventions were noted for the resident's behaviors. Review of the resident's nurses notes, dated 10/9/21 at 6:25 A.M., by RN D showed: - Resident #1 got into an altercation with Resident #2. - Resident #1 was going into other resident's rooms. - Resident #2 told Resident #1 to leave his/her room. - Both residents hit each other with open hands on the face, arms, and head. - Staff instructed both residents to stop hitting each other and separated. - No interventions were noted. Review of the resident's nurses notes, dated 10/15/21 at 2:25 P.M., by LPN A showed: - LPN A heard yelling and Resident #1 and an unnamed resident were hitting each other. - Staff separated both residents. - LPN A notified Resident #1's physician who gave the order to send the resident to the emergency department for evaluation. Review of the resident's nurses notes, dated 10/15/21 at 6:51 P.M., by RN A showed: - The resident was returned to the facility around 5:20 P.M. - The resident started arguing with another resident. - RN A notified the Director of Nursing who placed the resident on 1:1 supervision. Review of the resident's medical records showed on 10/15/21 the resident received 15 minute checks from 5:45 P.M. to 10:30 P.M. No other 15 minute checks documented for the resident. Review of the resident's care plan, updated on 10/15/21, showed: - The resident transferred to the hospital for evaluation. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident placed on Depakote (used to treat psychiatric disorders) to treat impulse control. -Review showed no new interventions put in place for the resident's behaviors. Review of the resident's care plan, dated 10/17/21, showed a consult with the facility psychiatrist. Review of Resident #3's nurses notes, dated 10/23/21 at 5:15 P.M., by LPN D showed: - Resident #3 said that Resident #1 struck him/her in the face three times. - Resident #3 had bruising and swelling on the left outer eye. - Resident #3 was sent to the hospital. During an interview on 10/26/21 at 8:35 A.M., the Resident #3 said: - Resident #1 walked into his/her room. - Resident #1 grabbed his/her belongings. - Resident #1 then hit Resident #3 in the left eye three times. - Resident #1 was always going into other residents' rooms. - Staff did nothing to stop Resident #1 from going into other residents' rooms. Observation on 10/26/21 at 8:35 A.M., showed no interventions to help Resident #1 find his/her room or signs indicating where the resident's room was located. During an interview on 10/25/21 at 11:50 A.M., LPN A said: - He/she frequently worked the Special Care Unit (SCU) where Resident #1, Resident #2, and Resident #3 lived. - Resident #1 was aggressive with residents and staff. - Resident #1 went into other resident rooms frequently and upset the residents. - The facility did not provide interventions after incident of wandering in other resident's rooms for Resident #1. During an interview on 10/25/21 at 3:30 P.M., Certified Nurse Assistant (CNA) C said: - He/she often worked on the SCU. - Resident #1 had frequent outbursts. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- There were no new interventions on the CNA care plan after each outburst. -He/she said the resident's had aggressive behaviors prior to the resident to resident's altercations. -The CNA did not know what to do when the resident's had aggressive behaviors. -He/she did not know who puts interventions in place after the resident's behaviors. During an interview on 10/25/21 at 3:35 P.M., Certified Medication Technician (CMT) B said: - He/she often worked on the SCU. - Staff tried to redirect Resident #1 when he/she was aggressive. - Resident #1 usually did not know where his/her room was located and frequently went in other residents' rooms. - Staff had not placed signs to help the resident find his/her room. During an interview on 10/26/21 at 8:00 A.M., CNA G said: - He/she frequently worked on the SCU. - Resident #1 frequently did not know how to find his/her room. - Staff did not provide any signage to show the resident where his/her room was located. During an interview on 10/26/21 at 8:25 A.M., CMT C said: - He/she worked on the SCU. - Many residents were afraid of Resident #1, because the resident was aggressive and went into other residents' rooms. During an interview on 10/26/21 at 8:50 A.M., LPN A said: - Resident #1 was aggressive. - He/she would swing his/her arms while walking. - The resident was confused and did not know how to find his/her room. - There were no care planned interventions to deal with the resident's behaviors. During an interview on 10/26/21 at 12:05 P.M., the resident's physician A said: - Staff notified him/her the resident had behavioral issues. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she expected interventions to be put in place for the resident's aggressive behaviors. During an interview on 10/26/21 at 1:05 P.M., the MDS Coordinator (MDS C) said: - He/she attended morning meeting. - When issues were identified in morning meeting, he/she provided interventions. - He/she notified the resident's charge nurse of changes in a resident's care plan. - The charge nurse should review the care plan changes at change of shift report. - Staff did not report that Resident #1 was aggressive and could not find his/her room. - He/she should have interventions to find his/her room. - He/she should have interventions for the resident's aggressive behaviors. - He/she updated the resident's care plan when his/her physician changed the resident's medications. During an interview on 10/26/21 at 2:15 P.M., the resident's psychiatrist B said: - Staff did not tell him/her the resident was being aggressive. - He/she evaluated the resident. - At the time of his/her evaluation the resident was calm. During an interview on 10/26/21 at 10:06 A.M., the ADM said: - Resident #1 did not have a behavior management care plan. - Staff should have created a behavior management care plan. - Staff should have provided interventions to help Resident #1 find his/her room. - It would have helped to have signs indicating where the resident's room was located. - Staff should have put interventions into place to deal with the resident's aggressive behaviors. MO192597, MO192589