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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or

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psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to have interventions in place to prevent resident to resident abuse. This applies to 3 of 3 residents (R1, R2, R3) reviewed for abuse in the sample of 3. This failure resulted in R1 being sent to the hospital, receiving a hematoma, and experiencing pain with activities of daily living.

The findings include.

R2's Admission Record (Face Sheet) showed an original admission date of 3/8/24 with diagnoses to include dementia with behavioral disturbances, depression, and anxiety.

R2's 3/15/24 Admission Minimum Data Set (MDS) showed he had severe cognitive impairment with a brief interview for mental status (BIMS) score of 3 out of 15. The MDS showed he had physical behavioral symptoms directed towards others 1 to 3 days a week (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually.) The MDS showed he had verbal behavioral symptoms directed towards others 4 to 6 days a week (e.g., threatening others, screaming at others, cursing at others.) The MDS showed he was independent in walking 150 feet, and he only needed setup assistance for eating, dressing, oral hygiene, and toileting hygiene.

R2's 3/8/224 Behavior Note from 5:41 PM showed "Per staff, when resident was informed

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that he would be spending the night he stated, then I'm gonna hurt people..."

R2's 3/10/24 Behavior Note from 5:34 PM showed, "Resident opened window in the [dementia unit] sitting area and said, 'I'm going to climb out that window.' Staff stood in front of the window. Resident attempted to push staff away from the window x3 (three times) without success..."

R2's 3/13/24 Behavior Note from 1:45 PM showed, "...resident had been entering resident rooms, breaking window blinds, and pulling curtains down throughout the [day] shift. Also received report from CNA (certified nursing assistant) that resident had taken his name tag off of his room door, then sunk his nails into her fingers when redirected..."

R2's 3/13/24 Behavior Note from 5:45 PM showed, "...resident was noted trying to kiss another resident without success. Resident redirected. Residents kept apart. Subsequently holding another resident's hand and [walking] with her at times. Difficult to redirect...Admin (Administrator) notified."

R2's 3/13/24 Behavior Note from 8:04 PM showed, "Received report from CNA that resident had grabbed the back of her chair and tried to push her out of it. When this writer entered [dementia unit] to take the CNA's statement, she was noted in the corner of the hallway near the entrance. [R2] had his right fist cocked as if to punch her and was leaning and stepping toward her as if to punch her. He ceased this motion without hitting her when this writer stood between them. Admin notified..."

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R2's 3/19/24 Behavior Note from 8:49 PM showed, "CNA reported that resident came to her and poured a full container of water on her as well as the resident she was standing next to. The CNA was found with saturated clothing, trying to separate this resident from the area ..."

On 4/2/24 at 2:06 PM, V9 CNA stated R2 had taken her water bottle and dumped it on her. V9 said R2 believed she was on fire. V9 said immediately after that R2 cocked his fist as if he was going to hit her. V9 said she turned her face away from R2 because she was certain he was going to hit her, however, he did not.

R2's 3/20/24 Behavior Note from 6:00 PM showed, "[R2] noted putting his fingers around another resident's left forearm. The other resident touched [R2's] abdomen with his left hand. [R2] then walked away. No apparent injury noted..."

R3's Face Sheet showed an original admission date of 3/6/24 with diagnoses to include dementia with anxiety and agitation; delirium; and altered mental status.

R3's 3/13/24 Admission Minimum Data Set showed moderate cognitive impairment with a BIMS score of 8 out of 15. The MDS showed no physical of verbal behavioral symptoms. The MDS showed R3 was independent in walking 150 feet and needed setup assistance for eating, dressing, oral hygiene, and toileting hygiene.

The facility's 3/22/24 Final Incident report showed R2 and R3 were on the locked dementia unit. The incident showed R3 was near entry doors to the unit with his wife. The report showed R3 was attempting to leave the unit with his wife when

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staff redirected him away from the door. While staff were escorting R3 away from the unit, R2 was upset about the "commotion" and R2 pushed R3. R3 then attempted to push a wheelchair into R2; however, staff intervened.

On 4/2/24 at 12:08 PM, V4 Licensed Practical Nurse (LPN) stated R3 was wanting to leave the unit with his wife. V4 stated she redirected R3 away from the door and was walking with him when R2 came "out of nowhere. [R2] came behind and pushed [R3] from behind. He pushed him enough that he stumbled forward." V4 said R3 then attempted to pick up a wheelchair; however, staff intervened.

On 4/2/24 at 12:51 PM, 3/22/24 security camera footage was reviewed for the dementia unit. The footage showed, on 3/22/24 at approximately 3:40 PM, V4 was escorting R3 away from the unit doors down the hallway when R2 shoved R3 from behind. R2 stumbled several feet forward, catching himself on a wheelchair in the hallway. R3 then grabbed the wheelchair and attempted to move it in the direction of R2; however, staff intervened.

R2's 3/22/24 Behavior Note from 5:24 PM described the incident above. The note showed V1 Administrator was notified and staff were directed to contact psychiatric services.

R2's 3/22/24 Nursing Note from 5:23 PM showed psychiatric services requested R2 be sent to the emergency department for evaluation.

R2's 3/23/24 Nursing Note from 12:04 AM showed, "Resident continues to have increasing agitation. Attempted to give resident Haldol [antipsychotic medication] ...Resident took med

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cup and threw it down hallway."

R2's 3/27/24 Behavior Note from 3:10 PM, showed R2's right fist was raised as if he was going to punch staff, he then crushed a bottle of hand sanitizer, and then grabbed a staff member's forearm.

R2's 3/27/24 Nursing Note from 9:30 PM showed he was sent to a local inpatient psychiatric facility for an involuntary psychiatric admission.

R3's 3/24/24 Behavior Note from 4:01 PM, showed "Resident noted in his room, grabbing another resident by the shoulders and attempting to push him out of the room. Resident's separated...MD and Admin notified." (Note authored by V6 Registered Nurse (RN))

On 4/2/24 at 12:21 PM, V6 was unclear on the events leading up to the incident on 3/24/24; however, V6 stated R2 was in R3's room, R3 grabbed R2 by the shoulders and "tried to push him out of the room...." V6 said, "It was only R3 that R2 got agitated with. They would have words and push each other. It seemed like it happened every few days...I think they should be separated. In an ideal world, I would do that by putting them on a 1 to 1, at least one of them on a 1 to 1. I would do that so that the staff with them could make sure they don't get near each other and deescalate the situation."

The facility's Incident Report from 3/26/24 showed, "...At 3:40 PM, a resident was standing at the entrance to his bedroom conversing with another resident. A third resident approached and attempted to enter the bedroom which resulted in [R1] stumbling backwards into his garbage can and landing on his buttocks on the

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floor..."

On 4/2/24 at 9:32 AM, V3 Activities Director stated she heard a "...commotion and went into the hallway..." V3 stated she saw R2, R3, and V12 (R3's Spouse) in R3's room. V3 said the "commotion" was "loud talking." V3 said she witnessed "...[R2] pushed [R3], [R3] lost his balance and he fell into [R1] and [R1] I think his arm hit the garbage can." V3 stated V7 also responded to the incident.

On 4/2/24 at 10:25 AM, V7 Activity Aide/Dietary Aide stated regarding the incident on 3/26/24, "I was doing 1 on 1's with [R2] because of the issues [R2] was having." V7 said, "He (R2) had been restless. They told me he needed extra watching. There was an incident that had happened a couple of days earlier...they told me to try and keep him (R2) away from [R3]." V7, while she was 1 on 1 with R2 on 3/26/24, she was not aware R2 had shoved R3 on 3/22/24. V7 said she would like to have known about the incident on 3/22/24 prior to being on a 1 to 1 with R2. V7 said, on 3/26/24 she was walking with R2 when R2 saw R3 and V12 in the doorway to R3's room. V7 said R2 "pushed at him (R3). I'm not sure if he made contact." V7 said R3 "bumped" into R1. V7 said, in hindsight, she would not have done anything differently.

R1's 3/26/24 Nursing Note from 6:34 PM showed, "Resident with increased c/o (complaints of) pain in the lower back and upper hip."

R1's 3/26/34 Nursing Note from 10:30 PM showed the Xray was completed and R1 had three compression fractures. The note showed R1 was sent to a local area Emergency Room.

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R1's CT scan from 3/26/24 showed the spinal fractures were most likely "chronic" fractures.

R1's After Visit Summary (Hospital Discharge Orders) from 3/27/24 showed, "The hematoma (a pool of clotted blood within the body) on the left will extend into the buttock and down the leg..."

R1's 3/28/24 Nursing Note from 11:34 AM showed, "Resident monitored post fall. (R1's progress notes show no previous falls except for the incident on 3/26/24) He had tears in his eyes from pain while receiving AM (morning) cares. Pain is to his left side where his hematoma is. After breakfast, and AM medications, resident stated that the pain is worse with movement..."

R1's 3/29/24 Nursing Note from 4:25 PM showed, "...Reports 5/10 (rating pain at a 5 out of 10) left hip pain. No new injury noted..."

R1's 4/1/24 Weekly Skin Observations note showed he had a 4-inch by 17-inch bruise to his left abdomen. The note showed he had a 11-inch by 23-inch bruise that extended from his left hip to left buttock. The note showed a third bruise to his left thigh which was 11-inches by 48-inches long.

On 4/2/24 at 12:51 PM, video footage, provided by the facility, showed on 3/26/24 at approximated 3:45 PM, V3 walking quickly out of a resident room. V3 was walking down the hallway looking in resident rooms as if she was searching for something. When V3 reached R3's room, she immediately entered the room, and she was out of sight. Several seconds later, V7 (who stated she was on 1 to 1 supervision with R2) exited the dining room and entered R3's room. Several seconds after later, V3 exited the

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room and then nursing staff arrived. The footage provided by the facility did not show R2 entering R3's room or how long R2 was in the room.

On 4/2/24 at 2:27 PM, V8 Licensed Practical Nurse (LPN) stated she was on the dementia unit nurse on 3/26/24. V8 said she was not aware of R2 being on 1 to 1 supervision on 3/26/24. V8 said she was not aware of any incidents between R2 and R3 prior to 3/26/24. V8 said, "I would expect to be aware of any previous issues just so I would know what to look out for. I would follow whatever direction management provided as far as keeping them separated. That day (3/26/24) I had no direction from management about keeping them separated."

On 4/3/24 at 11:45 AM, V2 Director of Nursing stated after incidents occur, such as the incident on 3/22/24, interventions are put in place to protect the residents. V2 said the interventions for R2 were mainly medications and psychiatric services. V2 said, "In retrospect, we could have separated him sooner, but we were trying to work on medications. Medication changes can take a while to take effect. The orders we got were for long term medications (medications that take time before they reach full effect). V2 said, R2's interventions for safety should be in his care plan. V2 said, "I would expect the nurse on the 26th to be aware of the previous incidents. I would want to know so I could keep an eye on them and try to keep them separated." V2 said, "It wasn't me that put her (V7) on 1 to 1 (supervision) but it seems like it was a good idea. We were trying to keep extra staff back there [on the dementia unit] because of the issues we had back there with [R2]." V2 said R2 and R3 should not have been in the same room unsupervised.

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On 4/3/24 at 12:20 PM, V1 Administrator stated she was the abuse coordinator. V1 said abuse interventions are a team effort and all the interventions should be in the care plan. V1 said R2's abuse interventions were psychiatric services, medications, activities, and redirection. V1 said, "There was never any interventions put in place to keep them (R2 and R3) separated. I don't think it would be an appropriate intervention to keep them separated. They had a lot of positive interactions together...I think they were reacting to the stimuli around them. I don't think it was directed behavior I think he was responding to the environment. I think the staff were aware of the incident on the 22nd (3/22/24) and they increased their supervision."

On 4/3/24 at 10:15 AM, V10 R3's Power of Attorney/Daughter stated, "They have called me twice about incidents with my dad and another resident. He was on memory care, my mom was visiting, he (R3) was following her to the door, and the resident shoved him, I believe. Dad defended himself and the nurse got between them and stopped it. Another incident they called, my mom was there, what they told me was a scuffle between the same resident and another resident, not my dad...There may have been a third time, it was kind of an on-going thing with this particular resident and my dad...He (R2) would have been upset over these incidents, he is more about protecting others than himself, he would defend himself. He would be more worried about others than himself. He was a teacher for 40 years, so he was always on the lookout for bullies. After the incident on the 22nd he would have wanted to stay away from him. He would have stayed away from him and just work to not interact with him...I think it would have been best to just keep them separated at all times, to keep

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them safe."

R2's Care Plan showed R2 "has a behavior problem. Becomes agitated quickly. He responds to a male staff member better than he does female staff members." (This care plan area was initiated on 3/27/24, two weeks after resident attempted to kiss another resident, several days after a raised fist at staff, 5 days after R3 was initially pushed, and the day he was sent out for involuntary psychiatric admission.) The interventions for this care plan focus area do not show close monitoring of R2 when he is around other residents, specifically R3. The interventions do not show to keep R2 separated from R3.

R3's Care Plan showed no interventions for close monitoring when around R2 and/or interventions to keep them separated.

On 4/3/24 at 11:30 AM, V11 Medical Director stated, based on the CT scans from the hospital the fractures may have been from a previous fall for R1. V11 said, "Hematomas and bruising most definitely can be painful and that could be the source of his pain. Ideally, they would have interventions in place to keep them (R2 and R3) separated but on a locked memory care unit that can be difficult. Moving him (R3 was moved off the memory care unit following the incident on 3/26/24) off the memory care unit to be away from [R2] does seem like a good intervention to keep them separated. [R2]is non-compliant, which makes it difficult to manage those behaviors.

The facility's Abuse Prevention Program policy (Reviewed 10/2023) showed, "This facility affirms the right of our residents to be free from abuse..."

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S9999	Continued From page 12 The policy continued, "Resident Assessment: ...staff will identify residents with increased vulnerability for abuse...Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect exploitation, mistreatment or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis, and update as necessary..." The policy showed, "The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents." The policy showed, "Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...The term "willful" in the definition of "abuse" means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm..." (B)	S9999		