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F 000	INITIAL COMMENTS Correction date 4/5/19 The following deficiencies result from the facility's annual health survey and. Complaint # 81400-C was not substantiated. Investigation of facility-reported incidents # 80707-I and # 81820-I resulted in deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interviews, and facility record review, the facility failed to protect residents from abuse that resulted in injury and psychological harm for 5 of 6 residents reviewed for abuse (Residents #2,	F 600		

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

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F 600	Continued From page 1 #47, #55, #36 and #33). The facility reported a census of 67 residents. Findings include: 1. The admission Minimum Data Set (MDS) assessment dated 11/2/18 for Resident #2 documented an admit date of 10/22/18. The MDS identified a BIMS score of 3 with sign/symptom of delirium with fluctuating presence of inattention; a score of 3 indicated severe memory and cognitive impairment. The MDS documented the resident exhibited physical and verbal behavioral symptoms directed toward others and wandering on 1 to 3 days of the 7-day look back period. The MDS recorded the resident's behaviors impacted others putting others at significant risk for physical injury and significantly disrupted care or the living environment. The MDS recorded he was independent with transfers, walking in the room and corridor, and locomotion on the unit. The MDS documented diagnoses that included Non-Alzheimer's dementia, depression, delirium due to known physiological condition, unspecified/uncomplicated nicotine dependence, other uncomplicated psychoactive substance abuse, and metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood). The MDS assessment dated 1/4/19 for Resident #2 documented a Discharge Return Not Anticipated. The MDS dated 2/19/19 for Resident #2 documented the resident re-entered the facility. The care plan focus area dated 11/1/18 identified Resident #2 as independent with ADLs (activities	F 600		

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of daily living) and transferred independently. The care plan focus area dated 11/5/18 identified an elopement risk/wanderer with behaviors of exit seeking, kicking exit doors, pacing, and going into other residents' rooms related to increased agitation when he did not have cigarettes and could not go out to smoke when he wanted. The care plan informed staff the resident resided on the CCDI (or dementia) unit. The care plan focus area dated 11/5/18 identified a behavior deficit related to physical and verbal behaviors towards others, hitting other residents, shoving another resident; increased agitation when out of cigarettes or couldn't go out to smoke when he wanted or get into the fridge when he wanted and throwing items off nurses cart and throwing nurses tablet breaking it. The care plan informed staff the resident with a history of: yelling/cursing at others; getting upset because the fridge locked; threw juice at staff; took items off med cart, shook drawers on med cart and tried to open them; threatened staff; lifted up a chair and threatened to break window; rammed his shoulder into nurses station door causing damage to facility property; kicked exit door and damaged facility property; and broke locks on cupboard doors in dining area. The care plan identified the resident diagnosed with vascular dementia, delusional disorder, depression, metabolic encephalopathy, and had a long history of substance abuse with nicotine dependence. An intervention dated 11/5/18 directed staff to intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention; and remove from situation and take to alternate location as needed. An intervention dated 11/7/18 directed staff to monitor behavior episodes and attempt to determine underlying cause; consider location,

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F 600	Continued From page 3 time of day, persons involved, and situations; and document behavior and potential causes. The care plan intervention dated 12/28/18 directed staff to educate the resident expectations of keeping his hands to himself and on successful coping, interaction strategies. The care plan instructed when Resident #2 became agitated, staff should attempt to intervene and redirect him before agitation escalated, guide him away from the source of distress, engage calmly in conversation and if he had an aggressive response, staff should walk calmly away and approach later. The care plan focus area dated 11/9/18 identified a mood deficit related to diagnosis of depression and placement in facility. The care plan directed staff to monitor, record, report to physician as needed risk for harming others (increased anger, labile mood or agitation), if he feels threatened by others or thoughts of harming someone and possession of weapons or objects that could be used as weapons. The Progress Notes dated 10/26/18 at 7:23 a.m. documented the nurse asked to go to the CCDI unit at 2:45 a.m. to help watch Resident #2 along with another nurse because of behaviors. Resident #2 complained/cussed because of a cold room, a locked refrigerator and he wanted something to drink. When staff gave the resident mile and juice, he threw the juice at the nurse saying it was not the kind he wanted. The Progress Notes dated 10/27/18 at 1:22 a.m. documented Resident #2 was upset at 3:00 a.m. and the nurse called back to the unit. At 9:52 a.m., at 6:15 a.m. Resident #2 acted agitated due to wanting to smoke and the refrigerator being locked. The entry recorded Resident # 2 threatened staff with foul language, took items off	F 600		

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F 600	Continued From page 4 the med cart, shook the drawers to try to open them, tried to go in others' rooms and the office, then got more agitated when told he couldn't go out to smoke because no staff were available to go with him. The Progress Notes dated 10/28/18 at 3:46 a.m. documented Resident #2 became agitated due to the lack of a lighter, cursed, stated someone stole his lighter and threatened assault. The nurse attempted to redirect the resident 3 times and he continued to make comments regarding the lighter. Staff assisted the resident to smoke and he demanded staff return his lighters or he would leave after breaking a window. He then picked up a chair and headed towards the window. Staff removed residents and Resident #2 put the chair down then rammed his shoulder against the outside door. Staff then called the police and Resident #2 transferred to the ER (Emergency Room). Resident #2 said he would rather be on the streets. ER called the facility, stated Resident #2 was alert and oriented in the ER, without signs/symptoms of violence, and they needed to send Resident #2 back as he was a frequent flyer with too many visits too count and this was the best they had ever seen him. The Progress Notes dated 11/2/18 at 2:28 p.m. documented Resident #2 acted agitated after being assisted with smoke breaks at 6:10 a.m., 7:30 a.m., 10:00 a.m., 11:45 a.m., and 12:30 p.m. Resident # 2 displayed agitation after the nurse did not go out right that minute for a cigarette and demanded the supervisor be called. While waiting Resident # 2 kicked the doors so staff paged for help and took the resident out to smoke. The Progress Notes dated 11/2/18 at 4:46 p.m.	F 600		

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documented a Plan of Care Note and documented staff reported Resident # 2 had verbal behaviors and would curse/yell at staff when agitated/upset. Staff reported physical behaviors. Resident #2 would threaten staff, threw juice at the nurse, threatened to break a window with a chair, rammed his shoulder into a door of the nurses' station, kicked a door, took items off nurses cart, and shook drawers on the nurses cart to try to open them. Resident # 2 got easily agitated and upset related to the refrigerator in the CCDI unit being locked with increased behaviors when he didn't have cigarettes or couldn't go out to smoke whenever he wanted. The entry recorded Resident # 2 wandered on occasion, paced, and would go into other residents' rooms.

The Progress Notes dated 11/15/18 at 2:28 p.m. documented the resident kicked the CCDI unit door open while waiting for staff to get him cereal and broke all the cupboard locks in the dining area by pulling the doors apart until they broke.

The Progress Notes dated 11/15/18 at 10:36 p.m. documented Resident #2 was found in a female resident's room with his head towards her groin area. Staff removed the resident from the area, and called to the DON (Director of Nursing) to ask if they needed to report the event. At 10:57 p.m. staff placed the resident on 15 minute observation checks and then found the resident back in the female resident's room, sitting on the end of her bed.

The Progress Notes dated 11/16/18 at 10:51 a.m. documented Resident #2 wanted a razor and then kicked open the locked supply door when staff did not respond to his request fast enough.

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At 11:30 a.m. staff informed his physician of Resident # 2's behaviors which involved staff members, other residents, as well as damage of property. Staff received an order received to send the resident to the ER due to a high risk of injury to himself and others. At 12:30 p.m. Resident transferred to ER and at 4:50 p.m. he returned to the facility.

The Progress Notes dated 12/3/18 at 3:24 p.m. documented Resident #2 approached another male resident to request salt and pepper and when that resident did not understand, Resident #2 became verbally aggressive and grabbed the salt/pepper from that resident. Resident #2 said told that resident to not act stupid. At 5:57 p.m. Resident #2 refused medication, stating he felt like a prisoner and after being served a plain hamburger. Resident #2 threatened to go to his room to get his boots in order to kick in the door and he told staff he could smoke anytime he wanted, he did not care what the nurse said. Staff responded they needed Resident #2 to wait a bit because they did not have a second person in the unit at the time to take him out.

The Progress Notes dated 12/5/18 at 6:32 a.m. documented Resident #2 as awake and pacing since 4:00 a.m. waiting for a cigarette with no staff available to take him out to smoke.

The Progress Notes dated 12/7/18 at 3:01 p.m. documented the CCDI unit nurse paged to the unit and the ADON (Assistant DON) found another resident lying on the floor with spilled coffee around him and a skin tear. Resident # 2 made contact with the other resident, resulting in a fall. Resident # 2 said he wanted in to the other room to make a phone call and the other resident

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stood in the doorway so he asked him to move but he didn't move. Resident # 2 said he didn't push him, he moved him, and would never push another man. The entry documented Resident # 2 placed on 15 minute checks. At 3:06 p.m., another nurse documented Resident # 2 had approached the nurses station, shoved another resident at the doorway at the same time he told that resident to get out of his way as he wanted to call his sister.

The Progress Notes dated 12/7/18 at 11:06 p.m. documented Resident # 2 with 1 episode of questionable behavior when he yelled at another resident about the TV remote.

The Progress Notes dated 12/11/18 at 5:47 p.m. documented Resident # 2 left the dining room stating he wanted the boss called to get some decent food. When staff informed him the boss had gone for the day, Resident # 2 said he would kick the door in and pack his stuff up to go back to the streets. Staff called the Administrator at home and instructed kitchen staff to cook what Resident # 2 agreed to. Resident # 2 responded that he didn't want that, yelled, appeared threatening in his approach in the dining room and upsetting other residents, so staff asked Resident # 2 to leave the room with the writer, which he did.

The late entry Progress Notes dated 12/14/18 at 8:10 a.m., created by the MDS Coordinator, documented upon the MDS Coordinator's arrival to the facility at 5:00 p.m. Resident # 2 was found standing in front of the TV in the West dining area of the facility yelling about the food being the same for 4 days. The MDS Coordinator approached the aide standing next to Resident #

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2 to ask why he was out of the unit to which the CNA responded to ask his nurse. The charge nurse in the CCDI unit attempted to call the on-call staff. The MDS Coordinator walked the resident back to the CCDI unit and Resident # 2 stated he would pack his bags to get out of the place. The MDS Coordinator went back to the Assisted Living (AL) side of the facility and 20 minutes later, staff called to inform her Resident # 2 refused his medications and wanted to smoke; she instructed them to take the resident to smoke. Twenty minutes after that, staff reported Resident # 2 kicked open the CCDI door again and headed out the front door with a CNA following behind. Staff called the police to assist in redirecting Resident # 2 back to the facility and into the CCDI unit.

The Progress Notes dated 12/14/18 at 1:27 p.m. recorded Resident # 2 with increased agitation when another resident wore his socks and with increased anxiety when another resident wandered into his bathroom. At 5:31 p.m. Resident # 2 went to the dining area and wanted some 'real food'. Resident # 2 cursed and walked straight to the CCDI unit door, kicked it open and stated staff couldn't keep him there, he was leaving. Resident #2 went and told the kitchen staff they had served that food for 4 days but he refused any substitutes. Management staff walked him back to the unit where he packed his belongings. At 9:53 p.m. the notes documented that at 6:05 p.m. Resident # 2 knocked open the CCDI unit door again and a CNA escorted him to the main entrance of the building and called police.

The Progress Notes dated 12/16/18 at 5:30 a.m. documented Resident # 2 yelled at another

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resident who watched TV in the activity room. Resident #2 complained that resident didn't know what he was doing and needed to stop messing with the TV. Resident # 2's behaviors came out of nowhere; he scolded a wandering resident and had unpredictable behavior, hard to redirect. At 9:17 p.m. Resident # 2 told the night nurse he would kick the door in that night so she would have paperwork. The entry recorded Resident #2 then calmed to take his medications but escalated within a few seconds to yell at a resident watching TV. The felt anxious and afraid of Resident # 2's unpredictability and potential for violence, so she called the DON to report and the DON reshuffled staff to ensure the nurse was not alone with Resident # 2 after 8:30 p.m.

The Progress Notes dated 12/19/18 at 7:19 a.m. documented Resident # 2 wanted to smoke at 6:30 but staff informed him they had no lighter as the resident had it in his room from another staff member. The resident laughed at staff and denied having the lighter but when he realized he couldn't go to smoke he obtained the lighter from his room.

The Progress Notes dated 12/21/18 at 8:53 p.m. documented Resident # 2 ran out of his room into the commons area and yelled at 2 residents in the TV room; the nurse noted Resident # 2's behavior as very unpredictable. At 9:23 p.m. Resident # 2 again yelled at 2 residents watching TV telling them they should be in bed and stop messing with the TV.

The Progress Notes dated 12/22/18 at 9:26 p.m. documented Resident # 2 screamed at another resident who accidentally entered his room then he wanted to go smoke. When staff couldn't go

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right away, Resident # 2 became upset and screamed at the ladies sitting in the hallway and upon returning from a smoke break went to a room looking for 'that idiot'.

The Progress Notes dated 12/23/18 at 3:40 p.m. documented Resident # 2 walked in the hallway when another resident with an episode of increased agitation yelled inappropriate language to him at which time Resident # 2 called the resident a crazy b**** and staff redirected him away. At 7:47 p.m. Resident # 2 appeared cocky and strutted arrogantly in the hallway scaring female residents (#47 and #33), by saying 'Boo' in their faces and then yelled at another resident (#24) for messing with the TV.

The Progress Notes dated 12/26/18 at 9:59 p.m. documented Resident # 2 exhibited increased agitation toward another resident yelling and getting in the other resident's face to tell him to stay out of his room and to stop messing with the TV.

The Progress Notes dated 12/28/18 at 2:42 p.m. documented a late entry for 12/22/18. The entry recorded a CNA reported after breakfast Resident # 2 walked past another resident and smacked them on the bottom. The other resident swung at Resident # 2 and hit him in the left shoulder. Staff separated both residents immediately and noted no injuries.

The Progress Notes dated 12/29/18 at 2:50 a.m. documented Resident # 2 had 2 unpleasant interactions with Resident #24 about the TV. The entry recorded Resident # 2 as difficult to redirect.

The Progress Notes dated 12/30/18 at 4:14 a.m.

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documented Resident # 2 had 3 episodes of using abusive language towards Resident #24 early in the shift when Resident # 2 called Resident #24 names and told him to stop messing with the TV. The nurse intervened with limited success.

The Progress Notes dated 1/2/19 at 2:03 a.m. documented Resident # 2 called Resident #24 an idiot at snack time and said the resident would have a bowel movement (BM) all over the place.

The late entry Progress Notes dated 1/2/19 at 8:14 a.m. documented Resident # 2 refused his meds and wanted to smoke. Resident # 2 pushed past the nurse cursing and stating, he could do whatever he wanted at the facility, could smoke whenever he wanted and staff couldn't stop him or tell him what to do. Resident # 2 went into the nurses office, threw a side table down the hall and grabbed his cigarettes and lighter. Staff I, CNA, took him out to smoke. Resident # 2 refused to return the lighter and stated he didn't mind going back to jail because the food better and he hadn't eaten in 3 days, and that he could do what he wanted because the state paid for him to stay at the facility. The nurse contacted the Administrator who informed staff the resident was no longer allowed to light his own cigarettes and staff must maintain possession of the lighter and keep the nursing office door closed at all times.

The Progress Notes dated 1/4/19 at 10:45 p.m., created by the MDS Coordinator, documented at approximately 8:15 p.m. she spoke with another staff member on the phone while Resident # 2 stood 2.5 feet behind her asking to go smoke in a loud voice. The MDS Coordinator informed

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F 600	Continued From page 12 Resident # 2 she was the only staff member in the unit and no one could take him outside. Resident # 2 yelled he wanted to go f***ing smoke and they better get staff back here to take me. The MDS Coordinator locked the medication cart, went into the nurses station, and shut the door. The MDS Coordinator documented she was not going to cater to Resident # 2's temper tantrum. The MDS Coordinator documented Resident # 2 ripped the computer from the wall plug, threw it down the hallway, and cleared the medication cart of every single item on it. The MDS Coordinator called 911 then a code red for help and a nurse from the west side of the facility arrived within a few minutes to find Resident # 2 standing up against the railing and within 2 more minutes, the police arrived. The MDS Coordinator informed the Administrator and then police and EMS (Emergency Medical Services) who escorted the resident from the premises. The Progress Notes dated 2/19/19 at 2:05 p.m. documented Resident # 2 returned to the facility via a taxi service, he recognized staff and greeted them accordingly. At 3:25 p.m. the resident recognized all management staff and made jokes about the gang being back together and he already broke the rules. The Progress Notes dated 2/24/19 at 1:00 a.m. documented staff educated Resident # 2 after he jumped around in hallway in front of others yelling, Hi-Ya, and kicking his leg and waving his arms. Resident # 2 said he was just showing them his karate moves and repeated his actions in front of the nurse. They educated Resident # 2 on inappropriate behavior. At 12:57 p.m. Resident # 2 continued 15 with minute checks and he had been very demanding that day.	F 600		

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F 600	Continued From page 13 Resident # 2 waved a paper in a female resident's face and antagonizing her. When staff attempted to redirect him, Resident # 2 was slow to respond and stared at that person in a defiant manner. The Progress Notes dated 2/25/19 at 6:49 p.m., created by Staff G, LPN (Licensed Practical Nurse) documented she received report Resident # 2 sought out staff to take him to smoke and was agitated he couldn't go; he had a smoking schedule to follow. Staff G documented Resident # 2 was in the TV lounge, smacked a resident in the left temple of face, then went down CCDI hallway, smacked another resident on the buttocks and then ducked aside in another residents room. The nurse immediately notified the management team of the behavior/incidents, police arrived at 1:15 p.m. and Resident #2 transferred to the hospital. Observation on 2/25/19 at 11:57 a.m. revealed Resident # 2 requested Staff K, Certified Nurse Aide (CNA) to take him out to smoke then shower. Staff K informed Resident # 2 the next smoke break would be at 1:00 p.m., asked him to shower and have lunch and then it would be almost time for his smoke break. Resident # 2 demanded Staff K call the director to report he couldn't go out to smoke. Staff K informed the resident she would call but had something to do right that moment. Resident # 2 became angry and stated he was going out to smoke and Staff K better call the director right then. Staff K responded she would call but the director in a meeting at that time and would just tell him the same thing. Observation on 2/25/19 at 12:04 p.m. revealed	F 600		

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F 600	Continued From page 14 Staff C, Certified Medication Aide (CMA) took 3 other residents out the CCDI unit doors to the East hallway. Resident # 2 stood at the medication cart by the door and got in line behind the others to leave. Staff K blocked the entrance when Resident # 2 attempted to walk through with the others. Staff K held onto both doors as Resident # 2 pushed against her. Staff K continued to hold the doors and Resident # 2 increased his agitation. The Admissions Coordinator intervened at the door and told Staff K to let Resident #2 through and then walked with Resident # 2 hand in hand to the front offices. The DON and the Admissions Coordinator walked with the resident back to the CCDI unit. The DON was able to keep the resident calm and approached him gently; joking lightly with the resident. Resident # 2 allowed the DON to tie his shoes once on the unit and discussed smoking times. Resident # 2 interacted well with the DON. Resident #2 agreed to the 1:00 p.m. smoke time and shower and the DON encouraged him to take off his coat. As Resident # 2 took off his coat, he repeated shower-smoke, shower-smoke, then Resident # 2 said he wanted to smoke now. The DON had to continue to interact with the resident to redirect him away from the topic of smoking. The Admissions Coordinator accompanied the DON and Resident # 2 back to his room with encouragement to lay down for a while. Observation on 2/25/19 at 12:45 p.m. revealed Resident #2 walked up the hallway from the TV room by the nurse's station passing Resident #47. A loud slap could be heard and Resident #47 yelled "Ouch; I'm tired of you hitting me". Resident #2 made eye contact with surveyor and quickly walked into room 20. Resident #47	F 600		

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turned and walked back down to the TV room. Another resident (#36) walked up the hall to the nurses station from the TV room at the same time and informed Staff K that Resident #2 just slapped him. The surveyor reported the slap on Resident #47's buttocks immediately to Staff J, CNA, and Staff K. Staff J called for management help in the unit immediately.

Staff Interviews revealed the following information:

On 2/25/19 at 11:53 a.m., the Activities Assistant stated Resident #2's current condition was about the same as before he left the unit to the hospital. The Activities Assistant confirmed the resident lived in the facility since approximately October of 2018. The Activities Assistant commented that residents seemed intimidated by Resident # 2.

On 2/25/19 at 11:59 a.m., Staff K stated she did not know the resident's previous level of functioning as she was new to the facility and only worked her third orientation day. Staff K was not working on her own yet.

On 2/25/19 at 2:11 p.m., the Administrator and the owner reported a police officer was in the building and would be escorting Resident # 2 to the hospital as they were actively initiating an involuntary discharge related to resident safety. The Administrator and owner reported they were forced by the Administrative Law Judge (ALJ) to take the resident back from the hospital 2/19/19. They stated the ALJ informed them they provided the wrong language in the Emergency Involuntary Discharge notice they gave upon discharge in January (1/4/19). They didn't want to take the resident back but they had to follow the judge's

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F 600	Continued From page 16 order. In an interview on 2/25/19 at 2:55 p.m., Staff G, LPN, stated she assessed Resident #47 and she did not have any marks (on 2/25/19). Staff G responded Resident # 47 recalled what happened and stated she felt scared of Resident #2. Staff G didn't think Resident #2 had been gone long enough for the residents to get him out of their heads (when he left 1/4/19). Staff G said Resident #47 stated she always walked on the far side of the hall because she had to look out for Resident #2. At 3:25 p.m., Staff G stated she thought Resident # 2's behaviors for that day were set off by his desire to go out and smoke. Staff G stated she was a rule follower and told Resident # 2 he had to wait until the scheduled smoke time of 1:00 p.m. to go out. When the resident first came to the facility he was more aware of the exits and of the other residents' disabilities which frustrated him. Staff G felt Resident # 2 did not understand mentally why the other residents were confused due to their cognitive declines. Staff G gave the example when a resident would be exit seeking, Resident # 2 informed the exit seeker there was a back door and he would take them to the door to try to help them out. On 2/26/19 at 7:46 a.m., Staff G reported the residents were much calmer than the day before. Their anxiety level were way down since Resident #2 left the night before versus when Resident #2 resided on the unit. Staff G thought the residents were aware Resident #2 had gone and thought they had been hesitant to even sit next to Resident #2 for fear he would bully them. On 2/26/19 at 8:00 a.m., Staff L, CNA, stated she had worked for the facility for 3 years. The	F 600		

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F 600	Continued From page 17 residents acted more calm that day and she felt they knew when Resident # 2 was on and off the unit. Staff L stated Resident #33 acted scared of Resident # 2; she felt Resident # 2 knew it and focused in on Resident #33's fear. Resident #2 always had behaviors since his admission in October 2018. Staff tried to redirect Resident # 2 to the TV room or to play checkers but activities did not divert Resident # 2. Resident # 2 would get into the residents' personal spaces, especially Resident #33. Resident # 2 would get into Resident #33's face, wave his arms around, and when Resident #33 tried to walk away with staff, Resident # 2 followed them and continued to antagonize the residents. Staff L thought Resident # 2 knew what he was doing when he intimidated the other residents and it was possible the resident did things to other residents that staff were unaware of when they weren't looking due to being a full watch hall. Staff L explained a full watch hall meant they were constantly going up and down the halls to observe everything going on, so if they went down the hall one way and Resident # 2 went the other way, it would be possible for Resident # 2 to have interactions with other residents without her being aware of it. On 2/26/19 at 2:25 p.m., the DON discussed her summary of what the facility did to increase supervision of Resident #2 after signs of aggression and resident-to-resident altercations occurred. The DON said for the incident of resident-to-resident contact between Resident # 2 and Resident # 55 that occurred on 12/7/18, they increased to 15 minute checks, the doctor evaluated Resident # 2 on 12/13/19 and changed medications. The DON stated for the incident of resident-to-resident contact between Resident # 2	F 600		

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and Resident # 47 that occurred on 12/22/18, they did not become aware of the incident until 12/28/18. The DON said at that time they notified the DIA (Department of Inspections and Appeals), disciplined a charge nurse for not reporting immediately and placed Resident #2 on 15 minute checks; when 15 minute observation checks were initiated, they conducted them for 72 hours, but if the behaviors continued they would put a resident back on the checks. The DON had Resident #2 sign a contract agreement to acknowledge the expectation that all residents keep their hands to themselves, residents cannot pinch, slap, grab, or make contact with another resident in any other manner, it was not a joke, it was not funny, and it was not allowed. The DON confirmed the resident a BIMS score of 3 but they still presented the contract as they felt he was aware of his actions. When the facility accepted Resident # 2 back the second time 2/19/19, they did not get any information about him needing to be held down in the hospital for injections or that he had been moved units due to some sexual interactions. The DON stated they did not receive that information until approximately 2 days after the resident returned to the facility. The DON stated when Administrative Law Judge (ALJ) ruled they must take Resident # 2 back on 2/19/19, they decided to place him on 15 minute checks indefinitely. The DON reported the facility called the police who witnessed the resident's sister receiving notification of an Emergency Involuntary Discharge notice and then the police officer escorted the ambulance to the hospital to deliver the paperwork to the hospital 2/25/19.

In an interview on 2/27/19 at 11:00 a.m., Staff N, CNA/Scheduler stated she knew of 2 residents on the unit who showed they were bothered by

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F 600	Continued From page 19 Resident # 2: Resident #47 and Resident #33. Staff N stated she had not received a directive to staff 2 staff members on the CCDI unit until Resident # 2 returned to the facility on 2/19/19. In an interview on 2/27/19 at 11:30 a.m., Staff E, LPN, stated she worked for the facility for 5 years but did not work back on the unit often. At the time of the interview, Staff E worked as the charge nurse on the CCDI unit. Staff E had only worked with Resident # 2 one time but she had heard staff report every day that Resident # 2 tried to intimidate staff and residents with weird noises, kicking doors, and hitting people. Staff E responded they usually just staffed 2 people on the CCDI unit even when a resident exhibited behaviors. In an interview on 2/27/19 at 11:40 a.m., Staff J, CNA, responded she did not work back on the CCDI unit often. Staff J acknowledged she was familiar with Resident # 2 and the resident always had behaviors. 2. The MDS assessment dated 11/9/18 for Resident #47 identified BIMS score of 3 without signs/symptoms of delirium. The MDS documented the resident exhibited no behavioral symptoms during the 7-day look back period. The Resident #47 transferred and walked in her room independently and required supervision while walking in the corridor and with locomotion on her living unit. The MDS documented diagnoses that included Alzheimer's disease, Non-Alzheimer's dementia, depression, and schizoaffective disorder. Incident # 1: The Progress Notes dated 11/15/18 at 10:30	F 600		

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F 600	Continued From page 20 p.m., written by Staff H, Licensed Practical Nurse (LPN), documented an incident at 10:20 p.m. another resident was not seated in the TV room and not found in their own room. Staff searched for the resident (#2) and found him in Resident #47's room, sitting at the end of her bed and leaning over towards her groin area. Staff reported Resident #47 did not have any blankets on her, but was clothed as when put to bed. Staff removed the other resident from Resident #47's room and Staff H contacted the DON to report the incident. Staff H put both residents on 15 minutes checks and the DON planned to call the Administrator and call Staff H back. At 10:50 p.m. Staff H received a call from the DON who instructed her to monitor both residents and talk with Resident #47 to see if the other resident had touched her inappropriately and then call the DON back if the resident stated she was touched inappropriately. At10:55 p.m. as soon as the call ended with the DON, staff called from the CCDI unit to report to Staff H the other resident had entered Resident #47's room a second time when staff went into another resident's room to provide assistance. Staff called the DON who instructed they put a second staff member in the CCDI unit and continue 15 minute checks on both residents. Staff H and another staff member asked Resident #47 if she had been touched inappropriately or if she remembered another resident entering her room twice; Resident #47 said she knew the other resident came in twice, she told him to get out of there, and he did not touch her inappropriately but did rub her arms to wake her up. The entry documented staff visually assessed Resident #47 visually assessed and no injuries or issues noted. The Progress Notes dated 11/15/18 at 11:00 p.m.	F 600		

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F 600	Continued From page 21 documented 2 staff members in the CCDI unit and monitoring residents and 15 minute checks would continue on Resident #47 and the other resident for safety precautions. On 2/28/19 at 12:50 p.m., the Administrator provided a summary of the resident-to-resident interaction that occurred on 11/15/18 between Resident #2 and Resident #47. The Administrator confirmed the facility did not conduct or document any staff interviews or formal investigation of the incident. The Administrator confirmed the term 'other resident' in Resident #47's progress notes dated 11/15/18 referred to Resident #2. They concluded that no inappropriate contact had been made between the residents based on a verbal, informal, undocumented investigation with staff members. The undated, unsigned facility investigation titled, Investigation of Incident on 11/15/18 regarding Resident #2 and Resident #47 documented the following: On 11/15/18 at approximately 10:20 p.m., Resident #2 and Resident #47 seen sitting at the end of Resident #47's bed. It was reported that Resident #2's head was in the direction of Resident #47's groin area. Staff H reported the observation to the DON at 10:30 p.m. and the DON reported the observation to the Administrator. Both residents were fully clothed and Resident #2 seen in the TV room at approximately 10:10 p.m. according to staff. Resident #47 denied Resident #2 touched her inappropriately or in a sexual manner. Resident #47 stated Resident #2 just rubbed her arms to wake her up. Both residents placed on 15 minute checks and an additional staff member brought to the CCDI unit for supervision. It was determined	F 600		

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F 600	Continued From page 22 that no inappropriate or sexual touching occurred. On 3/4/19 at 9:00 a.m., Staff H stated she had worked for the facility approximately a year before quitting in 11/18. Staff H recalled working the night of 11/15/18 and assigned to the East hall with also covering the CCDI unit if they needed help. Staff H reported the unit only staffed with a med aide or CNA usually. Staff H stated Staff M, CNA, reported to her Resident #2 was found in Resident #47's room in a compromising position; Staff M reported Resident #47 laid in bed dressed with her legs spread open, Resident #2 sat on the end of the bed leaning down towards Resident #47's groin but not touching. Staff H said she called the DON immediately to report and she quit partly due to not feeling management responded appropriately. Staff H felt management did not take the report seriously as she felt it should be reported to the state within 2 hours. Staff H felt they needed extra staff in the unit due to Resident #2's unpredictable and violent behaviors. Staff H reported to the management they needed more staff and their response would be they would put 2 staff members on the unit, but they never followed through with 2 staff members on the unit. When Staff H worked in the unit she felt very nervous and scared of Resident #2. Staff H stated she did not feel educated on how to deal with Resident #2's violent behaviors and did not feel his placement appropriate in the dementia unit. Staff H knew of another incident where the staff had to yell at all other residents to get back to their rooms and out of the hallway while Resident #2 threw chairs; she feared for the safety of the residents. Staff H wrote a statement about the incident that occurred 11/15/18 as did Staff M and they slid the statements under the DON's office	F 600		

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F 600	Continued From page 23 door that night. Staff H said after that, she never heard back from management and no one asked her for an interview about the incident. On 3/4/19 at 9:20 a.m., the DON confirmed both Staff H and Staff M no longer worked for the facility. The DON acknowledged both Staff H and Staff M wrote witness statements from the night of 11/15/18 but she could not locate them. Incident # 2: The Progress Notes dated 12/22/18 at 8:10 p.m. and 11:22 p.m. documented Resident #47 received acetaminophen (Tylenol) for right arm pain, noted as effective on follow-up. The Progress Notes contained no other entries for the date of 12/22/18. The Progress Notes dated 12/28/18 at 2:35 p.m. documented a late entry created by Staff G, LPN. On 12/22/18 a CNA (Certified Nurse Aide) reported Resident #47 in the hallway after breakfast and another resident walked by smacking Resident #47 on the bottom, who in turn, swung at the other resident, hitting them in the left shoulder. Staff separated both residents, noted no injuries and completed skin assessments with no skin issues found. The Progress Notes dated 12/28/18 at 3:32 p.m. documented staff placed a call to Resident #47's guardian to inform them of the incident. The unsigned, typed facility investigation dated 12/28/18, titled Self-Report, documented: On 12/22/18 at approximately 10:00 a.m., Staff I, CNA observed Resident #2 swatted Resident #47 on the backside. Resident #47 slapped Resident #2 on the shoulder and told him not to touch her	F 600		

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ever again. Staff I immediately separated the residents. Resident #2 thought his actions were funny and Staff I educated Resident #2 that it was not funny and never appropriate to touch another resident. There was no injury to either resident in relation to this incident. Staff I immediately reported the incident to Staff G. Staff G reported she thought Resident #47 had a delusion and the incident did not really occur. Resident #2 had a BIMS score of 3, expressive aphasia (difficulty communicating) and difficulty responding to the questions on the BIMS. Resident #2 could address and ask for staff members by name and the BIMS score not a reliable method of determining Resident #2's cognitive status. Staff I reported the incident to the DON and the Administrator at approximately 3:00 p.m. on 12/27/18. The DPOA (Durable Power of Attorney) and physicians for both residents received notice of the incident. Resident #2 continued 15 minute checks and staff observed both residents to keep them separated. Both residents lived in the CCDI unit. Staff G received a written warning on 12/28/18 regarding the reporting of all resident-to-resident contact to the DON or Administrator so that an investigation could be carried out in a timely manner to avoid further incidents. Resident #2 received education that it was not permissible to ever place his hands on another resident. Both resident care plans were reviewed and updated to address this situation.

Staff I's witness statement, signed 12/28/18, documented on 12/22/18 after breakfast, she stood outside the dining room in the hallway. Resident #2 leaned up against the wall with his hands behind his back waiting to go smoke and talking to another resident. When Resident #47 walked by Resident #2, he smacked Resident

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F 600	Continued From page 25 #47's bottom open handed. Resident #47 turned around and smacked Resident #2 on the shoulder open handed and told him not to touch her again. Staff I went down the hall and told Resident #2 he could not do that, to which Resident #2 laughed and replied 'you seen, she hit me'. Staff I took Resident #47 to tell the charge nurse, Staff G. Staff I told Staff G everything that happened as did Resident #47. Incident #3: Observation on 2/25/19 at 12:45 p.m. revealed Resident #2 walked up the hallway from the TV room by the nurse's station passing Resident #47. A loud slap could be heard and Resident #47 yelled "Ouch, I'm tired of you hitting me". Resident #2 made eye contact with surveyor and quickly walked into room 20. Resident #47 turned and walked back down to the TV room. Another resident (#36) walked up the hall to the nurses station from the TV room at the same time and informed Staff K that Resident #2 just slapped him. The surveyor reported the slap on Resident #47's buttocks immediately to Staff J, CNA, and Staff K. Staff J called for management help in the unit immediately. On 2/25/19 at 3:07 p.m. an interview attempted with Resident #47. When asked if she recalled the incident from earlier that day, Resident # 47 said no one had touched her that day, then responded that he comes out of nowhere so she watches where she's going, then she changed topics. The Progress Notes dated 2/25/19 at 4:00 p.m., created by Staff G, recorded she received a report that Resident #47 walked in hallway of the CCDI unit when she yelled and said 'ouch, I'm	F 600		

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F 600	Continued From page 26 sick of you touching me' while a loud smack could be heard. Another resident walked up to Resident #47 and smacked her on the buttock. 3. The MDS assessment dated 11/21/18 for Resident #55 documented an admission date of 11/12/18. The resident had a BIMS score of 3 and signs of delirium with fluctuating behavior of disorganized thinking. Resident #55 had delusions and displayed physical and verbal behavioral symptoms directed toward others during 1 to 3 days and wandered 4 to 6 days during the 7-day look back period. Resident #55 transferred and walked independently in his room and required supervision while walking in the corridor and during locomotion on the unit. The MDS documented diagnoses that included Non-Alzheimer's dementia, schizophrenia, and unspecified altered mental status. Incident # 4: The Progress Notes dated 12/7/18 at 2:39 p.m., by Staff R, LPN documented as Resident #55 waited for Staff R to take him for a walk, another resident shoved him and he fell backward hitting his right elbow on the wall. Resident #55 sustained a 3 cm (centimeter) U-shaped skin tear to his right elbow. Resident #55 landed on his buttock and spilled his milk, his upper torso went back resting flat on the floor but did not hit his head. The Progress Notes dated 12/7/18 at 2:49 p.m. documented the CCDI nurse paged for assistance with the ADON responding to find Resident #55 on the floor, on his back with legs stretched out, empty coffee cup with spill around him. The entry recorded the resident as very calm, not upset, and stating he must have ran	F 600		

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F 600	Continued From page 27 into the wrong one, he guessed. Resident #55 could not voice details of what occurred, but the nurse witnessed another resident push Resident #55 from the doorway, and Resident #55 fell backwards to ground landing on his buttocks. Staff assessed Resident #55's skin tear to the right elbow and provided treatment of steri-strip in place. The undated, unsigned, typed facility investigation titled, Self Report Incident Date 12/7/18 documented that on 12/7/18 at 2:39 p.m. a situation occurred between Resident #55 and Resident #2. Resident #55 stood in front of the nurses station door in the CCDI unit waiting for the nurse to take him for a walk. Resident #2 approached the nurses station door and shoved Resident #55 telling him to get out of his way. Resident #55 lost his balance, fell to the floor, and sustained a 3 cm skin tear to his right elbow. 4. The admission MDS assessment dated 1/16/19 for Resident #36 identified a BIMS score of 4 without signs/symptoms of delirium, indicating severe cognitive impairment. Resident #36 exhibited wandering behavior during 1 to 3 days of the 7-day look back period. The resident transferred and walked in his room independently and required supervision while walking in the corridor and during locomotion on his unit. The MDS documented diagnoses that included non-Alzheimer's dementia and unspecified dementia without behavioral disturbance. Incident 5: Observation on 2/25/19 at 12:45 p.m. revealed Resident # 2 walked up the hallway from the TV room by the nurses station and quickly into room	F 600		

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F 600	Continued From page 28 20 after hitting Resident #47. Resident #36 walked up the hall to the nurses station from the TV room at the same time and reported to Staff K that Resident #2 just slapped him. Staff J, CNA, and Staff K called for management help to the unit immediately. The Progress Notes created 2/25/19 at 6:06 p.m. by Staff G, LPN, documented the nurse notified at 12:40 p.m. Resident #36 reported sitting in TV lounge on couch when another resident come up to him and hit him in the left side of the face Resident #36 stated he didn't do anything and had never seen the other resident before. Initial assessment revealed Resident #36 had a red mark on the left temple and the area faded and was no longer present at the time she wrote the entry: 6:06 p.m. 5. The MDS assessment dated 1/11/19 for Resident #33 identified a BIMS score of 6 without signs/symptoms of delirium, indicating severe cognitive impairment. The resident exhibited wandering behavior during 1 to 3 days of the assessment reference period. The resident was independent with transfers and required supervision while walking in her room, in the corridor, and during locomotion on the unit. In an interview on 2/26/19 at 8:00 a.m., Staff L, CNA, stated Resident #33 was scared of Resident # 2 and she felt Resident # 2 knew it and focused in on Resident #33's fear. Resident # 2 would get into the residents' personal spaces, especially Resident #33. Resident # 2 would get into Resident #33's face, wave his arms around, and when Resident #33 tried to walk away with staff, Resident # 2 followed them and continued to antagonize the residents.	F 600		

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F 600	Continued From page 29 In an interview on 2/26/19 at 2:25 p.m., the DON confirmed Resident # 2 antagonized Resident # 33. In an interview on 2/27/19 at 11:00 a.m., Staff N, CNA/Scheduler, responded she knew of 2 residents on the unit who showed they were bothered by Resident # 2; Resident #47 and Resident #33. Staff N stated she had not been given a directive to staff 2 staff members on the CCDI unit until Resident # 2 returned to the facility on 2/19/19. The facility policy titled Abuse Prevention, Identification, Investigation, and Reporting revised 9/9/16 included the following documentation: Policy Statement - All residents have the right to be free from verbal, sexual, and mental abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Key Definitions - Point 5. Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Each resident has the right to be free from all types of abuse, including mental abuse. The above situations resulted in an Immediate Jeopardy (IJ) situation for facility residents from 12/7/18 until 2/27/19 when staff abated the IJ situation. The facility abated the IJ situation through system changes and education which included:	F 600		

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F 600	Continued From page 30 a. Immediate identification of resident aggressive behaviors and implementation of direct supervision. b. Continued direct supervision until aggressive resident(s) are no longer a threat to other residents. c. Continued observation and assessment of affected residents. d. Communication with the affected residents' primary care providers. e. Behavior resolution meetings by facility staff to develop interventions for future actions. f. All staff education of the actions listed above.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		

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F 609	Continued From page 31 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility record review, the facility failed to report two different allegations of abuse to the Iowa Department of Inspections & Appeals (DIA) within 24 hours for 2 of 6 residents reviewed for abuse (Resident #47 and #2). The facility reported a census of 67 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 11/9/18 for Resident #47 identified BIMS score of 3 without signs/symptoms of delirium. The MDS documented the resident exhibited no behavioral symptoms during the 7-day look back period. The Resident #47 transferred and walked in her room independently and required supervision while walking in the corridor and with locomotion on her living unit. The MDS documented diagnoses that included Alzheimer's disease, Non-Alzheimer's dementia, depression, and schizoaffective disorder. The care plan focus area dated 11/12/18 identified an ADL (Activities of Daily Living) self-care deficit related to diagnoses of dementia, schizoaffective disorder, depression, and debility. The care plan intervention revised 11/12/18 informed staff the resident transferred independently. The care plan focus area dated 11/12/18 identified the resident wandered and	F 609		

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F 609	Continued From page 32 resided on the CCDI (Chronic Confusion Dementing Illness) unit related to dementia. The care plan identified impaired cognitive function/impaired thought processes and the resident usually understood related to diagnosis of dementia. Incident 1: The Progress Notes dated 11/15/18 at 10:30 p.m., written by Staff H, Licensed Practical Nurse (LPN), documented an incident at 10:20 p.m. another resident was not seated in the TV room and not found in their own room. Staff searched for the resident (#2) and found him in Resident #47's room, sitting at the end of her bed and leaning over towards her groin area. Staff reported Resident #47 did not have any blankets on her, but was clothed as when put to bed. Staff removed the other resident from Resident #47's room and Staff H contacted the DON to report the incident. Staff H put both residents on 15 minutes checks and the DON planned to call the Administrator and call Staff H back. At 10:50 p.m. Staff H received a call from the DON who instructed her to monitor both residents and talk with Resident #47 to see if the other resident had touched her inappropriately and then call the DON back if the resident stated she was touched inappropriately. At 10:55 p.m. as soon as the call ended with the DON, staff called from the CCDI unit to report to Staff H the other resident had entered Resident #47's room a second time when staff went into another resident's room to provide assistance. Staff called the DON who instructed they put a second staff member in the CCDI unit and continue 15 minute checks on both residents. Staff H and another staff member asked Resident #47 if she had been touched inappropriately or if she remembered another resident entering her	F 609		

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room twice; Resident #47 said she knew the other resident came in twice, she told him to get out of there, and he did not touch her inappropriately but did rub her arms to wake her up. The entry documented staff visually assessed Resident #47 visually assessed and no injuries or issues noted.

The Progress Notes dated 11/15/18 at 11:00 p.m. documented 2 staff members in the CCDI unit and monitoring; 15 minute checks would continue on Resident #47 and the other resident for safety precautions.

In an interview on 2/28/19 at 12:50 p.m., the Administrator provided a summary of the resident-to-resident interaction that occurred on 11/15/18 between Resident #2 and Resident #47. The Administrator confirmed the facility did not conduct or document any staff interviews or formal investigation of the incident. The Administrator confirmed the other resident involved was Resident #2. The Administrator stated they concluded no inappropriate contact had been made between the residents based on a verbal, informal, undocumented investigation with staff members.

The undated, unsigned facility investigation titled, Investigation of Incident on 11/15/18 regarding Resident #2 and Resident #47 documented the following:
On 11/15/18 at approximately 10:20 p.m., Resident #2 and Resident #47 seen sitting at the end of Resident #47's bed. It was reported that Resident #2's head was in the direction of Resident #47's groin area. Staff H reported the observation to the DON at 10:30 p.m. and the DON reported the observation to the

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Administrator. Both residents were fully clothed and Resident #2 seen in the TV room at approximately 10:10 p.m. according to staff. Resident #47 denied Resident #2 touched her inappropriately or in a sexual manner. Resident #47 stated Resident #2 just rubbed her arms to wake her up. Both residents placed on 15 minute checks and an additional staff member brought to the CCDI unit for supervision. It was determined that no inappropriate or sexual touching occurred.

In an interview on 3/4/19 at 9:00 a.m., Staff H stated she had worked for the facility approximately a year before quitting in November 2018. Staff H recalled working the night of 11/15/18 and assigned to the East hall with also covering the CCDI unit if they needed help. Staff H reported the unit only staffed with a med aide or CNA (Certified Nurse Aide) usually. Staff H stated Staff M, CNA, reported to her Resident #2 was found in Resident #47's room in a compromising position. Staff M reported Resident #47 laid in bed dressed with her legs spread open, Resident #2 sat on the end of the bed leaning down towards Resident #47's groin but not touching her. Staff H said she called the DON immediately to report and part of the reason she quit due to not feeling management responded appropriately. Staff H stated she felt management did not take the report seriously as she felt it should be reported to the state within 2 hours. Staff H wrote a statement about the incident that occurred 11/15/18 as did Staff M and they slid the statements under the DON's office door that night. Staff H said after that, she never heard back from management and no one asked her for an interview about the incident.

In an interview on 3/4/19 at 9:20 a.m., the DON

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F 609	Continued From page 35 confirmed both Staff H and Staff M no longer worked for the facility. The DON acknowledged both Staff H and Staff M wrote witness statements from the night of 11/15/18 but she could not locate them. The facility failed to report the allegation of abuse to the Iowa DIA within 24 hours of receiving the report. Incident 2: The Progress Notes dated 12/22/18 at 8:10 p.m. and 11:22 p.m. documented the resident received acetaminophen (Tylenol) for right arm pain and noted as effective on follow-up. The Progress Notes contained no other entries for the date of 12/22/18. The Progress Notes dated 12/28/18 at 2:35 p.m. documented a late entry created by Staff G, LPN. On 12/22/18 a CNA (Certified Nurse Aide) reported Resident #47 in the hallway after breakfast and another resident walked by smacking Resident #47 on the bottom, who in turn, swung at the other resident, hitting them in the left shoulder. Staff separated both residents, noted no injuries and completed skin assessments with no skin issues found. The Progress Notes dated 12/28/18 at 3:32 p.m. documented staff placed a call to Resident #47's guardian to inform them of the incident. The unsigned, typed facility investigation dated 12/28/18, titled Self-Report, documented: On 12/22/18 at approximately 10:00 a.m., Staff I, CNA observed Resident #2 swatted Resident #47 on the backside. Resident #47 slapped Resident #2 on the shoulder and told him not to touch her	F 609		

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ever again. Staff I immediately separated the residents. Resident #2 thought his actions were funny and Staff I educated Resident #2 that it was not funny and never appropriate to touch another resident. There was no injury to either resident in relation to this incident. Staff I immediately reported the incident to Staff G. Staff G reported she thought Resident #47 had a delusion and the incident did not really occur. Resident #2 had a BIMS score of 3, expressive aphasia (difficulty communicating) and difficulty responding to the questions on the BIMS. Resident #2 could address and ask for staff members by name and the BIMS score not a reliable method of determining Resident #2's cognitive status. Staff I reported the incident to the DON and the Administrator at approximately 3:00 p.m. on 12/27/18. The DPOA (Durable Power of Attorney) and physicians for both residents received notice of the incident. Resident #2 continued 15 minute checks and staff observed both residents to keep them separated. Both residents lived in the CCDI unit. Staff G received a written warning on 12/28/18 regarding the reporting of all resident-to-resident contact to the DON or Administrator so that an investigation could be carried out in a timely manner to avoid further incidents. Resident #2 received education that it was not permissible to ever place his hands on another resident. Both resident care plans were reviewed and updated to address this situation.

Staff I's witness statement, signed 12/28/18, documented on 12/22/18 after breakfast, she stood outside the dining room in the hallway. Resident #2 leaned up against the wall with his hands behind his back waiting to go smoke and talking to another resident. When Resident #47 walked by Resident #2, he smacked Resident

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 37 #47's bottom open handed. Resident #47 turned around and smacked Resident #2 on the shoulder open handed and told him not to touch her again. Staff I went down the hall and told Resident #2 he could not do that, to which Resident #2 laughed and replied 'you seen, she hit me'. Staff I took Resident #47 to tell the charge nurse, Staff G. Staff I told Staff G everything that happened as did Resident #47. The DON typed the following 12/28/18 as education to staff: All resident to resident contact reported to you as a nurse must be reported to a member of management immediately. If you do not witness the resident to resident contact, it still must be immediately reported to a member of management. An incident report must be completed on both residents involved as well as a head to toe assessment. Documentation must be very thorough in the nurse's notes. If you have questions regarding resident to resident contact, please see the ADON (Assistant Director of Nursing), Administrator, or the DON. By signing this you are acknowledging the above information. The Employee Warning & Discharge Notice dated 12/28/18 documented discipline presented to Staff G for failure to report a resident to resident contact on 12/22/18. The facility failed to report the allegation of abuse to the Iowa DIA within 24 hours of receiving the report. 2. The admission MDS assessment dated 11/2/18 for Resident #2 documented an admit date of 10/22/18. The MDS identified a BIMS	F 609		

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	165255	A. BUILDING _____ B. WING _____	03/07/2019

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F 609	Continued From page 38 score of 3 with sign/symptom of delirium with fluctuating presence of inattention; a score of 3 indicated severe memory and cognitive impairment. The MDS documented the resident exhibited physical and verbal behavioral symptoms directed toward others and wandering on 1 to 3 days of the 7-day look back period. The MDS recorded the resident's behaviors impacted others putting others at significant risk for physical injury and significantly disrupted care or the living environment. The MDS recorded he was independent with transfers, walking in the room and corridor, and locomotion on the unit. The MDS documented diagnoses that included Non-Alzheimer's dementia, depression, delirium due to known physiological condition, unspecified/uncomplicated nicotine dependence, other uncomplicated psychoactive substance abuse, and metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood). The care plan focus area dated 11/1/18 identified Resident #2 as independent with ADLs (activities of daily living) and transferred independently. The care plan focus area dated 11/5/18 identified an elopement risk/wanderer with behaviors of exit seeking, kicking exit doors, pacing, and going into other residents' rooms related to increased agitation when he did not have cigarettes and could not go out to smoke when he wanted. The care plan informed staff the resident resided on the CCDI (or dementia) unit. The care plan focus area dated 11/5/18 identified a behavior deficit related to physical and verbal behaviors towards others, hitting other residents, shoving another resident; increased agitation when out of cigarettes or couldn't go out to smoke when he wanted or get into the fridge when he wanted and	F 609		

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F 609	Continued From page 39 throwing items off nurses cart and throwing nurses tablet breaking it. The care plan informed staff the resident with a history of: yelling/cursing at others; getting upset because the fridge locked; threw juice at staff; took items off med cart, shook drawers on med cart and tried to open them; threatened staff; lifted up a chair and threatened to break window; rammed his shoulder into nurses station door causing damage to facility property; kicked exit door and damaged facility property; and broke locks on cupboard doors in dining area. The care plan identified the resident diagnosed with vascular dementia, delusional disorder, depression, metabolic encephalopathy, and had a long history of substance abuse with nicotine dependence. An intervention dated 11/5/18 directed staff to intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention; and remove from situation and take to alternate location as needed. An intervention dated 11/7/18 directed staff to monitor behavior episodes and attempt to determine underlying cause; consider location, time of day, persons involved, and situations; and document behavior and potential causes. The care plan intervention dated 12/28/18 directed staff to educate the resident expectations of keeping his hands to himself and on successful coping, interaction strategies. The care plan instructed when Resident #2 became agitated, staff should attempt to intervene and redirect him before agitation escalated, guide him away from the source of distress, engage calmly in conversation and if he had an aggressive response, staff should walk calmly away and approach later. The care plan focus area dated 11/9/18 identified a mood deficit related to diagnosis of depression and placement in facility.	F 609		

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F 609	Continued From page 40 The care plan directed staff to monitor, record, report to physician as needed risk for harming others (increased anger, labile mood or agitation), if he feels threatened by others or thoughts of harming someone and possession of weapons or objects that could be used as weapons. Incident 1: The Progress Notes dated 11/15/18 at 10:36 p.m. documented he was found in a female resident's room, his head towards her groin area. Staff removed the resident from the area, and called to the DON to ask if the event was reportable. At 10:57 p.m. the entry documented staff placed the resident on 15 minute observation checks then later found the resident back in the room sitting on the end of the female's bed. The Progress Notes dated 11/16/18 at 10:51 a.m. documented Resident #2 wanted a razor and therefore he kicked open the locked supply door when staff did not respond to his request fast enough. At 11:30 a.m. the notes recorded staff informed the physician Resident # 2's behaviors involved staff members, other residents, as well as damage of property; an order received to send the resident to the ER due to high risk of injury to self and others. At 12:30 p.m. the notes documented the resident transferred to the ER and noted the resident returned to the facility at 4:50 p.m. Incident 2: The Progress Notes dated 12/22/18 at 9:26 p.m. documented Resident # 2 screamed at another resident who accidentally entered his room then he wanted to go smoke. The note recorded when staff could not go right away, Resident # 2 became upset and screamed at the ladies sitting	F 609		

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F 609	Continued From page 41 in the hallway and upon returning from a smoke break went to room looking for 'that idiot'. The Progress Notes contained no other entries for the date of 12/22/18 pertaining to resident to resident contact. The Progress Notes dated 12/28/18 at 2:42 p.m. documented a late entry for 12/22/18. The entry recorded a CAN reported after breakfast Resident # 2 walked past another resident and smacked them on the bottom. The entry documented the other resident swung at Resident # 2 and hit him in the left shoulder, both were separated immediately, and no injury noted. On 12/28/18, Resident #2 signed his own full name on an education session that documented the following: It is expected that all residents keep their hands to themselves. Residents cannot pinch, slap, grab, or make contact with another resident in any other manner. It is not a joke. It is not funny. It is not allowed. This includes you. On 2/26/19 at 2:25 p.m., the DON stated for the incident of resident-to-resident contact between Resident #2 and Resident #47 that occurred on 12/22/18, they did not become aware of the incident until 12/28/18. At that time they notified DIA, disciplined the charge nurse for not reporting immediately, and placed the resident on 15 minute checks. The facility policy titled Abuse Prevention, Identification, Investigation, and Reporting revised 9/9/16 included the following documentation: Reporting -	F 609		

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F 609	Continued From page 42 If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the Iowa Department of Inspections & Appeals immediately, and in no event later than 24 hours, of any allegation, even on a weekend or holiday.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interviews, family interview, and facility record review, the facility failed to conduct and document thorough investigations of alleged allegations of abuse and failed to ensure residents were protected from further abuse during the investigation for 4 of 6 residents	F 610		

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F 610	Continued From page 43 reviewed for abuse (Residents #47, #2, #60 and #36). The facility reported a census of 67 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 11/9/18 for Resident #47 identified BIMS score of 3 without signs/symptoms of delirium. The MDS documented the resident exhibited no behavioral symptoms during the 7-day look back period. The Resident #47 transferred and walked in her room independently and required supervision while walking in the corridor and with locomotion on her living unit. The MDS documented diagnoses that included Alzheimer's disease, Non-Alzheimer's dementia, depression, and schizoaffective disorder. Incident 1: The Progress Notes dated 11/15/18 at 10:30 p.m., written by Staff H, Licensed Practical Nurse (LPN), documented an incident at 10:20 p.m. another resident was not seated in the TV room and not found in their own room. Staff searched for the resident (#2) and found him in Resident #47's room, sitting at the end of her bed and leaning over towards her groin area. Staff reported Resident #47 did not have any blankets on her, but was clothed as when put to bed. Staff removed the other resident from Resident #47's room and Staff H contacted the DON to report the incident. Staff H put both residents on 15 minutes checks and the DON planned to call the Administrator and call Staff H back. At 10:50 p.m. Staff H received a call from the DON who instructed her to monitor both residents and talk with Resident #47 to see if the other resident had touched her inappropriately and then call the	F 610		

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F 610	Continued From page 44 DON back if the resident stated she was touched inappropriately. At 10:55 p.m. as soon as the call ended with the DON, staff called from the CCDI unit to report to Staff H the other resident had entered Resident #47's room a second time when staff went into another resident's room to provide assistance. Staff called the DON who instructed they put a second staff member in the CCDI unit and continue 15 minute checks on both residents. Staff H and another staff member asked Resident #47 if she had been touched inappropriately or if she remembered another resident entering her room twice; Resident #47 said she knew the other resident came in twice, she told him to get out of there, and he did not touch her inappropriately but did rub her arms to wake her up. The entry documented staff visually assessed Resident #47 visually assessed and no injuries or issues noted. The Progress Notes dated 11/15/18 at 11:00 p.m. documented 2 staff members in the CCDI unit and monitoring residents and 15 minute checks would continue on Resident #47 and the other resident for safety precautions. The clinical record lacked documentation of an incident report for the occurrence. On 2/28/19 at 12:50 p.m., the Administrator provided a summary of the resident-to-resident interaction that occurred on 11/15/18 between Resident #2 and Resident #47. The Administrator confirmed the facility did not conduct or document any staff interviews or formal investigation of the incident. The Administrator confirmed the term 'other resident' in Resident #47's progress notes dated 11/15/18	F 610		

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F 610	Continued From page 45 referred to Resident #2. They concluded that no inappropriate contact had been made between the residents based on a verbal, informal, undocumented investigation with staff members. The undated, unsigned facility investigation titled, Investigation of Incident on 11/15/18 regarding Resident #2 and Resident #47 documented the following: On 11/15/18 at approximately 10:20 p.m., Resident #2 and Resident #47 seen sitting at the end of Resident #47's bed. It was reported that Resident #2's head was in the direction of Resident #47's groin area. Staff H reported the observation to the DON at 10:30 p.m. and the DON reported the observation to the Administrator. Both residents were fully clothed and Resident #2 seen in the TV room at approximately 10:10 p.m. according to staff. Resident #47 denied Resident #2 touched her inappropriately or in a sexual manner. Resident #47 stated Resident #2 just rubbed her arms to wake her up. Both residents placed on 15 minute checks and an additional staff member brought to the CCDI unit for supervision. It was determined that no inappropriate or sexual touching occurred. In an interview on 3/4/19 at 8:50 a.m., the Administrator confirmed no incident report had been created for the contact made between Resident #47 and Resident #2 on 11/15/18. On 3/4/19 at 9:00 a.m., Staff H stated she had worked for the facility approximately a year before quitting in 11/18. Staff H recalled working the night of 11/15/18 and assigned to the East hall with also covering the CCDI unit if they needed help. Staff H reported the unit only staffed with a med aide or CNA usually. Staff H stated Staff M,	F 610		

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F 610	Continued From page 46 CNA, reported to her Resident #2 was found in Resident #47's room in a compromising position; Staff M reported Resident #47 laid in bed dressed with her legs spread open, Resident #2 sat on the end of the bed leaning down towards Resident #47's groin but not touching. Staff H said she called the DON immediately to report and she quit partly due to not feeling management responded appropriately. Staff H felt management did not take the report seriously as she felt it should be reported to the state within 2 hours. Staff H felt they needed extra staff in the unit due to Resident #2's unpredictable and violent behaviors. Staff H reported to the management they needed more staff and their response would be they would put 2 staff members on the unit, but they never followed through with 2 staff members on the unit. When Staff H worked in the unit she felt very nervous and scared of Resident #2. Staff H stated she did not feel educated on how to deal with Resident #2's violent behaviors and did not feel his placement appropriate in the dementia unit. Staff H knew of another incident where the staff had to yell at all other residents to get back to their rooms and out of the hallway while Resident #2 threw chairs; she feared for the safety of the residents. Staff H wrote a statement about the incident that occurred 11/15/18 as did Staff M and they slid the statements under the DON's office door that night. Staff H said after that, she never heard back from management and no one asked her for an interview about the incident. In an interview on 3/4/19 at 9:20 a.m., the DON confirmed both Staff H and Staff M no longer worked for the facility. The DON acknowledged both Staff H and Staff M wrote witness statements from the night of 11/15/18 but she	F 610		

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F 610	Continued From page 47 could not locate them. The facility investigation lacked documentation of observations, incident report, witness statements, staff interviews, and resident interviews. The investigation lacked documentation of interventions initiated to increase staffing/nursing supervision between Resident #2 and Resident #47 to ensure safety and prevent further inappropriate contact. Incident 2: The Progress Notes dated 12/22/18 at 8:10 p.m. and 11:22 p.m. documented Resident #47 received acetaminophen (Tylenol) for right arm pain, noted as effective on follow-up. The Progress Notes contained no other entries for the date of 12/22/18. The Progress Notes dated 12/28/18 at 2:35 p.m. documented a late entry created by Staff G, LPN. On 12/22/18 a CNA (Certified Nurse Aide) reported Resident #47 in the hallway after breakfast and another resident walked by smacking Resident #47 on the bottom, who in turn, swung at the other resident, hitting them in the left shoulder. Staff separated both residents, noted no injuries and completed skin assessments with no skin issues found. The Progress Notes dated 12/28/18 at 3:32 p.m. documented staff placed a call to Resident #47's guardian to inform them of the incident. The unsigned, typed facility investigation dated 12/28/18, titled Self-Report, documented: On 12/22/18 at approximately 10:00 a.m., Staff I, CNA observed Resident #2 swatted Resident #47 on the backside. Resident #47 slapped Resident	F 610		

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F 610	Continued From page 48	F 610		

#2 on the shoulder and told him not to touch her ever again. Staff I immediately separated the residents. Resident #2 thought his actions were funny and Staff I educated Resident #2 that it was not funny and never appropriate to touch another resident. There was no injury to either resident in relation to this incident. Staff I immediately reported the incident to Staff G. Staff G reported she thought Resident #47 had a delusion and the incident did not really occur. Resident #2 had a BIMS score of 3, expressive aphasia (difficulty communicating) and difficulty responding to the questions on the BIMS. Resident #2 could address and ask for staff members by name and the BIMS score not a reliable method of determining Resident #2's cognitive status. Staff I reported the incident to the DON and the Administrator at approximately 3:00 p.m. on 12/27/18. The DPOA (Durable Power of Attorney) and physicians for both residents received notice of the incident. Resident #2 continued 15 minute checks and staff observed both residents to keep them separated. Both residents lived in the CCDI unit. Staff G received a written warning on 12/28/18 regarding the reporting of all resident-to-resident contact to the DON or Administrator so that an investigation could be carried out in a timely manner to avoid further incidents. Resident #2 received education that it was not permissible to ever place his hands on another resident. Both resident care plans were reviewed and updated to address this situation.

Staff I's witness statement, signed 12/28/18, documented on 12/22/18 after breakfast, she stood outside the dining room in the hallway. Resident #2 leaned up against the wall with his hands behind his back waiting to go smoke and talking to another resident. When Resident #47

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F 610	Continued From page 49 walked by Resident #2, he smacked Resident #47's bottom open handed. Resident #47 turned around and smacked Resident #2 on the shoulder open handed and told him not to touch her again. Staff I went down the hall and told Resident #2 he could not do that, to which Resident #2 laughed and replied 'you seen, she hit me'. Staff I took Resident #47 to tell the charge nurse, Staff G. Staff I told Staff G everything that happened as did Resident #47. The DON typed the following 12/28/18 as education to staff: All resident to resident contact reported to you as a nurse must be reported to a member of management immediately. If you do not witness the resident to resident contact, it still must be immediately reported to a member of management. An incident report must be completed on both residents involved as well as a head to toe assessment. Documentation must be very thorough in the nurse's notes. If you have questions regarding resident to resident contact, please see the ADON (Assistant Director of Nursing), Administrator, or the DON. By signing this you are acknowledging the above information. The Employee Warning & Discharge Notice dated 12/28/18 documented discipline presented to Staff G for failure to report a resident to resident contact on 12/22/18. The facility investigation lacked documentation of interventions initiated to increase staffing/nursing supervision between Resident #2 and Resident #47 to ensure safety and prevent further inappropriate contact.	F 610		

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F 610	Continued From page 50 Incident 3: Observation on 2/25/19 at 12:45 p.m. revealed Resident #2 walked up the hallway from the TV room by the nurses station passing Resident #47. A loud slap could be heard and Resident #47 yelled "Ouch, I'm tired of you hitting me". Resident #2 made eye contact with surveyor and quickly walked into room 20. Resident #47 turned and walked back down to the TV room. Another resident (#36) walked up the hall to the nurses station from the TV room at the same time and informed Staff K that Resident #2 just slapped him. The surveyor reported the slap on Resident #47's buttocks immediately to Staff J, CNA, and Staff K. Staff J called for management help in the unit immediately. In an interview on 2/25/19 at 2:55 p.m., Staff G responded she assessed Resident #47 that day and she did not have any marks. Resident #47 recalled what happened and stated feeling scared of Resident #2. Staff G said she didn't think Resident #2 had been gone to the hospital long enough for the residents to get him out of their heads. Staff G said Resident #47 stated she always walked on the far side of the hall because she had to look out for Resident #2. On 2/25/19 at 3:07 p.m. an interview attempted with Resident #47. When asked if she recalled the incident from earlier that day, Resident # 47 said no one had touched her that day, then responded that he comes out of nowhere so she watches where she's going, then she changed topics. The Progress Notes dated 2/25/19 at 4:00 p.m., created by Staff G, recorded she received a report that Resident #47 walked in hallway of the	F 610		

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F 610	Continued From page 51 CCDI unit when she yelled and said 'ouch, I'm sick of you touching me' while a loud smack could be heard. Another resident walked up to Resident #47 and smacked her on the buttock. The doctor was in the facility at the time of the incident and made aware with call placed to the DON. 2. The admission MDS assessment dated 11/2/18 for Resident #2 documented an admit date of 10/22/18. The MDS identified a BIMS score of 3 with sign/symptom of delirium with fluctuating presence of inattention; a score of 3 indicated severe memory and cognitive impairment. The MDS documented the resident exhibited physical and verbal behavioral symptoms directed toward others and wandering on 1 to 3 days of the 7-day look back period. The MDS recorded the resident's behaviors impacted others putting others at significant risk for physical injury and significantly disrupted care or the living environment. The MDS recorded he was independent with transfers, walking in the room and corridor, and locomotion on the unit. The MDS documented diagnoses that included Non-Alzheimer's dementia, depression, delirium due to known physiological condition, unspecified/uncomplicated nicotine dependence, other uncomplicated psychoactive substance abuse, and metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood). The care plan focus area dated 11/1/18 identified Resident #2 as independent with ADLs (activities of daily living) and transferred independently. The care plan focus area dated 11/5/18 identified an elopement risk/wanderer with behaviors of exit seeking, kicking exit doors, pacing, and going into	F 610		

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F 610	Continued From page 52 other residents' rooms related to increased agitation when he did not have cigarettes and could not go out to smoke when he wanted. The care plan informed staff the resident resided on the CCDI (or dementia) unit. The care plan focus area dated 11/5/18 identified a behavior deficit related to physical and verbal behaviors towards others, hitting other residents, shoving another resident; increased agitation when out of cigarettes or couldn't go out to smoke when he wanted or get into the fridge when he wanted and throwing items off nurses cart and throwing nurses tablet breaking it. The care plan informed staff the resident with a history of: yelling/cursing at others; getting upset because the fridge locked; threw juice at staff; took items off med cart, shook drawers on med cart and tried to open them; threatened staff; lifted up a chair and threatened to break window; rammed his shoulder into nurses station door causing damage to facility property; kicked exit door and damaged facility property; and broke locks on cupboard doors in dining area. The care plan identified the resident diagnosed with vascular dementia, delusional disorder, depression, metabolic encephalopathy, and had a long history of substance abuse with nicotine dependence. An intervention dated 11/5/18 directed staff to intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention; and remove from situation and take to alternate location as needed. An intervention dated 11/7/18 directed staff to monitor behavior episodes and attempt to determine underlying cause; consider location, time of day, persons involved, and situations; and document behavior and potential causes. The care plan intervention dated 12/28/18 directed staff to educate the resident expectations	F 610		

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F 610	Continued From page 53 of keeping his hands to himself and on successful coping, interaction strategies. The care plan instructed when Resident #2 became agitated, staff should attempt to intervene and redirect him before agitation escalated, guide him away from the source of distress, engage calmly in conversation and if he had an aggressive response, staff should walk calmly away and approach later. The care plan focus area dated 11/9/18 identified a mood deficit related to diagnosis of depression and placement in facility. The care plan directed staff to monitor, record, report to physician as needed risk for harming others (increased anger, labile mood or agitation), if he feels threatened by others or thoughts of harming someone and possession of weapons or objects that could be used as weapons. Incident 1: The Progress Notes dated 11/15/18 at 10:36 p.m. documented the resident found in a female resident's room, with his head towards her groin area. Staff removed Resident #2 from the area and called to the DON to ask if the event was reportable. At 10:57 p.m. staff placed the resident on 15 minute observation checks and then found the resident back in the female resident's room, sitting on the end of her bed. Incident 2: The Progress Notes dated 12/22/18 at 9:26 p.m. documented Resident # 2 screamed at another resident who accidentally entered his room when he wanted to go smoke. The note recorded when staff could not go right away, Resident # 2 became upset and screamed at the ladies sitting in the hallway and upon returning from a smoke break went to room looking for 'that idiot'. The Progress Notes contained no other entries for the	F 610		

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F 610	Continued From page 54 date of 12/22/18 pertaining to resident to resident contact. The Progress Notes dated 12/23/18 at 3:40 p.m. documented Resident # 2 walked in the hallway when another resident with an episode of increased agitation yelled inappropriate language to him at which time Resident # 2 called the resident a crazy b**** and staff redirected him away. At 7:47 p.m. Resident # 2 appeared cocky and strutted arrogantly in the hallway scaring female residents (#47 and #33), by saying 'Boo' in their faces and then yelled at another resident (#24) for messing with the TV. The Progress Notes dated 12/28/18 at 2:42 p.m. documented a late entry for 12/22/18. The entry recorded a CNA reported after breakfast Resident # 2 walked past another resident and smacked them on the bottom. The other resident swung at Resident # 2 and hit him in the left shoulder. Staff separated both residents immediately and noted no injuries. Incident 3: Observation on 2/25/19 at 12:45 p.m. revealed Resident #2 walked up the hallway from the TV room by the nurse's station passing Resident #47. A loud slap could be heard and Resident #47 yelled "Ouch, I'm tired of you hitting me". Resident #2 made eye contact with surveyor and quickly walked into room 20. Resident #47 turned and walked back down to the TV room. Another resident (#36) walked up the hall to the nurses station from the TV room at the same time and informed Staff K that Resident #2 just slapped him. The surveyor reported the slap on Resident #47's buttocks immediately to Staff J, CNA, and Staff K. Staff J called for management	F 610		

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F 610	Continued From page 55 help in the unit immediately. The Progress Notes dated 2/25/19 at 4:00 p.m., created by Staff G, recorded she received a report that Resident #47 walked in hallway of the CCDI unit when she yelled and said 'ouch, I'm sick of you touching me' while a loud smack could be heard. Another resident walked up to Resident #47 and smacked her on the buttock. In an interview on 2/26/19 at 8:00 a.m., Staff L commented Resident #2 would get into the residents' personal spaces. Staff L stated she felt Resident #2 knew what he was doing when he intimidated the other residents. Staff L responded she did think it was possible the resident doing things to other residents that they were unaware of when they weren't looking due to being a full watch hall. Staff L explained full watch hall meant they were constantly going up and down the halls to observe everything going on so if they went down the hall one way and Resident #2 went the other way, it would be possible for Resident #2 to have interactions with other residents without her being aware of it. In an interview on 2/26/19 at 2:25 p.m., the DON, discussed her summary of what the facility did to increase supervision of Resident #2 after signs of aggression and resident-to-resident altercations occurred. The DON summarized Resident #2 discharged on 1/4/19 to the hospital, came back to the facility on 2/19/19 when forced to accept the resident back, and then discharged on 2/25/19. The DON stated they increased staff on 2/19/19 to be 2 staff assigned on the unit whether it were 1 nurse, 1 aide or 2 aides up to 9 p.m. when most residents in bed. The DON stated they usually had 2 staff, and after bed a nurse	F 610		

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F 610	Continued From page 56 staffed on the unit. The DON reported the facility had struggled to staff the unit as they didn't always have 2 staff from 2:00 p.m. to 6:00 p.m. or 6:00 p.m. to 10 p.m. The management helped if needed Monday through Friday when in the building but weekends were difficult. When Resident # 2 on the unit prior to the most recent admit 2/19/19, the resident had not been as bad and they did not staff 2 persons on the unit at that time. The DON stated for the incident of resident-to-resident contact between Resident #2 and Resident #47 that occurred on 12/22/18, they did not become aware of the incident until 12/28/18. The DON stated they had the resident sign a contract agreement to acknowledge: it was expected that all residents keep their hands to themselves; residents cannot pinch, slap, grab, or make contact with another resident in any other manner; it was not a joke, it was not funny, and it was not allowed. The DON confirmed the resident a BIMS of 03 but they still presented the contract as they felt the resident aware of what he was doing. When the resident returned on 2/19/19 after the Administrative Law Judge (ALJ) ruled they must take Resident #2 back, they decided to place the resident on 15 minute checks indefinitely. The DON said the physician examined the resident on 2/20/19 and then again on 2/25/19 as the physician in the building right after the resident-to-resident contacts that occurred that day. The DON reported when they accepted Resident #2 back the second time 2/19/19, they did not get any information about the resident needing held down in the hospital for injections or that the resident had been moved units due to some sexual interactions. The DON stated they did not receive that information until approximately 2 days after the resident returned to the facility.	F 610		

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F 610	Continued From page 57 In an interview on 2/26/19 at 4:00 p.m., the DON responded the staff on the unit is responsible for completing the 15 minute observation checks and confirmed no additional staff would have been put back in the unit to assist with 15 minute checks. Review of the clinical record revealed Resident #2 on daily 15 minute observation checks from 10/29/18 thru 2/25/19 and therefore 15 minute checks not a new intervention for supervision on 11/15/18, 12/28/18, or 2/19/19. 3. The admission MDS assessment dated 2/8/19 for Resident #60 identified short and long term memory impairment with cognitive skills for daily decision making severely impaired. The MDS recorded the presence of delirium with continuous behaviors of inattention and altered level of consciousness. The MDS documented the resident exhibited physical and verbal behavioral symptoms directed toward others and wandering on 1 to 3 days of the 7-day look back assessment reference period. The MDS revealed the resident required the physical assistance of one for bed mobility, transfers, walking in room/corridor, and locomotion on the unit. The MDS documented diagnoses that included Non-Alzheimer's dementia, anxiety disorder, schizoaffective disorder, and other frontotemporal (location in the brain) dementia. In a family interview on 2/25/19 at 12:34 p.m., Resident #60's husband reported an episode that occurred about a week prior, possibly on a Monday morning around 9 a.m. He found a male resident in bed with Resident #60. The resident's husband told the facility and they determined nothing happened as there was no time to have it	F 610		

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F 610	Continued From page 58	F 610		

happen. The spouse reported the residents' clothes were on and the residents were not touching when he went in to find them. He wondered if there were not enough staff to supervise the unit. The facility responded they would monitor Resident #60 more closely, he knew who the guy was and came to think of him as a womanizer. He identified the resident in bed with his wife as Resident #36, who walked in the hallway independently at the time of the interview.

A Plan of Care note dated 2/8/19 at 5:44 p.m. documented Resident # 60 is short-tempered and easily annoyed most days. The entry documented the resident had physical behaviors towards other staff and residents, rejected cares and became agitated at times; would hit, spat out medications, and refused cares, wandered on occasion and would go into other residents' rooms and lay in their beds, which intruded on other residents' privacy. The entry recorded Resident #60's behaviors put her and others at risk for harm and interfered with her personal cares.

The Progress Notes dated 2/23/19 at 10:36 a.m. documented Resident #60 in room 23 fully clothed, in bed with another confused male resident. Staff redirected her to her room with her husband.

In an interview on 2/28/19 at 12:50 p.m., the Administrator provided a short summary of the resident-to-resident interaction that occurred on 2/23/19 between Resident #60 and Resident #36. The Administrator confirmed the facility did not conduct or document any staff interviews or formal investigation of the incident. She stated Resident #60's husband had some dementia as

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F 610	Continued From page 59 well. They concluded that no inappropriate contact had been made between the residents based on a verbal, informal, undocumented investigation with staff members. The undated, unsigned facility investigation titled, Investigation 2/23/19 Resident #60 and Resident #36, documented on 2/23/19 at 10:00 a.m. Resident #60 and Resident #36 were found lying on the unmade bed in room 23. They were arm in arm, both residents fully dressed and they were last been seen at 9:55 am. This was reported to the DON at 10:15 a.m.; she instructed them to place Resident #36 on 15 minute checks. The residents' physicians and Power of Attorney (POA) were notified of the incident. Since both residents had been seen 5 minutes prior to them being found and both were fully dressed, no inappropriate sexual behaviors occurred. Resident #36 denied anything happened, Resident #36 placed on 15 minute checks, Resident #60 did not appear to be in any distress, and both residents' clothing or appearance not disheveled. The facility investigation lacked documentation of observations, incident report, witness statements, staff interviews, and resident interviews. 4. The admission MDS assessment dated 1/16/19 for Resident #36 identified a BIMS score of 4 without signs/symptoms of delirium; indicating severe cognitive impairment. The MDS documented he exhibited wandering behavior on 1 to 3 days of the 7-day look back assessment reference period. The resident displayed independence with bed mobility, transfers and walking in his room, and required supervision while walking in corridor and with locomotion on the unit. The MDS documented diagnoses that	F 610		

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F 610	Continued From page 60 included Non-Alzheimer's dementia and unspecified dementia without behavioral disturbance. The care plan focus area dated 1/17/19 identified the resident wandered into other residents' rooms and resided on the CCDI unit related to diagnosis of dementia. The care plan identified a behavior deficit related to making inappropriate comments towards others. The Progress Notes dated 2/23/19 at 10:31 a.m. documented a behavior note which recorded the resident located in room 23 in bed with a very confused lady. The resident was fully clothed but did not redirect easily and defiant when told the other resident's husband was there ... he told staff to tell the husband to get lost. The entry documented after very being firm with him, Resident #36 complied. In an interview on 3/4/19 at 8:50 a.m., the Administrator confirmed no incident report had been created for the contact made between Resident #60 and Resident #36. The facility policy titled Abuse Prevention, Identification, Investigation, and Reporting revised 9/9/16 included the following documentation: Investigation - All allegations of Resident abuse should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Director of Nursing, Administrator, or designated representative. Should an incident or suspect incident of Resident abuse be reported or observed, the Administrator of his/her designee will designate a	F 610		

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F 610	Continued From page 61 member of management to investigate the alleged incident. The Administrator of designee will complete documentation of the allegation of Resident abuse and collect any supporting documents relative to the alleged incident.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or	F 622		

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F 622	Continued From page 62 (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.	F 622		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 63 (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide discharge and medical information to the receiving health care institution at the time of discharge for two of five residents reviewed who transferred to the hospital (Residents #49 and #68). The facility reported a census of 67 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated 10/26/18 revealed Resident #49 re-entered the facility from the hospital on 10/22/18. The MDS assessment dated 1/25/19 revealed Resident #49 re-entered the facility from the hospital on 11/8/18. Review of the facility's electronic medical record Census List revealed the resident transferred to the hospital on 10/18/18 and 11/2/18. The Progress Notes revealed the following:	F 622		

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	165255	A. BUILDING _____ B. WING _____	03/07/2019

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F 622	Continued From page 64 a. On 10/18/18 at 9:42 P.M., Resident #49 sent to the Emergency Department for evaluation of an elevated temperature, vomiting, and decreased oxygen saturations. b. On 10/22/18 at 4:43 P.M., Resident #49 returned to the facility from the hospital. c. On 11/2/18 at 6:00 P.M., Resident #49 sent to the hospital for evaluation of abdominal pain and vomiting. d. On 11/8/18 at 3:06 P.M., Resident #49 returned from the hospital. The clinical record lacked documentation of information sent with the resident when she had transferred to the hospital 10/18/18 and 11/2/18. During an interview 2/27/19 at 2:30 P.M., Staff D, Registered Nurse (RN) reported when a resident went to the hospital or another facility, they printed a discharge form from the computer and wrote on the form the reason for transfer. Staff F reported they sent the discharge form, a copy of the advanced directive, power of attorney paperwork, and the medication record. Staff F acknowledged they had not made a copy of the transfer form or other forms sent with the resident to the hospital. During an interview 2/27/19 at 3:36 P.M., the Assistant Director of Nursing (ADON) reported when they sent a resident to the hospital, she expected the nurse documented what forms were sent with the resident to the receiving facility. The ADON confirmed no documentation of discharge forms sent to the receiving facility for Resident #49 when she went to the hospital on 10/18/18 and 11/2/18. During an interview 2/28/19 at 8:32 A.M., the	F 622		

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F 622	Continued From page 65 Administrator reported when staff sent a resident to the hospital, they printed off a form from the electronic health record which included the facesheet, allergies, and medications. The Administrator stated the nurse wrote on the bottom of the form the reason why a resident had been sent to the hospital or another facility. The Administrator reported the nurse documented in the progress notes the forms sent with the resident. A facility policy dated 2012 titled "Discharge/Transfer of the Resident" revealed a transfer form completed when a resident transferred to a higher level of care and a copy of all forms completed and placed in the resident's medical record. 2. During an interview on 2/28/19 at 8:20 a.m. Staff E, Licensed Practical Nurse reported that when a resident goes to the hospital, they fill out a transfer sheet with the residents information. Under Point Click Care you go to the resident under Profile, a blank form is there for the nurse to fill out, it is printed out and then sent to the hospital, along with the residents medication and treatment sheets. Staff E reported that another place to chart about the transfer would be in the progress notes. The Progress Note dated 2/11/19 at 11:45 p.m., documented that Resident #68 transported to hospital for treatment and evaluation. The resident's clinical record lacked documentation of information sent to the hospital on 2/11/19.	F 622		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		

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F 623	Continued From page 66 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		

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F 623	Continued From page 67 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 68 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review, and interview the facility failed to notify the state Long Term Care (LTC) Ombudsman for 5 of 6 residents reviewed for transfers out of the facility (Residents #68, #49, #34, #61 and #2). The facility reported a census of 67 residents. Findings include: 1. The Nurses Note dated 2/11/19 at 11:35 p.m. documented that Resident#68 had been transported to Iowa Methodist Medical Center for evaluation and treatment. The Nurses Note dated 2/14/19 at 6:34 p.m. documented that Resident#68 had returned to the facility. During an interview on 2/27/19 at 3:31 p.m. a representative from the State Ombudsman Office reported that the facility did not submit resident	F 623		

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F 623	Continued From page 69 transfer information to their office. 2. Review of the Census list for Resident #49 revealed the resident's status as on Hospital Leave on 10/18/18 and returned on 10/22/18, and on hospital leave 11/2/18 and returned on 11/8/18. Review of the Minimum Data Set (MDS) assessment dated 10/25/18 revealed Resident #49 had re-admitted to the facility on 10/22/18 from the hospital. The MDS assessment dated 1/25/19 recorded Resident #49 had recently admitted to the facility on 11/8/18 from the hospital. The facility had no documentation that staff notified the LTC Ombudsman when Resident #49 transferred from the facility on 10/22/18 and 11/8/18. In an interview 2/27/19 at 2:23 P.M., the Business Office Manager reported they had received a letter from the LTC Ombudsman office on 2/4/19 which included information the LTC Ombudsman needed to be notified of any resident transfers or discharges. The Business Office Manager reported prior to this she didn't know they needed to notify the LTC Ombudsman whenever a resident had transferred or discharged. In an interview 2/27/19 at 1:44 P.M., the Social Worker (SW) reported she had not notified the LTC Ombudsman whenever a resident transferred or discharged from the facility. The SW stated didn't know the LTC Ombudsman needed notified of any resident transfers or discharges. 3. Resident # 34's MDS assessment showed that	F 623		

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F 623	Continued From page 70 Resident # 34 entered the facility on 12/27/18. The MDS indicated intact cognition with a brief interview for mental status (BIMS) score of 14 and listed diagnoses that included hypertension, pneumonia, cerebrovascular vascular accident (CVA), cerebral infarction, respiratory failure, hypokalemia, insomnia, and chronic pain. On 2/25/19 at 11:18 AM, Resident # 34 stated that he had to be hospitalized for 2 days related to bronchitis. Review of Resident # 34's and facility records lacked evidence to show the LTC Ombudsman received notice regarding Resident # 34's hospitalization. 4. Resident # 61 MDS quarterly assessment dated 2/13/19 documented diagnoses that included heart failure, orthostatic hypotension, pneumonia, depression, asthma, chronic obstructive pulmonary disease (COPD), and respiratory failure. The MDS tracking history also showed the following: Entry on 11/30/18, Admission on 12/7/18, Discharge return anticipated on 1/20/19, and Entry on 1/25/19. The resident's Progress Notes dated 1/20/19 also documented Resident # 61's transfer to the hospital on this date. However, there lacked documentation or evidence that the Ombudsman became aware of Resident # 61's hospitalization. 5. The MDS assessment dated 11/2/18 for Resident #2 documented the resident admitted to the facility on 10/22/18. The Progress Notes dated 10/28/18 at 3:46 p.m. documented the resident sent to the ER	F 623		

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F 623	Continued From page 71 (Emergency Room) at 7:40 p.m. and returned to the facility at 8:45 p.m. after the ER informed staff they had no reason to keep the resident. The Progress Notes dated 11/16/18 at 12:30 p.m. documented the resident sent to the ER at noon with the ER informing the facility if they couldn't find anything wrong with the resident they would send the resident back. The Progress Notes dated 11/16/18 at 4:50 p.m. documented the resident returned from the hospital. Review of facility records revealed a lack of documentation to show staff notified the Long Term Care (LTC) Ombudsman of the resident's transfer out of the facility.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a	F 625		

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F 625	Continued From page 72 resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews, the facility failed to provide bed hold notices to 4 of 6 residents and or the resident's responsible person, when residents transferred out of the facility (Residents # 68, #49, #61, and #2). The facility reported a census of 67 residents. Findings include: 1. The Nurses Note dated 2/11/19 at 11:35 p.m. documented Resident#68 transported to the hospital for evaluation and treatment. The Nurses Note dated 2/14/19 at 6:34 p.m. documented that Resident #68 had returned to the facility. The Bed-Hold Policy for Hospitalization or Temporary Leave of Absence dated 12/22/10 for the resident documented the resident/responsible person would determine later if they wanted a bed hold. Resident #68's record lacked documentation that staff provided a bed hold notice to the resident/responsible person. on or within 24	F 625		

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F 625	Continued From page 73 hours of the transfer to the hospital. 2. The MDS (minimum data set) assessment dated 10/25/18 documented Resident #49 had diagnoses of depression, schizophrenia, cerebrovascular accident (stroke), and diabetes. The MDS assessment revealed the resident had re-admitted to the facility on 10/22/18 from the hospital. Review of the MDS assessment dated 1/25/19 revealed Resident #49 had recently admitted to the facility on 11/8/18 from the hospital. Review of the Census list for Resident #49 revealed the resident's status as on Hospital Leave on 10/18/18 and returned on 10/22/18, and on hospital leave 11/2/18 and returned on 11/8/18. The clinical record and progress notes dated 10/18/18 to 11/8/18 lacked documentation of any explanation of the bed hold notification to the resident or resident's representative when Resident #49 discharged to the hospital. Review of a Bed hold policy for hospitalization and temporary leave of absence signed 1/10/17 by the resident's representative revealed the resident wanted her bed held during an absence. The facility lacked documentation of bed hold notification provided when the resident had discharged to the hospital on 10/18/18 or 11/2/18. During an interview 2/27/19 at 1:40 P.M., the Business Office Manager reported the Marketing Director went over bed hold information with the resident and/or resident's representative and as far as she knew, nobody provided bed hold information whenever a resident admitted to the	F 625		

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F 625	Continued From page 74 hospital. During an interview on 2/27/19 at 1:44 P.M., the Social Worker reported when a resident admitted to the facility, the Marketing Director went over bed hold information kept in the admission packet with the resident and/or representative. The Social Worker acknowledged they had not provided bed hold information when a resident transferred or admitted to the hospital. A facility policy dated 2012 titled "Discharge/Transfer of the Resident" revealed a bed hold notification form completed when a resident transferred, and the bed hold notification documented in the resident's medical record of whether or not the resident wanted a bed hold. 3. Resident # 61 MDS quarterly assessment dated 2/13/19 showed Resident # 61's diagnoses including heart failure, orthostatic hypotension, pneumonia, depression, asthma, chronic obstructive pulmonary disease (COPD), and respiratory failure. The MDS tracking history also showed the following: Entry on 11/30/18, Admission on 12/7/18, Discharge return anticipated on 1/20/19, Entry on 1/25/19. The progress notes dated 1/20/19, also indicated Resident # 61's transfer to the hospital on this date. However, there lacked documentation or evidence that Resident # 61 or his representative became aware of the facility's bedhold policy during this particular hospitalization. 4. The MDS assessment dated 11/2/18 for Resident #2 documented the resident admitted to the facility on 10/22/18. The Progress Notes dated 10/28/18 at 3:46 p.m.	F 625		

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F 625	Continued From page 75 documented the resident sent to the ER (Emergency Room) at 7:40 p.m. and returned to the facility at 8:45 p.m. after the ER informed the resident they had no reason to keep the resident. The Progress Notes dated 11/16/18 at 12:30 p.m. documented the resident sent to the ER at noon with the ER informing the facility if they couldn't find anything wrong with the resident they would send the resident back. The Progress Notes dated 11/16/18 at 4:50 p.m. documented the resident returned from the hospital. The clinical record lacked documentation the resident or resident representative received a bed hold notice at the time of transfer or within 24 hours of the emergent transfer on 10/28/18 or 11/16/18.	F 625		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640		

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F 640	Continued From page 76 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on clinical record review and resident and staff interviews, the facility did not complete a discharge Minimum Data Set (MDS) assessment for 1 of 5 residents (Resident # 34) reviewed for hospitalization. The facility reported a census of	F 640		

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F 640	Continued From page 77 67 during the survey. Findings include: The MDS quarterly assessment showed that Resident # 34 entered the facility on 12/27/18. Resident # 34's MDS indicated intact cognition with a brief interview for mental status (BIMS) score of 14 and listed diagnoses that included hypertension, pneumonia, cerebrovascular vascular accident (CVA), cerebral infarction, respiratory failure, hypokalemia, insomnia, and chronic pain. On 2/25/19 at 11:18 AM, Resident # 34 stated that he had to be hospitalized for bronchitis for 2 days. The progress notes also revealed that the facility discharged Resident # 34 to the hospital on 1/30/19 related to respiratory problems. The progress notes also showed that Resident # 34 returned to the facility on 2/1/19. However, there lacked evidence to show completion of a discharge and re-entry MDS regarding Resident # 24's hospitalization. On 2/27/19 at 1:52 PM, the Director of Nursing (DON) verified facility staff did not complete a discharge MDS for Resident # 34's hospitalization. On 2/27/19 at 4:57 PM, the Administrator reported that the MDS Coordinator had just completed a late discharge MDS related to Resident # 34's hospitalization.	F 640		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		

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F 644	Continued From page 78 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and policy review the facility failed to refer four of six residents with a negative Level I result for the Preadmission Screening and Resident Review (PASRR), who were later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination (Residents #40, #49, #37, and #2), and failed to refer two of six residents who had a Level II PASRR when they had a significant change in mental health status and treatment (Residents #15 and #52). The facility reported a census of 67 residents. Findings include:	F 644		

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F 644	Continued From page 79 1. The annual Minimum Data (MDS) assessment dated 7/20/18 for Resident #40 identified the resident was not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The assessment documented Resident #40 entered the facility on 9/5/13. The MDS documented Resident #40 had diagnoses that included depression and psychotic disorder. The MDS indicated the resident took an antipsychotic and an antidepressant seven of the seven days during the look-back period, The care plan revised on 1/19/19 identified Resident #40 had diagnoses of delusional disorder and depression. The care plan directed staff to administer psychotropic medications as ordered, and monitor the effectiveness and the side effects of the medications. Review of the clinical record revealed a Notice of Negative Level I Screen Outcome dated 3/10/15. The Level I screen documented Resident #40 had no diagnoses of dementia, Alzheimer's disease, intellectual disability, or major mental illness such as delusional disorder or major depression. The PASRR documented the resident took Lexapro for depressive disorder. The PASRR documented no further PASRR screening required unless the resident had a suspected major mental illness of intellectual or developmental disability or had a significant change in treatment needs. The Diagnosis Report in the electronic health record documented Resident #40 had major depressive disorder and delusional disorder since 11/29/16.	F 644		

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F 644	Continued From page 80 The physician's orders directed staff to administer Lexapro daily for a depressive disorder beginning on 7/31/17 and Seroquel twice a day for delusional disorder started on 3/29/18. In an interview on 2/26/19 at 4:03 P.M., the Social Worker reported a PASRR is done on a resident prior to admission to the facility. The Social Worker reported she had recently received education about PASRR's, and had just found out she needed to check the resident diagnoses to ensure it matched the diagnoses on the PASRR and then re-submit a request to ASCEND to do a PASRR re-evaluation when the resident had a significant change in diagnoses or status. The Social Worker reported she checked the ASCEND website, and confirmed Resident #40 last had a PASRR completed 3/10/15. Review of an undated facility policy titled "Preadmission Screening and Annual Resident Review" revealed the facility will refer all Level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or related condition for a Level II review upon a significant change in status assessment to the State PASRR representative. 2. The annual MDS assessment dated 10/26/18 for Resident #49 identified the resident was not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The assessment documented Resident #49 entered the facility on 1/10/17. The MDS documented Resident #49 had diagnoses that included depression and schizophrenia. The MDS indicated the resident took an antidepressant for four of the seven days	F 644		

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F 644	Continued From page 81 during the look-back period, and took no antipsychotic or antianxiety medication during the look-back period. The MDS documented the resident had no behaviors. The care plan revised on 1/29/19 identified Resident #49 had diagnoses of schizoaffective disorder and major depressive disorder, and had frequent crying outbursts. The care plan directed staff to administer medications as ordered, and monitor the effectiveness and the side effects of the medications. Review of the clinical record revealed a Notice of Negative Level I Screen Outcome dated 12/30/16. The Level I screen documented Resident #49 had no diagnoses of dementia, Alzheimer's disease, intellectual disability, or major mental illness such as schizoaffective disorder or major depression, The PASRR documented no further PASRR screening required unless the resident had a suspected major mental illness of intellectual or developmental disability or had a significant change in treatment needs. The Diagnosis Report in the electronic health record documented Resident #49 had schizoaffective disorder 10/13/17 and major depressive disorder 10/23/18. The clinical record lacked documentation the resident had been referred for a Level II evaluation and determination. In an interview on 2/26/19 at 4:03 P.M., the Social Worker reported she checked the ASCEND website, and confirmed Resident #49 last had a PASRR completed 12/30/16.	F 644		

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F 644	Continued From page 82 3. The MDS assessment dated 7/28/18 for Resident #15 identified the resident not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The assessment documented Resident #15 entered the facility on 10/1/06. The MDS documented Resident #15 had diagnoses that included anxiety disorder, depression, psychotic disorder, and schizophrenia. The MDS indicated the resident took an antipsychotic, antidepressant, and antianxiety medication for seven of the seven days during the look-back period. The MDS documented the resident had no behaviors. The care plan revised on 1/4/19 identified Resident #15 had diagnoses of anxiety disorder, major depressive disorder, delusional disorder, schizoaffective disorder, and bipolar disorder. The care plan directed staff to administer psychotropic medications as ordered, and monitor the effectiveness and the side effects of the medications. Review of the clinical record revealed a Level II PASRR Notice dated 3/14/17. The Level II screen documented Resident #15 had diagnoses of delusional disorder and depression. The PASRR documented the nursing facility needed to report if the resident had any significant change in status. The Diagnosis Report in the electronic health record revealed the following diagnoses and the dates each diagnoses had been added: Anxiety disorder 10/1/06 Major depressive disorder 10/1/06 Delusional disorder 10/1/06	F 644		

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F 644	Continued From page 83 Schizoaffective disorder 8/22/16 Schizoaffective disorder, bipolar type 12/10/18 A physician's order dated 1/15/19 revealed the following: a. Lorazepam 0.5 milligrams (mg) by mouth three times a day for anxiety disorder started on 11/30/2018 b. Risperidone 2 mg twice a day for schizoaffective disorder started 11/30/18. c. Venlafaxine 150 mg daily and Venlafaxine 75 mg daily for major depressive disorder started 12/1/18. In an interview on 2/26/19 at 4:03 P.M., the Social Worker reported she checked the ASCEND website, and confirmed Resident #15 last had a PASRR completed 3/14/17. 4. The annual MDS assessment dated 7/28/18 for Resident #52 identified the resident not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The assessment documented Resident #52 entered the facility on 2/4/16. The MDS documented Resident #52 had diagnoses that included anxiety disorder, depression, bipolar disease, psychotic disorder, and schizophrenia. The care plan revised on 2/4/19 identified Resident #52 had diagnoses of schizoaffective disorder, anxiety disorder, major depressive disorder, delusional disorder, and bipolar disease. The care plan directed staff to administer psychotropic medications as ordered, and monitor the effectiveness and the side effects of the medications.	F 644		

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F 644	Continued From page 84 Review of the clinical record revealed a Level II PASRR Notice dated 2/15/16. The Level II screen documented Resident #52 had diagnoses of depressive disorder, alcohol abuse, delusional disorder and anxiety disorder. The PASRR documented the nursing facility needed to report any significant change in resident status. The Diagnosis Report in the electronic health record revealed Resident #52 had the following diagnoses and the dates each diagnoses had been added: Schizoaffective disorder 8/22/16 Alcohol abuse 2/4/16 Delusional disorder 2/4/16 Generalized anxiety disorder 2/4/16 Bipolar disorder 2/4/16 Major depressive disorder 2/4/16. The clinical record lacked documentation that staff referred the resident for a Level II re-evaluation and determination when had a significant change in health status. In an interview on 2/26/19 at 4:03 P.M., the Social Worker reported she checked the ASCEND website, and confirmed Resident #52 last had a PASRR completed 2/15/16. 5. The MDS quarterly assessment dated 1/16/19, showed that Resident # 37 entered the facility on 4/13/111, and the MDS listed Resident # 37's diagnoses included depression, psychotic disorder, schizophrenia, and vascular dementia without behavioral disturbance. The MDS indicated that Resident # 37 received an antipsychotic medication on a routine basis. Resident # 37's care plan documented she had impaired cognition related to diagnosis of	F 644		

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F 644	Continued From page 85 anterograde amnesia. The care plan identified a potential for behavioral problems related to diagnoses of delusional disorder, schizoaffective disorder, and depression. The care plan also identified potential for verbally aggressive behaviors towards other residents and staff. The care plan further identified risk for elopement and wandering. The care plan interventions included monitoring behaviors, redirections, and psyche consult/referral as needed. A review of Resident # 37's PASRR Notice of Exemption from PASRR dated 7/6 /17 indicated findings that Resident # 37 as ruled out from further assessments through the PASRR program as dementia will likely be the primary focus of behavioral health treatment. As of 2/28/19, the facility failed to provide a copy of Resident # 37's original or prior PASRR to show that Resident # 37's had been re-evaluated. 6. The admission MDS assessment dated 11/2/18 for Resident #2 identified the resident as not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS documented diagnoses that included non-Alzheimer's dementia, depression, delirium due to known physiological condition, unspecified/uncomplicated nicotine dependence, other uncomplicated psychoactive substance abuse, and metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood). The MDS coded the use of antipsychotic medication on 7 out of 7 days of the assessment reference period. Review of the clinical record revealed a Notice of	F 644		

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F 644	Continued From page 86 Negative Level I Screen Outcome dated 10/18/18. The care plan focus area dated 11/5/18 identified a behavior deficit related to physical and verbal behaviors towards others, hitting other residents, shoving another resident, increased agitation when out of cigarettes or he couldn't go out to smoke when he wanted or get into fridge when he wanted and throwing items off nurses cart and throwing nurses tablet breaking it. The care plan informed staff Resident #2 had a history of yelling/cursing at others, getting upset because the fridge locked, throwing juice at staff, taking items off med cart, shaking drawers on the med cart and trying to open them, he threatened staff, lifted up a chair and threatened to break window, rammed his shoulder into the nurses station door causing damage to facility property, kicked exit door and damaged facility property and broke locks on cupboard doors in dining area. The care plan identified the resident diagnosed with vascular dementia, delusional disorder, depression, metabolic encephalopathy, and had a long history of substance abuse with nicotine dependence. The Progress Notes dated 10/28/18 at 3:46 a.m. documented Resident #2 became agitated due to the lack of a lighter, cursed, stated someone stole his lighter and threatened assault. The nurse attempted to redirect the resident 3 times and he continued to make comments regarding the lighter. Staff assisted the resident to smoke and he demanded staff return his lighters or he would leave after breaking a window. He then picked up a chair and headed towards the window. Staff removed residents and Resident #2 put the chair down then rammed his shoulder against the	F 644		

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F 644	Continued From page 87 outside door. Staff then called the police and Resident #2 transferred to the ER (Emergency Room). Resident #2 said he would rather be on the streets. ER called the facility, stated Resident #2 was alert and oriented in the ER, without signs/symptoms of violence, and they needed to send Resident #2 back as he was a frequent flyer with too many visits too count and this was the best they had ever seen him. The Progress Notes dated 11/16/18 at 10:51 a.m. documented Resident #2 wanted a razor and kicked open the locked supply door when staff did not respond to his request fast enough. At 11:30 a.m. staff informed the physician that Resident # 2's behaviors involved staff members, other residents, and damage of property. Staff received an order to send the resident to the ER due to high risk of injury to self and others. At 12:30 p.m. the notes documented the resident sent to the ER and at 4:50 p.m. noted the resident returned to the facility. The Progress Notes dated 12/7/18 at 3:01 p.m. documented the CCDI unit nurse paged to the unit and the ADON found another resident lying on the floor with spilled coffee around him with a skin tear. The entry recorded staff reported Resident # 2 made contact with other resident resulting in a fall. The entry documented Resident # 2 said he wanted in to the other room to make a phone call and the other resident stood in the doorway so he asked him to move but he didn't move. The entry noted Resident # 2 said, I didn't push him I moved him I would never push another man. The entry documented Resident # 2 placed on 15 minute checks. At 3:06 p.m., another nurse documented Resident # 2 had approached the nurses station, shoved another	F 644		

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F 644	Continued From page 88 resident at the doorway at the same time he told that resident to get out of his way as he wanted to call his sister. The Progress Notes dated 12/16/18 at 5:30 a.m. documented Resident # 2 yelled at another resident who watched TV in the activity room. Resident #2 complained that resident didn't know what he was doing and needed to stop messing with the TV. Resident # 2's behaviors came out of nowhere; he scolded a wandering resident and had unpredictable behavior, hard to redirect. At 9:17 p.m. Resident # 2 told the night nurse he would kick the door in that night so she would have paperwork. The entry recorded Resident #2 then calmed to take his medications but escalated within a few seconds to yell at a resident watching TV. The felt anxious and afraid of Resident # 2's unpredictability and potential for violence, so she called the DON to report and the DON reshuffled staff to ensure the nurse was not alone with Resident # 2 after 8:30 p.m. The Progress Notes dated 12/21/18 at 8:53 p.m. documented Resident # 2 ran out of his room into the commons area and yelled at 2 residents in the TV room; nurse noted Resident # 2's behavior very unpredictable. At 9:23 p.m. the notes documented Resident # 2 again yelled at 2 residents watching TV telling them, you should be in bed stop messing with the TV. The Progress Notes dated 12/23/18 at 3:40 p.m. documented Resident # 2 walked in the hallway when another resident having episode of increase agitation yelling inappropriate language to which Resident # 2 stated, you a crazy b****, and staff redirected him away. At 7:47 p.m. the notes documented Resident # 2 cocky and strutting arrogantly in the hallway scaring female	F 644		

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F 644	Continued From page 89 residents, (Residents #47 and #33), by saying "Boo" in their faces and yelled at Resident #24 for messing with the TV. The Progress Notes dated 1/4/19 at 10:45 p.m., created by the MDS Coordinator, documented at approximately 8:15 p.m. she spoke with another staff member on the phone while Resident # 2 stood 2.5 feet behind her asking to go smoke in a loud voice. The MDS Coordinator informed Resident # 2 she was the only staff member in the unit and no one could take him outside. Resident # 2 yelled he wanted to go f***ing smoke and they better get staff back here to take me. The MDS Coordinator locked the medication cart, went into the nurses station, and shut the door. The MDS Coordinator documented she was not going to cater to Resident # 2's temper tantrum. The MDS Coordinator documented Resident # 2 ripped the computer from the wall plug, threw it down the hallway, and cleared the medication cart of every single item on it. The MDS Coordinator called 911 then a code red for help and a nurse from the west side of the facility arrived within a few minutes to find Resident # 2 standing up against the railing and within 2 more minutes, the police arrived. The MDS Coordinator informed the Administrator and then police and EMS (Emergency Medical Services) who escorted the resident from the premises. The resident's clinical record contained no documentation that the facility referred Resident #2 for a Level II evaluation and determination prior to 2/13/19. Review of the clinical record revealed the resident re-submitted for PASRR screening by the hospital when hospitalized on 2/13/19 with an outcome of	F 644		

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F 644	Continued From page 90 Short-Term Nursing Facility Approval for 180 days. The MDS dated 2/19/19 for Resident #2 documented the resident re-entered the facility. An interview was conducted on 2/26/19 at 4:10 p.m. with the Social Service Designee, (SSD) related to the PASRR screening process. The SSD reported the Admissions Coordinator obtained the PASRR screenings completed by hospitals prior to admission. The SSD acknowledged the facility pretty much just accepted the screen at face value and assumed it had been completed correctly. The SSD commented as of 2/26/19, she had learned the facility should be reviewing the PASRRs to ensure they contained the same diagnoses the facility documented in the report for proper determination of need for Level II reviews. The SSD reported she was learning more and more everyday on PASRRs and she had reached out to a sister facility to ask questions. The SSD responded the process for PASRR reviews as she had access to Ascend to see the reports that had been previously submitted. The SSD stated as of 2/26/619 she was in the process of printing off all residents PASRRs to compare them against residents' current diagnoses to ensure everything accurate. The SSD confirmed she would be the staff person responsible for submitting new PASRRs for review if a resident demonstrated a newly emerged or evident mental illness. The SSD responded nurses did not report to her if a resident received a new diagnoses that qualified as a serious mental health illness. The SSD stated the DON also working on getting a report from pharmacy of residents that received antipsychotic medications	F 644		

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F 644	Continued From page 91 in order to ensure those residents reviewed as well.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to revise the care plan for 1 of 2 residents (Resident # 34) reviewed for respiratory care. The facility reported a census of	F 657		

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F 657	Continued From page 92 67 residents. Findings include: The quarterly MDS (Minimum Data Set) assessment dated 2/13/19 recorded that Resident # 34 entered the facility on 12/27/18. Resident # 34's MDS indicated intact cognition with a brief interview for mental status (BIMS) score of 14 and listed active diagnoses including hypertension, pneumonia, cerebrovascular vascular accident (CVA), cerebral infarction, respiratory failure, hypokalemia, insomnia, and chronic pain. On 2/25/19 at 11:18 AM, when asked if he had any recent infection, Resident # 34 answered that he had been admitted to the hospital for 2 days because of bronchitis. The progress notes indicated a history and high risk for respiratory problem, as follows: a. On 1/18/19, Resident # 34 had chest X-ray related to congestion and cough. The physician ordered administration of a diuretic (for fluid) for 3 days and antibiotic (for infection) for 7 days. b. On 1/30/19 at 9:09 AM, the facility sent Resident # 34 to the hospital related to signs of respiratory problem such as difficulty talking, audible gurgling sounds when breathing, and abnormal lung sounds through out all lobes. c. On 2/1/19 at Resident # 34 returned to the facility. The admission assessment indicated that Resident # 34 had abnormal lung sounds described as rubbing on inspiration and wheezing on expiration. The notes also indicated Resident	F 657		

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F 657	Continued From page 93 # 34's ongoing antibiotic medications and also an order for nebulizer treatment to be administered as needed. The Order Summary Report printed on 2/27/19 directed staff to administer Albuterol Sulfate nebulization solution orally via nebulizer every 6 hours as needed for shortness of breath/wheezing, and Rocephin solution reconstituted 1 gram intramuscularly given every night related to acute bronchitis for 7 days, which started on 2/22/19 and ending 3/1/19, as treatment for respiratory problems. Resident # 34's current care plan identified problems that included the potential for nutritional deficit related to dependence of tube feeding for intakes, an actual activities of daily living (ADL) self-care deficit related to impaired mobility, and left-sided paralysis and weakness. However, the care plan did not show an update or revision to address Resident # 34's actual respiratory problems. On 2/27/19 at 1:52 PM, the Director of Nursing (DON) verified the care plan lacked comprehensive written guidelines to direct staff members in caring and treating the resident's respiratory issues and to prevent the same from recurring. The facility's undated Care Plan Process policy documented the purposes were to provide a comprehensive plan of care for the highest functioning level that residents may be expected to attain and to create care directives for the maintenance of optimal health for residents.	F 657		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689 SS=K	Continued From page 94 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, resident interview, staff interviews, and facility record review, the facility failed to increase nursing supervision on the CCDI (Chronic Confusion Dementing Illness) unit after several incidents involving resident to resident interactions to prevent potential for abuse for 5 of 6 residents reviewed for abuse (Residents #2, #47, #55, #36 and #33). The facility failed to identify the need for increased supervision housing multiple residents, with the potential for physical and verbal behaviors directed towards others, on the same unit. The facility failure resulted in an Immediate Jeopardy situation identified on 12/8/18 and abated on 2/27/19. Fourteen residents resided on the CCDI unit. In addition, based on clinical record review and staff interviews, the facility failed to provide adequate transfer assistance during a resident transfer that resulted in a fall with fracture for one of 23 residents reviewed (#25). The facility reported a total census of 67 residents. Findings include: 1. The admission Minimum Data Set (MDS) assessment dated 11/2/18 for Resident #2	F 689		

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documented an admit date of 10/22/18. The MDS identified a BIMS score of 3 with sign/symptom of delirium with fluctuating presence of inattention; a score of 3 indicated severe memory and cognitive impairment. The MDS documented the resident exhibited physical and verbal behavioral symptoms directed toward others and wandering on 1 to 3 days of the 7-day look back period. The MDS recorded the resident's behaviors impacted others putting others at significant risk for physical injury and significantly disrupted care or the living environment. The MDS recorded he was independent with transfers, walking in the room and corridor, and locomotion on the unit. The MDS documented diagnoses that included Non-Alzheimer's dementia, depression, delirium due to known physiological condition, unspecified/uncomplicated nicotine dependence, other uncomplicated psychoactive substance abuse, and metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood).

The MDS dated 1/4/19 for Resident #2 documented a Discharge Return Not Anticipated.

The MDS dated 2/19/19 for Resident #2 documented the resident re-entered the facility.

The care plan focus area dated 11/1/18 identified Resident #2 as independent with ADLs (activities of daily living) and transferred independently. The care plan focus area dated 11/5/18 identified an elopement risk/wanderer with behaviors of exit seeking, kicking exit doors, pacing, and going into other residents' rooms related to increased agitation when he did not have cigarettes and could not go out to smoke when he wanted. The

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F 689	Continued From page 96 care plan informed staff the resident resided on the CCDI (or dementia) unit. The care plan focus area dated 11/5/18 identified a behavior deficit related to physical and verbal behaviors towards others, hitting other residents, shoving another resident; increased agitation when out of cigarettes or couldn't go out to smoke when he wanted or get into the fridge when he wanted and throwing items off nurses cart and throwing nurses tablet breaking it. The care plan informed staff the resident with a history of: yelling/cursing at others; getting upset because the fridge locked; threw juice at staff; took items off med cart, shook drawers on med cart and tried to open them; threatened staff; lifted up a chair and threatened to break window; rammed his shoulder into nurses station door causing damage to facility property; kicked exit door and damaged facility property; and broke locks on cupboard doors in dining area. The care plan identified the resident diagnosed with vascular dementia, delusional disorder, depression, metabolic encephalopathy, and had a long history of substance abuse with nicotine dependence. An intervention dated 11/5/18 directed staff to intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention; and remove from situation and take to alternate location as needed. An intervention dated 11/7/18 directed staff to monitor behavior episodes and attempt to determine underlying cause; consider location, time of day, persons involved, and situations; and document behavior and potential causes. The care plan intervention dated 12/28/18 directed staff to educate the resident expectations of keeping his hands to himself and on successful coping, interaction strategies. The care plan instructed when Resident #2 became agitated,	F 689		

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staff should attempt to intervene and redirect him before agitation escalated, guide him away from the source of distress, engage calmly in conversation and if he had an aggressive response, staff should walk calmly away and approach later. The care plan focus area dated 11/9/18 identified a mood deficit related to diagnosis of depression and placement in facility. The care plan directed staff to monitor, record, report to physician as needed risk for harming others (increased anger, labile mood or agitation), if he feels threatened by others or thoughts of harming someone and possession of weapons or objects that could be used as weapons.

The Progress Notes dated 10/26/18 at 7:23 a.m. documented the nurse asked to go to the CCDI unit at 2:45 a.m. to help watch Resident #2 along with another nurse because of behaviors. The entry recorded Resident #2 complained/cussed because of a cold room, upset the refrigerator locked, and he wanted something to drink and when staff gave drinks the resident threw the juice at the nurse as not the kind he wanted.

The Progress Notes dated 10/27/18 at 1:22 a.m. documented Resident #2 was upset at 3:00 a.m. and the nurse called back to the unit. At 9:52 a.m., at 6:15 a.m. Resident #2 acted agitated due to wanting to smoke and the refrigerator being locked. The entry recorded Resident # 2 threatened staff with foul language, took items off the med cart, shook the drawers to try to open them, tried to go in others' rooms and the office, then got more agitated when told he couldn't go out to smoke because no staff were available to go with him.

The Progress Notes dated 10/28/18 at 3:46 a.m.

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documented Resident #2 became agitated due to the lack of a lighter, cursed, stated someone stole his lighter and threatened assault. The nurse attempted to redirect the resident 3 times and he continued to make comments regarding the lighter. Staff assisted the resident to smoke and he demanded staff return his lighters or he would leave after breaking a window. He then picked up a chair and headed towards the window. Staff removed residents and Resident #2 put the chair down then rammed his shoulder against the outside door. Staff then called the police and Resident #2 transferred to the ER (Emergency Room). Resident #2 said he would rather be on the streets. ER called the facility, stated Resident #2 was alert and oriented in the ER, without signs/symptoms of violence, and they needed to send Resident #2 back as he was a frequent flyer with too many visits too count and this was the best they had ever seen him.

The Progress Notes dated 11/2/18 at 2:28 p.m. documented the resident upset and demanding after assisted with smoke breaks at 6:10 a.m., 7:30 a.m., 10:00 a.m., 11:45 a.m., and 12:30 p.m. The entry recorded Resident # 2 agitated the nurse did not go out right that minute for a cigarette and demanded the supervisor be called; while waiting Resident # 2 kicked the doors so staff paged for help and the resident taken out to smoke.

The Progress Notes dated 11/2/18 at 4:46 p.m. documented a Plan of Care Note and documented staff reported Resident # 2 had verbal behaviors and would curse/yell at staff when agitated/upset. Staff reported physical behaviors. Resident #2 would threaten staff, threw juice at the nurse, threatened to break a

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window with a chair, rammed his shoulder into a door of the nurses' station, kicked a door, took items off nurses cart, and shook drawers on the nurses cart to try to open them. Resident # 2 got easily agitated and upset related to the refrigerator in the CCDI unit being locked with increased behaviors when he didn't have cigarettes or couldn't go out to smoke whenever he wanted. The entry recorded Resident # 2 wandered on occasion, paced, and would go into other residents' rooms.

The Progress Notes dated 11/15/18 at 2:28 p.m. documented the resident kicked the CCDI unit door open and broke all the cupboard locks in the dining area by pulling the doors apart until they broke.

The Progress Notes dated 11/15/18 at 10:36 p.m. documented Resident #2 was found in a female resident's room with his head towards her groin area. Staff removed the resident from the area, and called to the DON (Director of Nursing) to ask if they needed to report the event. At 10:57 p.m. staff placed the resident on 15 minute observation checks and then found the resident back in the female resident's room, sitting on the end of her bed.

The Progress Notes dated 11/16/18 at 10:51 a.m. documented Resident #2 wanted a razor and therefore he kicked open the locked supply door when staff did not respond to his request fast enough. At 11:30 a.m. the notes recorded staff informed the physician Resident # 2's behaviors involved staff members, other residents, as well as damage of property; an order received to send the resident to the ER due to high risk of injury to self and others. At 12:30 p.m. the notes

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F 689	Continued From page 100 documented the resident sent to the ER and at 4:50 p.m. noted the resident returned to the facility. The Progress Notes dated 12/3/18 at 3:24 p.m. documented Resident #2 approached another male resident to request salt and pepper and when that resident did not understand, Resident #2 became verbally aggressive and grabbed the salt/pepper from that resident. Resident #2 said told that resident to not act stupid. At 5:57 p.m. Resident #2 refused medication, stating he felt like a prisoner and after being served a plain hamburger. Resident #2 threatened to go to his room to get his boots in order to kick in the door and he told staff he could smoke anytime he wanted, he did not care what the nurse said. Staff responded they needed Resident #2 to wait a bit because they did not have a second person in the unit at the time to take him out. The Progress Notes dated 12/5/18 at 6:32 a.m. documented Resident # 2 had paced since 4:00 a.m. waiting for a cigarette as no staff available to take the resident out to smoke. The Progress Notes dated 12/7/18 at 3:01 p.m. documented the CCDI unit nurse paged to the unit and the ADON (Assistant DON) found another resident lying on the floor with spilled coffee around him and a skin tear. Resident # 2 made contact with the other resident, resulting in a fall. Resident # 2 said he wanted in to the other room to make a phone call and the other resident stood in the doorway so he asked him to move but he didn't move. Resident # 2 said he didn't push him, he moved him, and would never push another man. The entry documented Resident # 2 placed on 15 minute checks. At 3:06 p.m.,	F 689		

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another nurse documented Resident # 2 had approached the nurses station, shoved another resident at the doorway at the same time he told that resident to get out of his way as he wanted to call his sister.

The Progress Notes dated 12/7/18 at 11:06 p.m. documented Resident # 2 yelled at another resident about the TV remote.

The Progress Notes dated 12/11/18 at 5:47 p.m. documented Resident # 2 left the dining room stating he wanted the boss called to get some decent food. When staff informed him the boss had gone for the day, Resident # 2 said he would kick the door in and pack his stuff up to go back to the streets. Staff called the Administrator at home and instructed kitchen staff to cook what Resident # 2 agreed to. Resident # 2 responded that he didn't want that, yelled, appeared threatening in his approach in the dining room and upsetting other residents, so staff asked Resident # 2 to leave the room with the writer, which he did.

The late entry Progress Notes dated 12/14/18 at 8:10 a.m., created by the MDS Coordinator, documented upon the MDS Coordinator's arrival to the facility at 5:00 p.m. Resident # 2 was found standing in front of the TV in the West dining area of the facility yelling about the food being the same for 4 days. The MDS Coordinator approached the aide standing next to Resident # 2 to ask why he was out of the unit to which the CNA responded to ask his nurse. The charge nurse in the CCDI unit attempted to call the on-call staff. The MDS Coordinator walked the resident back to the CCDI unit and Resident # 2 stated he would pack his bags to get out of the

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place. The MDS Coordinator went back to the Assisted Living (AL) side of the facility and 20 minutes later, staff called to inform her Resident # 2 refused his medications and wanted to smoke; she instructed them to take the resident to smoke. Twenty minutes after that, staff reported Resident # 2 kicked open the CCDI door again and headed out the front door with a CNA following behind. Staff called the police to assist in redirecting Resident # 2 back to the facility and into the CCDI unit.

The Progress Notes dated 12/14/18 at 1:27 p.m. recorded Resident # 2 with increased agitation when another resident wore his socks and with increased anxiety when another resident wandered into his bathroom. At 5:31 p.m. Resident # 2 went to the dining area and wanted some 'real food'. Resident # 2 cursed and walked straight to the CCDI unit door, kicked it open and stated staff couldn't keep him there, he was leaving. Resident #2 went and told the kitchen staff they had served that food for 4 days but he refused any substitutes. Management staff walked him back to the unit where he packed his belongings. At 9:53 p.m. the notes documented that at 6:05 p.m. Resident # 2 knocked open the CCDI unit door again and a CNA escorted him to the main entrance of the building and called police.

The Progress Notes dated 12/16/18 at 5:30 a.m. documented Resident # 2 yelled at another resident who watched TV in the activity room. Resident #2 complained that resident didn't know what he was doing and needed to stop messing with the TV. Resident # 2's behaviors came out of nowhere; he scolded a wandering resident and had unpredictable behavior, hard to redirect. At

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F 689	Continued From page 103 9:17 p.m. Resident # 2 told the night nurse he would kick the door in that night so she would have paperwork. The entry recorded Resident #2 then calmed to take his medications but escalated within a few seconds to yell at a resident watching TV. The felt anxious and afraid of Resident # 2's unpredictability and potential for violence, so she called the DON to report and the DON reshuffled staff to ensure the nurse was not alone with Resident # 2 after 8:30 pm. The Progress Notes dated 12/19/18 at 7:19 a.m. documented Resident # 2 wanted to smoke at 6:30 but staff informed him they had no lighter as the resident had it in his room from another staff member. The note recorded the resident laughed at staff and denied having the lighter but when he realized he couldn't go to smoke he obtained the lighter from his room. The Progress Notes dated 12/21/18 at 8:53 p.m. documented Resident # 2 ran out of his room into the commons area and yelled at 2 residents in the TV room; the nurse noted Resident # 2's behavior as very unpredictable. At 9:23 p.m. Resident # 2 again yelled at 2 residents watching TV telling them they should be in bed and stop messing with the TV. The Progress Notes dated 12/22/18 at 9:26 p.m. documented Resident # 2 screamed at another resident who accidentally entered his room then he wanted to go smoke. When staff couldn't go right away, Resident # 2 became upset and screamed at the ladies sitting in the hallway and upon returning from a smoke break went to a room looking for 'that idiot'. The Progress Notes dated 12/23/18 at 3:40 p.m.	F 689		

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F 689	Continued From page 104 documented Resident # 2 walked in the hallway when another resident with an episode of increased agitation yelled inappropriate language to him at which time Resident # 2 called the resident a crazy b**** and staff redirected him away. At 7:47 p.m. Resident # 2 appeared cocky and strutted arrogantly in the hallway scaring female residents (#47 and #33), by saying 'Boo' in their faces and then yelled at another resident (#24) for messing with the TV. The Progress Notes dated 12/26/18 at 9:59 p.m. documented Resident # 2 exhibited increased agitation toward another resident yelling and getting in the other resident's face to tell him to stay out of his room and to stop messing with the TV. The Progress Notes dated 12/28/18 at 2:42 p.m. documented a late entry for 12/22/18. The entry recorded a CNA reported after breakfast Resident # 2 walked past another resident and smacked them on the bottom. The other resident swung at Resident # 2 and hit him in the left shoulder. Staff separated both residents immediately and noted no injuries. The Progress Notes dated 12/29/18 at 2:50 a.m. documented Resident # 2 had 2 unpleasant interactions with Resident #24 about the TV. The entry recorded Resident # 2 as difficult to redirect. The Progress Notes dated 12/30/18 at 4:14 a.m. documented Resident # 2 had 3 episodes of using abusive language towards Resident #24 early in the shift when Resident # 2 called Resident #24 names and told him to stop messing with the TV. The nurse intervened with limited success.	F 689		

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F 689	Continued From page 105 The Progress Notes dated 1/2/19 at 2:03 a.m. documented Resident # 2 called Resident #24 an idiot at snack time and said the resident would have a bowel movement (BM) all over the place. The late entry Progress Notes dated 1/2/19 at 8:14 a.m. documented Resident # 2 refused his meds and wanted to smoke. Resident # 2 pushed past the nurse cursing and stating, he could do whatever he wanted at the facility, could smoke whenever he wanted and staff couldn't stop him or tell him what to do. Resident # 2 went into the nurses office, threw a side table down the hall and grabbed his cigarettes and lighter. Staff I, CNA, took him out to smoke. Resident # 2 refused to return the lighter and stated he didn't mind going back to jail because the food better and he hadn't eaten in 3 days, and that he could do what he wanted because the state paid for him to stay at the facility. The nurse contacted the Administrator who informed staff the resident was no longer allowed to light his own cigarettes and staff must maintain possession of the lighter and keep the nursing office door closed at all times. The Progress Notes dated 1/4/19 at 10:45 p.m., created by the MDS Coordinator, documented at approximately 8:15 p.m. she spoke with another staff member on the phone while Resident # 2 stood 2.5 feet behind her asking to go smoke in a loud voice. The MDS Coordinator informed Resident # 2 she was the only staff member in the unit and no one could take him outside. Resident # 2 yelled he wanted to go f***ing smoke and they better get staff back here to take me. The MDS Coordinator locked the medication cart, went into the nurses station, and shut the	F 689		

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door. The MDS Coordinator documented she was not going to cater to Resident # 2's temper tantrum. The MDS Coordinator documented Resident # 2 ripped the computer from the wall plug, threw it down the hallway, and cleared the medication cart of every single item on it. The MDS Coordinator called 911 then a code red for help and a nurse from the west side of the facility arrived within a few minutes to find Resident # 2 standing up against the railing and within 2 more minutes, the police arrived. The MDS Coordinator informed the Administrator and then police and EMS (Emergency Medical Services) who escorted the resident from the premises.

The Progress Notes dated 2/19/19 at 2:05 p.m. documented Resident # 2 returned to the facility via a taxi service, he recognized staff and greeted them accordingly. At 3:25 p.m. the resident recognized all management staff and made jokes about the gang being back together and he already broke the rules.

The Progress Notes dated 2/21/19 at 5:03 a.m. documented Resident # 2 wanted a smoke and repeated 4 times he needed a smoke to go back to sleep. The nurse re-educated Resident # 2 of the signed rules to which Resident # 2 started to pace the halls stating, take me back to the hospital, you better call somebody. The nurse attempted to give as needed anxiety medication but Resident # 2 refused and pulled on the main door. The note documented after an inability to open the door, Resident # 2 sat down and finally relented.

The Progress Notes dated 2/24/19 at 1:00 a.m. documented staff educated Resident # 2 after he jumped around in hallway in front of others

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F 689	Continued From page 107 yelling, Hi-Ya, and kicking his leg and waving his arms. Resident # 2 said he was just showing them his karate moves and repeated his actions in front of the nurse. They educated Resident # 2 on inappropriate behavior. At 12:57 p.m. Resident # 2 continued 15 with minute checks and he had been very demanding that day. Resident # 2 waved a paper in a female resident's face and antagonizing her. When staff attempted to redirect him, Resident # 2 was slow to respond and stared at that person in a defiant manner. The Progress Notes dated 2/25/19 at 6:49 p.m., created by Staff G, LPN (Licensed Practical Nurse) documented she received report Resident # 2 sought out staff to take him to smoke and was agitated he couldn't go; he had a smoking schedule to follow. Staff G documented Resident # 2 was in the TV lounge, smacked a resident in the left temple of face, then went down CCDI hallway, smacked another resident on the buttocks and then ducked aside in another residents room. The nurse immediately notified the management team of the behavior/incidents, police arrived at 1:15 p.m. and Resident #2 transferred to the hospital. Review of the clinical record revealed Resident #2 on continual 15 minute observation checks from 10/29/18 through 2/25/19. Observations: Observation on 2/25/19 at 11:57 a.m. revealed Resident # 2 requested Staff K, Certified Nurse Aide (CNA) to take him out to smoke then shower. Staff K informed Resident # 2 the next smoke break would be at 1:00 p.m., asked him to	F 689		

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shower and have lunch and then it would be almost time for his smoke break. Resident # 2 demanded Staff K call the director to report he couldn't go out to smoke. Staff K informed the resident she would call but had something to do right that moment. Resident # 2 became angry and stated he was going out to smoke and Staff K better call the director right then. Staff K responded she would call but the director in a meeting at that time and would just tell him the same thing.

Observation on 2/25/19 at 12:04 p.m. revealed Staff C, Certified Medication Aide (CMA) took 3 other residents out the CCDI unit doors to the East hallway. Resident # 2 stood at the medication cart by the door and got in line behind the others to leave. Staff K blocked the entrance when Resident # 2 attempted to walk through with the others. Staff K held onto both doors as Resident # 2 pushed against her. Staff K continued to hold the doors and Resident # 2 increased his agitation. The Admissions Coordinator intervened at the door and told Staff K to let Resident #2 through and then walked with Resident # 2 hand in hand to the front offices. The DON and the Admissions Coordinator walked with the resident back to the CCDI unit. The DON was able to keep the resident calm and approached him gently; joking lightly with the resident. Resident # 2 allowed the DON to tie his shoes once on the unit and discussed smoking times. Resident # 2 interacted well with the DON. Resident #2 agreed to the 1:00 p.m. smoke time and shower and the DON encouraged him to take off his coat. As Resident # 2 took off his coat, he repeated shower-smoke, shower-smoke, then Resident # 2 said he wanted to smoke now. The DON had to continue to

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F 689	Continued From page 109 interact with the resident to redirect him away from the topic of smoking. The Admissions Coordinator accompanied the DON and Resident # 2 back to his room with encouragement to lay down for a while. Observation on 2/25/19 at 12:45 p.m. revealed Resident #2 walked up the hallway from the TV room by the nurse's station passing Resident #47. A loud slap could be heard and Resident #47 yelled "Ouch; I'm tired of you hitting me". Resident #2 made eye contact with surveyor and quickly walked into room 20. Resident #47 turned and walked back down to the TV room. Another resident (#36) walked up the hall to the nurses station from the TV room at the same time and informed Staff K that Resident #2 just slapped him. The surveyor reported the slap on Resident #47's buttocks immediately to Staff J, CNA, and Staff K. Staff J called for management help in the unit immediately. Staff Interviews revealed the following information: On 2/25/19 at 11:53 a.m., the Activities Assistant stated Resident #2's current condition was about the same as before he left the unit to the hospital. The Activities Assistant confirmed the resident lived in the facility since approximately October of 2018. The Activities Assistant commented that residents seemed intimidated by Resident # 2. On 2/25/19 at 11:59 a.m., Staff K stated she did not know the resident's previous level of functioning as she was new to the facility and only worked her third orientation day. Staff K was not working on her own yet.	F 689		

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F 689	Continued From page 110 On 2/25/19 at 2:11 p.m., the Administrator and the owner reported a police officer was in the building and would be escorting Resident # 2 to the hospital as they were actively initiating an involuntary discharge related to resident safety. The Administrator and owner reported they were forced by the Administrative Law Judge (ALJ) to take the resident back from the hospital 2/19/19. They stated the ALJ informed them they provided the wrong language in the Emergency Involuntary Discharge notice they gave upon discharge in January (1/4/19). They didn't want to take the resident back but they had to follow the judge's order. In an interview on 2/25/19 at 2:55 p.m., Staff G, LPN, responded she assessed Resident #47 and she did not have any marks (2/25/19). Staff G responded Resident # 47 recalled what happened and stated feeling scared of Resident #2. Staff G didn't think Resident #2 had been gone long enough for the residents to get him out of their heads (when he left 1/4/19). Staff G said Resident #47 stated she always walked on the far side of the hall because she had to look out for Resident #2. At 3:25 p.m., Staff G stated she thought Resident # 2's behaviors for that day were set off by his desire to go out and smoke. Staff G stated she was a rule follower and told Resident # 2 he had to wait until the scheduled smoke time of 1:00 p.m. to go out. When the resident first came to the facility he was more aware of the exits and of the other residents' disabilities which frustrated him. Staff G felt Resident # 2 did not understand mentally why the other residents were confused due to their cognitive declines. Staff G gave the example when a resident would be exit seeking, Resident # 2 informed the exit seeker there was a back	F 689		

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F 689	Continued From page 111 door and he would take them to the door to try to help them out. On 2/26/19 at 7:46 a.m., Staff G reported the residents were much calmer than the day before. Their anxiety level were way down since Resident #2 left the night before versus when Resident #2 resided on the unit. Staff G thought the residents were aware Resident #2 had gone and thought they had been hesitant to even sit next to Resident #2 for fear he would bully them. On 2/26/19 at 8:00 a.m., Staff L, CNA, stated she had worked for the facility for 3 years. The residents acted more calm that day and she felt they knew when Resident # 2 was on and off the unit. Staff L stated Resident #33 acted scared of Resident # 2; she felt Resident # 2 knew it and focused in on Resident #33's fear. Resident #2 always had behaviors since his admission in October 2018. Staff tried to redirect Resident # 2 to the TV room or to play checkers but activities did not divert Resident # 2. Resident # 2 would get into the residents' personal spaces, especially Resident #33. Resident # 2 would get into Resident #33's face, wave his arms around, and when Resident #33 tried to walk away with staff, Resident # 2 followed them and continued to antagonize the residents. Staff L thought Resident # 2 knew what he was doing when he intimidated the other residents and it was possible the resident did things to other residents that staff were unaware of when they weren't looking due to being a full watch hall. Staff L explained a full watch hall meant they were constantly going up and down the halls to observe everything going on, so if they went down the hall one way and Resident # 2 went the other way, it would be possible for Resident # 2 to have interactions with other residents without her being	F 689		

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F 689	Continued From page 112 aware of it. In an interview on 2/26/19 at 8:45 a.m., the Activities Assistant responded she was in charge of activities in the CCDI unit and out in the main facility. The Activities Assistant stated she did some activities on the unit but tried to gather residents from the CCDI unit and take them out to the main facility to join activities. The Activities Assistant stated she provided some supervision when present on the unit but she had no set times scheduled there. On 2/26/19 at 2:25 p.m., the DON discussed her summary of what the facility did to increase supervision of Resident #2 after signs of aggression and resident-to-resident altercations occurred. The DON said for the incident of resident-to-resident contact between Resident # 2 and Resident # 55 that occurred on 12/7/18, they increased to 15 minute checks, the doctor evaluated Resident # 2 on 12/13/19 and changed medications. The DON stated for the incident of resident-to-resident contact between Resident # 2 and Resident # 47 that occurred on 12/22/18, they did not become aware of the incident until 12/28/18. The DON said at that time they notified the DIA (Department of Inspections and Appeals), disciplined a charge nurse for not reporting immediately and placed Resident #2 on 15 minute checks; when 15 minute observation checks were initiated, they conducted them for 72 hours, but if the behaviors continued they would put a resident back on the checks. The DON had Resident #2 sign a contract agreement to acknowledge the expectation that all residents keep their hands to themselves, residents cannot pinch, slap, grab, or make contact with another resident in any other manner, it was not a joke, it	F 689		

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was not funny, and it was not allowed. The DON confirmed the resident a BIMS score of 3 but they still presented the contract as they felt he was aware of his actions. When the facility accepted Resident # 2 back the second time 2/19/19, they did not get any information about him needing to be held down in the hospital for injections or that he had been moved units due to some sexual interactions. The DON stated they did not receive that information until approximately 2 days after the resident returned to the facility. The DON stated when Administrative Law Judge (ALJ) ruled they must take Resident # 2 back on 2/19/19, they decided to place him on 15 minute checks indefinitely. The DON reported the facility called the police who witnessed the resident's sister receiving notification of an Emergency Involuntary Discharge notice and then the police officer escorted the ambulance to the hospital to deliver the paperwork to the hospital 2/25/19.

In an interview on 2/26/19 at 4:00 p.m., the DON responded the staff on the unit responsible for completing the 15 minute observation checks and confirmed no additional staff had been put back in the unit to assist with 15 minute checks.

In an interview on 2/27/19 at 11:00 a.m., Staff N, CNA/Scheduler stated she knew of 2 residents on the unit who showed they were bothered by Resident # 2: Resident #47 and Resident #33. Staff N stated she had not received a directive to staff 2 staff members on the CCDI unit until Resident # 2 returned to the facility on 2/19/19. Staff N said she received instruction to start staffing 2 staff persons on the CCDI unit during the waking hours of 6:00 a.m. to 9:00 p.m. when Resident # 2 returned. Staff N confirmed she had notmade any staffing changes to the amount

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F 689	Continued From page 114 of help assigned to the unit at any time before 2/19. If the facility had a float on the overnight shift, the float staff would go back to unit to give staff a break or supervise a resident to smoke. In reference to the previous months, Staff N stated they sometimes staffed a nurse or CNA, or both on the 6:00 a.m. to 2:00 p.m. (dayshift) and the 2:00 p.m. to 10:00 p.m. (afternoon shift), but always staffed just one staff member 10:00 p.m. to 6:00 a.m. (overnight shift). There were times Resident # 2 did well on the unit and she was not made by the DON to staff 2 during the second shifts. Staff N acknowledged difficulties filling the shifts as they only had 3 regular full time CNAs for the second shift; the facility did not use temporary staffing agencies. Staff N stated she was also on the on-call schedule and worked the floor as a CNA. In an interview on 2/27/19 at 11:30 a.m., Staff E, LPN, stated she worked for the facility for 5 years but did not work back on the unit often. At the time of the interview, Staff E worked as the charge nurse on the CCDI unit. Staff E had only worked with Resident # 2 one time but she had heard staff report every day that Resident # 2 tried to intimidate staff and residents with weird noises, kicking doors, and hitting people. Staff E responded they usually just staffed 2 people on the CCDI unit even when a resident exhibited behaviors. In an interview on 2/27/19 at 11:40 a.m., Staff J, CNA, responded she did not work back on the CCDI unit often. Staff J acknowledged she was familiar with Resident # 2 and he had always displayed behaviors. 2. The MDS assessment dated 11/9/18 for	F 689		

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F 689	Continued From page 115 Resident #47 identified BIMS score of 3 without signs/symptoms of delirium. The MDS documented the resident exhibited no behavioral symptoms during the 7-day look back period. The Resident #47 transferred and walked in her room independently and required supervision while walking in the corridor and with locomotion on her living unit. The MDS documented diagnoses that included Alzheimer's disease, Non-Alzheimer's dementia, depression, and schizoaffective disorder. The care plan focus area dated 11/12/18 identified an ADL (Activities of Daily Living) self-care deficit related to diagnoses of dementia, schizoaffective disorder, depression, and debility. The care plan intervention revised 11/12/18 informed staff the resident transferred independently. The care plan focus area dated 11/12/18 identified the resident wandered and resided on the CCDI (Chronic Confusion Dementing Illness) unit related to dementia. The care plan identified impaired cognitive function/impaired thought processes and the resident usually understood related to diagnosis of dementia. Incident 1: The Progress Notes dated 11/15/18 at 10:30 p.m., written by Staff H, Licensed Practical Nurse (LPN), documented an incident at 10:20 p.m. another resident was not seated in the TV room and not found in their own room. Staff searched for the resident (#2) and found him in Resident #47's room, sitting at the end of her bed and leaning over towards her groin area. Staff reported Resident #47 did not have any blankets on her, but was clothed as when put to bed. Staff	F 689		

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removed the other resident from Resident #47's room and Staff H contacted the DON to report the incident. Staff H put both residents on 15 minutes checks and the DON planned to call the Administrator and call Staff H back. At 10:50 p.m. Staff H received a call from the DON who instructed her to monitor both residents and talk with Resident #47 to see if the other resident had touched her inappropriately and then call the DON back if the resident stated she was touched inappropriately. At 10:55 p.m. as soon as the call ended with the DON, staff called from the CCDI unit to report to Staff H the other resident had entered Resident #47's room a second time when staff went into another resident's room to provide assistance. Staff called the DON who instructed they put a second staff member in the CCDI unit and continue 15 minute checks on both residents. Staff H and another staff member asked Resident #47 if she had been touched inappropriately or if she remembered another resident entering her room twice; Resident #47 said she knew the other resident came in twice, she told him to get out of there, and he did not touch her inappropriately but did rub her arms to wake her up. The entry documented staff visually assessed Resident #47 visually assessed and no injuries or issues noted.

The Progress Notes dated 11/15/18 at 11:00 p.m. documented 2 staff members in the CCDI unit and monitoring residents and 15 minute checks would continue on Resident #47 and the other resident for safety precautions.

The clinical record lacked documentation of an incident report for the occurrence.

On 2/28/19 at 12:50 p.m., the Administrator

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F 689	Continued From page 117 provided a summary of the resident-to-resident interaction that occurred on 11/15/18 between Resident #2 and Resident #47. The Administrator confirmed the facility did not conduct or document any staff interviews or formal investigation of the incident. The Administrator confirmed the term 'other resident' in Resident #47's progress notes dated 11/15/18 referred to Resident #2. They concluded that no inappropriate contact had been made between the residents based on a verbal, informal, undocumented investigation with staff members. The undated, unsigned facility investigation titled, Investigation of Incident on 11/15/18 regarding Resident #2 and Resident #47 documented the following: On 11/15/18 at approximately 10:20 p.m., Resident #2 and Resident #47 seen sitting at the end of Resident #47's bed. It was reported that Resident #2's head was in the direction of Resident #47's groin area. Staff H reported the observation to the DON at 10:30 p.m. and the DON reported the observation to the Administrator. Both residents were fully clothed and Resident #2 seen in the TV room at approximately 10:10 p.m. according to staff. Resident #47 denied Resident #2 touched her inappropriately or in a sexual manner. Resident #47 stated Resident #2 just rubbed her arms to wake her up. Both residents placed on 15 minute checks and an additional staff member brought to the CCDI unit for supervision. It was determined that no inappropriate or sexual touching occurred. In an interview on 3/4/19 at 8:50 a.m., the Administrator confirmed no incident report had been created for the contact made between Resident #47 and Resident #2 on 11/15/18.	F 689		

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F 689	Continued From page 118 On 3/4/19 at 9:00 a.m., Staff H stated she had worked for the facility approximately a year before quitting in 11/18. Staff H recalled working the night of 11/15/18 and assigned to the East hall with also covering the CCDI unit if they needed help. Staff H reported the unit only staffed with a med aide or CNA usually. Staff H stated Staff M, CNA, reported to her Resident #2 was found in Resident #47's room in a compromising position; Staff M reported Resident #47 laid in bed dressed with her legs spread open, Resident #2 sat on the end of the bed leaning down towards Resident #47's groin but not touching. Staff H said she called the DON immediately to report and she quit partly due to not feeling management responded appropriately. Staff H felt management did not take the report seriously as she felt it should be reported to the state within 2 hours. Staff H felt they needed extra staff in the unit due to Resident #2's unpredictable and violent behaviors. Staff H reported to the management they needed more staff and their response would be they would put 2 staff members on the unit, but they never followed through with 2 staff members on the unit. When Staff H worked in the unit she felt very nervous and scared of Resident #2. Staff H stated she did not feel educated on how to deal with Resident #2's violent behaviors and did not feel his placement appropriate in the dementia unit. Staff H knew of another incident where the staff had to yell at all other residents to get back to their rooms and out of the hallway while Resident #2 threw chairs; she feared for the safety of the residents. Staff H wrote a statement about the incident that occurred 11/15/18 as did Staff M and they slid the statements under the DON's office door that night. Staff H said after that, she never	F 689		

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F 689	Continued From page 119 heard back from management and no one asked her for an interview about the incident. On 3/4/19 at 9:20 a.m., the DON confirmed both Staff H and Staff M no longer worked for the facility. The DON acknowledged both Staff H and Staff M wrote witness statements from the night of 11/15/18 but she could not locate them. Incident 2: The Progress Notes dated 12/22/18 at 8:10 p.m. and 11:22 p.m. documented Resident #47 received acetaminophen (Tylenol) for right arm pain, noted as effective on follow-up. The Progress Notes contained no other entries for the date of 12/22/18. The Progress Notes dated 12/28/18 at 2:35 p.m. documented a late entry created by Staff G, LPN. On 12/22/18 a CNA (Certified Nurse Aide) reported Resident #47 in the hallway after breakfast and another resident walked by smacking Resident #47 on the bottom, who in turn, swung at the other resident, hitting them in the left shoulder. Staff separated both residents, noted no injuries and completed skin assessments with no skin issues found. The Progress Notes dated 12/28/18 at 3:32 p.m. documented staff placed a call to Resident #47's guardian to inform them of the incident. The unsigned, typed facility investigation dated 12/28/18, titled Self-Report, documented: On 12/22/18 at approximately 10:00 a.m., Staff I, CNA observed Resident #2 swatted Resident #47 on the backside. Resident #47 slapped Resident #2 on the shoulder and told him not to touch her ever again. Staff I immediately separated the	F 689		

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residents. Resident #2 thought his actions were funny and Staff I educated Resident #2 that it was not funny and never appropriate to touch another resident. There was no injury to either resident in relation to this incident. Staff I immediately reported the incident to Staff G. Staff G reported she thought Resident #47 had a delusion and the incident did not really occur. Resident #2 had a BIMS score of 3, expressive aphasia (difficulty communicating) and difficulty responding to the questions on the BIMS. Resident #2 could address and ask for staff members by name and the BIMS score not a reliable method of determining Resident #2's cognitive status. Staff I reported the incident to the DON and the Administrator at approximately 3:00 p.m. on 12/27/18. The DPOA (Durable Power of Attorney) and physicians for both residents received notice of the incident. Resident #2 continued 15 minute checks and staff observed both residents to keep them separated. Both residents lived in the CCDI unit. Staff G received a written warning on 12/28/18 regarding the reporting of all resident-to-resident contact to the DON or Administrator so that an investigation could be carried out in a timely manner to avoid further incidents. Resident #2 received education that it was not permissible to ever place his hands on another resident. Both resident care plans were reviewed and updated to address this situation.

Staff I's witness statement, signed 12/28/18, documented on 12/22/18 after breakfast, she stood outside the dining room in the hallway. Resident #2 leaned up against the wall with his hands behind his back waiting to go smoke and talking to another resident. When Resident #47 walked by Resident #2, he smacked Resident #47's bottom open handed. Resident #47 turned

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F 689	Continued From page 121 around and smacked Resident #2 on the shoulder open handed and told him not to touch her again. Staff I went down the hall and told Resident #2 he could not do that, to which Resident #2 laughed and replied 'you seen, she hit me'. Staff I took Resident #47 to tell the charge nurse, Staff G. Staff I told Staff G everything that happened as did Resident #47. Incident 3: Observation on 2/25/19 at 12:45 p.m. revealed Resident #2 walked up the hallway from the TV room by the nurse's station passing Resident #47. A loud slap could be heard and Resident #47 yelled "Ouch, I'm tired of you hitting me". Resident #2 made eye contact with surveyor and quickly walked into room 20. Resident #47 turned and walked back down to the TV room. Another resident (#36) walked up the hall to the nurses station from the TV room at the same time and informed Staff K that Resident #2 just slapped him. The surveyor reported the slap on Resident #47's buttocks immediately to Staff J, CNA, and Staff K. Staff J called for management help in the unit immediately. In an interview on 2/25/19 at 2:55 p.m., Staff G responded she assessed Resident #47 that day and she did not have any marks. Staff G responded Resident #47 did recall what happened and did state being scared of Resident #2. Staff G said she didn't think Resident #2 gone to the hospital long enough for the residents to get him out of their heads. Staff G said Resident #47 stated she always walked on the far side of the hall because she had to look out for Resident #2. On 2/25/19 at 3:07 p.m. an interview attempted	F 689		

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F 689	Continued From page 122 with Resident #47. When asked if she recalled the incident from earlier that day, Resident # 47 said no one had touched her that day, then responded that he comes out of nowhere so she watches where she's going, then she changed topics. The Progress Notes dated 2/25/19 at 4:00 p.m., created by Staff G, recorded the following: It was reported to this nurse that resident ambulated in hallway of CCDI when she let out a yell and said ouch, I'm sick of you touching me, while a loud smack heard. Another resident noted to walk up to this resident and smack her on the buttock. The resident immediately taken to her room, other resident left the hallway entering room 220, and skin assessment completed with no injury noted. Doctor in facility at the time of the incident and made aware with call placed to the DON. 3. The admission MDS assessment dated 11/21/18 for Resident #55 documented an admission date of 11/12/18. The MDS identified he had BIMS score of 3 and signs of delirium with fluctuating behavior of disorganized thinking. The MDS recorded the resident exhibited behaviors of delusions and physical and verbal behavioral symptoms directed toward others on 1 to 3 days of the 7-day look back period. The MDS recorded the resident wandered on 4 to 6 days of the 7-day look back period. The MDS revealed the resident as independent with transfer, walk in his room, and required supervision with walking in corridor and locomotion on the unit. The MDS documented diagnoses that included Non-Alzheimer's dementia, schizophrenia, and unspecified altered mental status. The MDS coded the use of antipsychotic, antianxiety, and	F 689		

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F 689	Continued From page 123 antidepressant medication all on 7 out of 7 days of the assessment reference period. The care plan focus area dated 11/14/18 identified the potential for an ADL (Activities of Daily Living) self-care deficit related to diagnoses of dementia with behavioral disturbances and schizoaffective disorder. The care plan informed staff the resident ambulated independently on the CCDI (dementia) unit. Incident 4: The Progress Notes dated 12/7/18 at 2:39 p.m., by Staff R, LPN documented as Resident #55 waited for Staff R to take him for a walk, another resident shoved him and he fell backward hitting his right elbow on the wall. Resident #55 sustained a 3 cm (centimeter) U-shaped skin tear to his right elbow. Resident #55 landed on his buttock and spilled his milk, his upper torso went back resting flat on the floor but did not hit his head. The Progress Notes dated 12/7/18 at 2:49 p.m. documented the CCDI nurse paged for assistance with the ADON responding to find Resident #55 on the floor, on his back with legs stretched out, empty coffee cup with spill around him. The entry recorded the resident as very calm, not upset, and stating he must have ran into the wrong one, he guessed. Resident #55 could not voice details of what occurred, but the nurse witnessed another resident push Resident #55 from the doorway, and Resident #55 fell backwards to ground landing on his buttocks. Staff assessed Resident #55's skin tear to the right elbow and provided treatment of steri-strip in place.	F 689		

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F 689	Continued From page 124 The undated, unsigned, typed facility investigation titled, Self Report Incident Date 12/7/18 documented that on 12/7/18 at 2:39 p.m. a situation occurred between Resident #55 and Resident #2. Resident #55 stood in front of the nurses station door in the CCDI unit waiting for the nurse to take him for a walk. Resident #2 approached the nurses station door and shoved Resident #55 telling him to get out of his way. Resident #55 lost his balance, fell to the floor, and sustained a 3 cm skin tear to his right elbow. The Progress Notes dated 11/18/18 at 1:39 p.m. documented the resident paced up and down hallway pushing on front door attempting to get out as well as pushing the numbers on the keypad. The resident required redirection to leave another resident's room and although visibly upset, could be redirected to the hallway. A family member of another resident reported they redirected the resident out of their room 4 times in order to visit with their loved one. Resident #55 then went back to front door and attempted to push on it and when the nurse tried to redirect, he started to get loud telling the nurse to, shut up and cursed at her. The nurse attempted to redirect the resident back to his room as other residents present but he refused stating he would go where he pleased. Another charge nurse spoke to him about calling his wife, walked him to the TV room to talk to him about his phone call, and engaged him in conversation. At 3:12 p.m. the resident paced the halls, hit doors, packed his suitcase, and carried it around. Staff attempted to redirect and distract with TV, food, fluids, cards, picture albums, conversation, and phoned his wife, but escalated and started to get physical. The note recorded the resident received as needed Ativan and he slowly started	F 689		

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F 689	Continued From page 125 to calm down. 4. The admission MDS assessment dated 1/16/19 for Resident #36 identified a BIMS score of 4 without signs/symptoms of delirium; a score of 4 indicated severe cognitive impairment. The MDS documented the resident exhibited wandering behavior on 1 to 3 days of the 7-day look back assessment reference period. The MDS revealed the resident independent with bed mobility, transfers and walking in his room, and required supervision to walk in the corridor and during locomotion on the unit. The MDS documented diagnoses that included Non-Alzheimer's dementia and unspecified dementia without behavioral disturbance. The care plan focus area dated 1/17/19 identified the resident wandered into other residents' rooms and resided on the CCDI unit related to diagnosis of dementia. The care plan identified a behavior deficit related to making inappropriate comments towards others. Incident 5: Observation on 2/25/19 at 12:45 p.m. revealed Resident # 2 walked up the hallway from the TV room by the nurses station and quickly into room 20 after hitting Resident #47. Resident #36 walked up the hall to the nurses station from the TV room at the same time and reported to Staff K that Resident #2 just slapped him. Staff J, CNA, and Staff K called for management help to the unit immediately. The Progress Notes created 2/25/19 at 6:06 p.m. by Staff G, LPN, documented the nurse notified at 12:40 p.m. Resident #36 reported sitting in TV lounge on couch when another resident come up	F 689		

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F 689	Continued From page 126 to him and hit him in the left side of the face Resident #36 stated he didn't do anything and had never seen the other resident before. Initial assessment revealed Resident #36 had a red mark on the left temple and the area faded and was no longer present at the time she wrote the entry: 6:06 p.m. 5. The MDS assessment dated 1/11/19 for Resident #33 identified a BIMS score of 6 without signs/symptoms of delirium, indicating severe cognitive impairment. The resident exhibited wandering behavior during 1 to 3 days of the assessment reference period. The resident was independent with transfers and required supervision while walking in her room, in the corridor, and during locomotion on the unit. The care plan focus area dated 1/14/19 identified an elopement risk/wanderer and informed the resident resided on the CCDI unit. In an interview on 2/26/19 at 8:00 a.m., Staff L, CNA, stated Resident #33 was scared of Resident # 2 and she felt Resident # 2 knew it and focused in on Resident #33's fear. Resident # 2 would get into the residents' personal spaces, especially Resident #33. Resident # 2 would get into Resident #33's face, wave his arms around, and when Resident #33 tried to walk away with staff, Resident # 2 followed them and continued to antagonize the residents. In an interview on 2/26/19 at 2:25 p.m., the DON confirmed Resident # 2 antagonized Resident # 33. In an interview on 2/27/19 at 11:00 a.m., Staff N, CNA/Scheduler, responded she knew of 2 residents on the unit who showed they were	F 689		

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F 689	Continued From page 127 bothered by Resident # 2; Resident #47 and Resident #33. Staff N stated she had not been given a directive to staff 2 staff members on the CCDI unit until Resident # 2 returned to the facility on 2/19/19. The above situations resulted in an Immediate Jeopardy (IJ) situation for facility residents from 12/7/18 until 2/27/19 when staff abated the IJ situation. The facility abated the IJ situation through system changes and education which included: a. Immediate identification of resident aggressive behaviors and implementation of direct supervision. b. Continued direct supervision until aggressive resident(s) are no longer a threat to other residents. c. Continued observation and assessment of affected residents. d. Communication with the affected residents' primary care providers. e. Behavior resolution meetings by facility staff to develop interventions for future actions. f. All staff education of the actions listed above. 6. The MDS assessment dated 1/1/19 for Resident #25 identified a BIMS score of 15 without signs/symptoms of delirium; a score of 15 indicated intact memory and cognition. The resident required the assistance of 2 with bed mobility, transfers and personal hygiene, and did not walk in room or corridor during the assessment reference period. During surface to surface transfers, the resident was unsteady and able to stabilize only with staff assistance. The MDS documented diagnoses that included diabetes mellitus, cerebrovascular accident (CVA), hemiplegia (weakness on 1/2 of the body),	F 689		

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F 689	Continued From page 128 and acute kidney failure. The MDS recorded the resident weighed 296 pounds. The care plan focus area dated 1/6/19 identified an ADL self-performance deficit related to diagnoses of left cerebral with right hemiplegia, OA (osteoarthritis), and amputation of the right great toe. The care plan directed staff to provide assistance of 2 persons with lateral scoot transfer to get into the wheelchair; may use the mechanical lift (Hoyer) for dialysis. The care plan revision dated 3/6/19 identified the resident's transfer status had changed to a mechanical lift with assistance of 2 persons. The care plan focus area dated 1/6/19 identified a potential for falls related to left cerebral stroke with right hemiplegia, debility, poor balance, and need for assistive devices. The care revision dated 3/5/19 identified a current fracture of the right distal femur. The care plan focus area initiated 3/5/19 identified acute pain related to recent fracture of the right distal femur and informed staff the resident used as needed narcotic pain medication. The Care Card updated 9/12/18 documented under Transfer: Lateral scoot support with assist times 2 (persons), may use mechanical lift with assist x2 for dialysis. The Progress Notes dated 2/22/19 at 6:16 p.m., created by Staff B, LPN, documented a CNA called Staff B to the resident's room and Resident # 25 was found on the floor. Staff B documented Resident # 25 laid on his side on the floor between his bed and dresser and denied hitting his head but stated he hit his right knee. Staff B assessed the resident, who had intact skin to his right knee with no bruising present and ROM	F 689		

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(range of motion) WNL (within normal limits). Staff B documented the CNA reported the resident told him he could stand up by himself while the CNA made his bed and Resident # 25 admitted saying that. Staff B educated the resident and CNA on the resident's transfer needs of the Hoyer at all times and both voiced understanding. Staff B recorded education given to the resident to not tell staff he could stand and to the CNA on following the care plan.

The Progress Notes dated 2/22/19 at 10:24 p.m. documented acetaminophen (Tylenol) pain medication 650 mg (milligrams) given as needed for knee pain rated a 10 out of 10. At 10:57 p.m. documented the resident refused all scheduled medications, complained of knee pain from recent fall, offered as needed Tylenol, but first refused as he wanted a pain pill. The note recorded the nurse informed him Tylenol was all they had available to give and the resident accepted the Tylenol. At 10:59 p.m. staff documented the Tylenol as effective with a follow up pain rating of 1 (on a scale of 10).

The Progress Notes dated 2/23/19 at 1:34 p.m. documented Resident # 25 complained of tenderness to the right knee, ROM WNL, just slow to move the right knee, and with no discolored areas or swelling found. At 8:44 p.m. Resident # 25 received Tylenol 650 mg as needed for pain rated 10 out of 10. At 9:30 p.m. staff documented the Tylenol as effective with a follow up rating of 6 out of 10. At 10:31 p.m. Resident # 25 complained of right knee pain and requested Tylenol with little effect.

The Progress Notes dated 2/24/19 at 1:01 p.m. documented Resident # 25 requested help to sit

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up on the edge of the bed and reported his knee felt tender from the fall. Resident # 25 stated he had arthritis in that knee and it gave him fits. Staff noted no increased swelling or discoloration to the knee.

The Progress Notes dated 2/25/19 at 6:15 a.m. documented staff sent a fax (facsimile) to the physician to request an order for a right knee X-ray due to the resident's fall and complaints of pain and discomfort. At 1:03 p.m. the fax returned with no new orders but direction to continue to monitor per fall protocol. At 5:57 p.m. the notes documented Resident # 25 complained of knee discomfort with no swelling or discoloration present.

The fax dated 3/3/19 documented the resident had a fall approximately 2 weeks prior during cares and that night complained of terrible right knee pain, stating he had pain for 2 weeks and not getting any better and asked for physician to advise. The signed physician response ordered an X-ray of the right knee and PT/OT (Physical Therapy/Occupational Therapy) evaluation.

The Patient Report dated 3/4/19 documented the results of the right knee X-ray with recorded findings of an impacted mildly displaced transversely (diagonally) oriented fracture through the distal femoral metaphysis (area of the leg just above the knee joint).

The Progress Notes dated 3/5/19 at 1:20 p.m. documented the results of the X-ray received with possible fracture found, the physician contacted, and staff to follow up with the physician in the morning. With assessment, the resident made no complaints of pain but he complained of

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tenderness to both knees and denied the need for pain medication. The note documented no edema, redness, or bruising observed.

The Progress Notes dated 3/5/19 at 6:18 a.m. documented the resident left for dialysis. At 9:53 a.m. the physician reviewed the X-ray results and ordered the resident be sent immediately to the orthopedic urgent care. At 4:00 p.m. staff documented the resident returned to the facility with a knee brace and orders to recheck and X-ray in 2 weeks and follow up with the physician in 4 weeks. At 4:41 p.m. staff documented the resident wore a right knee brace, transferred to bed via Hoyer, complained of pain with transfer, and after settled in bed the CNAs reported the resident complained of discomfort. At 5:08 p.m. the notes recorded a new order received for narcotic pain medication. At 5:26 p.m. notes documented the resident reported pain when moving, and the nurse administered an as-needed dose of the narcotic pain medication Norco.

On 3/5/19 at 3:45 p.m., Staff T, LPN, reported the resident was out of the facility being seen in the orthopedic urgent care. Staff T stated an X-ray came back the night before and it confirmed a fracture in the resident's leg. Staff T stated early in the morning the resident went to his dialysis appointment and then the physician ordered transfer from the dialysis appointment to urgent care. Staff T said the resident's transfer status had been the assist of 2 with a slide board.

In an interview on 3/5/19 at 3:50 p.m., the DON reported Resident # 25 was in his room on 2/22/19 with Staff S, CNA assisting the resident. The DON stated Resident # 25 sat on his bed

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while Staff S made the bed. The DON said Resident # 25 offered to stand to make it easier for Staff S to make the bed and Staff S handed Resident # 25 his walker. The DON stated Staff S knew he should follow the care card which listed Resident # 25 as an assist of 2 persons for transfers and Staff S should not have offered the resident his walker. Staff S did not discourage the resident from standing and as Staff S turned his back to continue making the bed, Resident # 25 attempted to stand and fell. The DON stated she awaited the resident's return from orthopedic urgent care to complete an interview about the fall. The DON reported the resident did not have a history of falls or attempts to get up. The DON said the resident did have the cognitive ability to follow commands and make decisions. The DON reported after the fall, the resident did complain of pain but described it as arthritic pain. The DON stated the original request for an X-ray denied by the physician citing no evidence to support the need for one. Nursing staff continued to monitor the resident's pain and as he continued to voice pain, they requested again for an X-ray and the physician able to order it. The DON reported the faxed results from X-ray received on the evening of 3/4/19. The DON reported they had enough staff that day with 3 CNAs scheduled up on West side of building on 2/22/19.

Observation on 3/5/19 at 4:00 p.m. revealed Resident #25 returned from the hospital accompanied by a family member and wore a brace to right leg. The family member reported to Staff T the urgent care ordered a brace to the leg and to follow up with X-ray in 2 weeks and the physician in 4 weeks.

On 3/6/19 at 11:05 a.m., the DON reported the

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F 689	Continued From page 133 resident recalled the incident of the fall on 2/22/19. The resident reported Staff S planned to change the bed linens due to the linens being soaked with urine, the resident then told Staff S to hand him his walker and he thought he could stand. Staff S was on the opposite side of the bed and raised the bed up. The DON stated Staff S had worked for the facility for a while and primarily worked on the West side of the facility so Staff S was familiar with Resident # 25. The DON stated the care cards for each resident hung on the back of residents' room doors and Resident # 25's care card had been in place on 2/22/19 listing the transfer status as lateral scoot with assist of 2 staff but that staff may use Hoyer lift as needed for dialysis related to fatigue. The DON stated a lateral scoot the same as a slide board and Hoyer lift same as the mechanical lift listed on the care plan. The DON stated they would be completing a transfer audit with Staff S when he arrived for work that afternoon. In an interview on 3/6/19 at 11:15 a.m., the Physical Therapist (PT), stated he had worked with Resident # 25 on and off in the past. Resident # 25 would have occasions where he requested PT to attempt to walk again but then a day or two later, refused and did not want to complete exercises. The PT said the walker would not be used with the lateral scoot transfer. At the time of the fall 2/22/19, Resident # 25 should have been a lateral scoot transfer. The PT demonstrated that staff would use the slid board from the bed to the wheelchair by scooting his bottom across the board. The PT had worked with Resident # 25 on the use of a brace to attempt to stretch out his leg as the resident could not fully extend his right knee. The PT knew of times the resident transferred himself when he	F 689		

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F 689	Continued From page 134 did not want to wait for help; staff would find him in bed after he had been in the wheelchair. In an interview on 3/6/19 at 11:20 a.m., Resident # 25 recalled the fall that occurred on 2/22/19. Resident # 25 reported the fall occurred in the evening before his supper and Staff S was the only aide in the room assisting him. Staff S informed him he needed to assist him to change the incontinence brief and the bed since they were wet with urine. Staff S told him to stand up as he handed him the walker. Resident # 25 stated he responded 'I'll try'. Resident # 25 did not even get stood up because he could not fully extend either leg and he fell right to the floor. Resident # 25 said Staff S had assisted him several times before and knew he was a Hoyer transfer. Resident # 25 acknowledged the care card hung on the back of the bathroom door at the time of the fall and accessible to Staff S. Resident # 25 stated immediately pain present in his right knee and he did report it to the nurses. Resident # 25 said all the staff could give him was Tylenol but that was not very effective. Resident # 25 had a brace he was supposed to wear prior to the fall each day but only for a couple hours. Resident # 25 did not have the brace on at the time of the fall and stated he could remove the brace himself when he wanted; the brace got uncomfortable when he slept so he would take it off in bed. Resident # 25 reported it had been a year and 2 months since he last stood and walked. Resident # 25 stated Staff S immediately sought help and staff got him off the floor with the Hoyer machine. Resident # 25 rated his pain a 10 on a scale of 0 to 10 with 10 being the worst pain ever felt. Resident # 25 said the nurse Staff T was aware of his pain and he had told her he would take a pain pill after he had	F 689		

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his lunch. Resident # 25 stated he thought the fall probably could have been preventable if Staff S would have assisted him to transfer to his wheelchair first. Resident # 25 responded he would have waited for Staff S if he had left to get help to transfer him.

In an interview on 3/6/19 at 2:00 p.m., Staff S reported he had worked for the facility for approximately 3 months. Staff S responded he was familiar with Resident #25 and his cares. Staff S recalled working 2/22/19 and stated he went in to assist Resident #25 with incontinence cares and a bed linen change. Staff S stated he just needed to do the corner on the right lower side of the bed and went to raise the bed then the resident stood up and fell. Staff S clarified that Resident #25 called for help because his whole bed needed to be changed, Staff S got most of the bed changed, then just needed the resident to stand to complete the corner. Staff S stated Resident #25 said he could use his walker to stand so Staff S gave him the walker. Staff S said the resident was on the side of bed facing the door, holding the bed rail and Staff S was on the other side to reach across the bed to hold up Resident #25. Staff S did not place a gait belt on the resident. Staff S stated when he raised the bed a little the resident went down to the floor without hitting his head. Resident #25 yelled about his leg and Staff S went to get the nurse. When Staff S returned, he found the resident had vomited. Staff S voiced he messed up by not following the resident's care plan that was in the bathroom and didn't know the resident needed a 2 person assist, he just went by the resident's word and he shouldn't have done that. Staff S had assisted Resident #25 to transfer twice before the fall and denied using the lateral scoot

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F 689	Continued From page 136 saying he just took the handle off the wheelchair and scooched him over. Staff S stated the facility told him about the care cards during orientation; he just didn't look at his.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident and staff interviews, the facility failed to ensure assessments pre and post hemodialysis treatments for one of one resident reviewed who required dialysis (Resident # 25). In addition, the facility failed to ensure that it had a contract with the dialysis clinic where Resident # 25 received dialysis treatments. The facility reported a census of 67 residents at the time of the survey. Findings include: The quarterly Minimum Data Set (MDS) assessment dated 1/1/19 indicated Resident # 25's intact cognition with a brief interview for mental status (BIMS) score of 15. The MDS listed Resident # 25's diagnoses included hypertension, peripheral vascular disease (PVD), diabetes mellitus, and Stage 5 chronic kidney disease. The MDS indicated Resident # 25 required dialysis treatment. Resident # 25's care plan, updated on 1/6/19,	F 698		

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identified renal insufficiency related to kidney disease, and indicated that Resident # 25 needed dialysis 3 times a week. The interventions directed staff to monitor and report changes in mental status, such as lethargy, tiredness, fatigue, tremors, and seizures; to monitor for signs of dehydration and/or fluid over load and to monitor/document/report any of the signs and symptoms including: swelling, weight gain of over 2 lbs a day, neck vein distension, difficulty breathing, increased heart rate, elevated blood pressure, abnormal skin temperature and peripheral pulses, level of consciousness, and breath sounds for crackles.

The Order Summary Report for Resident # 25, printed on 2/27/19, directed staff to check both of the resident's feet every night and notify physician for issues identified, to inspect his right arm dialysis access site every day and night shift, and to obtain weekly weights.

The Treatment Administration Record (TAR) dated 2/19 showed that staff members checked Resident # 25's right arm fistula daily during day and night shifts. There lacked indication as to when the assessments were completed in reference to Resident # 25's dialysis treatment. In addition, this record showed inconsistency with information taken from interviews as follows:

a. On 2/25/19 at 1:04 PM, Resident # 25 stated that staff members did not consistently complete assessments, such as inspecting his dialysis access site, checking vital signs, and/or gathering any pertinent data related to his general condition before and after dialysis treatments.

b. On 2/27/19 at 1:14 PM, the Director of Nursing

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F 698	Continued From page 138 (DON) verified a lack of documentation to show staff completed assessments before and after his dialysis treatments. c. On 2/28/19 at 7:35 AM, Staff D Registered Nurse (RN) stated that Resident # 25 is not on any hot charting for anything, and that no assessment is done before or after dialysis treatments. Staff D also stated that they do not complete and/or send anything such as assessment data with Resident # 25 to the dialysis clinic because Resident # 25 had been going there a long time that they do not require anything anymore. c. On 2/28/19 at 2:30 PM, the Administrator acknowledged that up to this time, the facility failed to secure contract with the dialysis clinic where Resident # 25 goes for treatment.	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide	F 725		

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F 725	Continued From page 139 nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interviews, and facility record review, the facility failed to provide sufficient staff to meet the behavioral needs of residents who resided in the dementia unit. Fourteen residents resided on the dementia unit and the facility reported a total census of 67 residents. Findings include: Review of Progress Notes and Care Plan Notes from 10/27/28 through 2/25/19, observations in the facility and staff interviews revealed that Resident #2 had 19 separate incidents of threatening, cursing and/or physical contact or aggression towards residents and staff in the CCDI (Chronic Confusion Dementing Illness) unit. On 2/26/19 at 2:25 p.m., the DON (Director of Nursing) discussed facility actions to increase supervision of Resident #2 after signs of aggression and resident-to-resident altercations occurred. On 12/7/18, they increased to 15 minute checks, the doctor evaluated Resident # 2 on 12/13/19 and changed medications. The DON stated on 12/22/18, they did not become aware of	F 725		

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the incident until 12/28/18. Staff placed Resident #2 on 15 minute checks. When 15 minute observation checks were initiated, they conducted them for 72 hours, but if the behaviors continued they would put a resident back on the checks. The DON had Resident #2 sign a contract agreement to acknowledge the expectation that all residents keep their hands to themselves, residents cannot pinch, slap, grab, or make contact with another resident in any other manner, it was not a joke, it was not funny, and it was not allowed. The DON stated Resident #2 had severe cognitive impairment, but staff still presented the contract as they felt he was aware of his actions. When the facility accepted Resident # 2 back the second time 2/19/19, they did not get any information about him needing to be held down in the hospital for injections or that he had been moved units due to some sexual interactions. The DON stated they did not receive that information until approximately 2 days after the resident returned to the facility. The DON stated when an Administrative Law Judge (ALJ) ruled the facility must take Resident # 2 back on 2/19/19, they decided to place him on 15 minute checks indefinitely.

In an interview on 2/26/19 at 4:00 p.m., the DON responded the staff on the unit responsible for completing the 15 minute observation checks and confirmed no additional staff had been put back in the unit to assist with 15 minute checks.

In an interview on 2/27/19 at 11:00 a.m., Staff N, CNA/Scheduler stated she knew of 2 residents on the unit who showed they were bothered by Resident # 2: Resident #47 and Resident #33. Staff N stated she had not received a directive to staff 2 staff members on the CCDI unit until

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F 725	Continued From page 141 Resident # 2 returned to the facility on 2/19/19. Staff N said she received instruction to start staffing 2 people on the CCDI unit during the waking hours of 6:00 a.m. to 9:00 p.m. when Resident # 2 returned. Staff N confirmed she had not made any staffing changes to the amount of help assigned to the unit at any time before 2/19. If the facility had a float on the overnight shift, the float staff would go back to unit to give staff a break or supervise a resident to smoke. In reference to the previous months, Staff N stated they sometimes staffed a nurse or CNA, or both on the 6:00 a.m. to 2:00 p.m. (dayshift) and the 2:00 p.m. to 10:00 p.m. (afternoon shift), but always staffed just one staff member 10:00 p.m. to 6:00 a.m. (overnight shift). There were times Resident # 2 did well on the unit and the DON did not require 2 staff during the second shifts. Staff N acknowledged difficulties filling the shifts as they only had 3 regular full time CNAs for the second shift; the facility did not use temporary staffing agencies. Staff N stated she was also on the on-call schedule and worked the floor as a CNA. In an interview on 2/27/19 at 11:30 a.m., Staff E, LPN, stated she worked for the facility for 5 years but did not work back on the unit often. At the time of the interview, Staff E worked as the charge nurse on the CCDI unit. Staff E had only worked with Resident # 2 one time but she had heard staff report every day that Resident # 2 tried to intimidate staff and residents with weird noises, kicking doors, and hitting people. Staff E responded they usually just staffed 2 people on the CCDI unit even when a resident exhibited behaviors. In an interview on 2/27/19 at 11:40 a.m., Staff J,	F 725		

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F 725	Continued From page 142 CNA, responded she did not work back on the CCDI unit often. Staff J acknowledged she was familiar with Resident # 2 and he had always displayed behaviors. On 3/5/19 at 11:15 a.m., Staff N confirmed a slash on the schedule indicated staff switched in the middle of the shift with one team member leaving the CCDI unit and it did not mean 2 staff were assigned. Staff N clarified "CI" meant a staff member called in sick for the day, "CX" meant canceled, and "P/U" meant a staff member picked up the hall assignment/shift. Staff N stated at no time from 11/1/18 through 3/4/19 would the staffing sheets reflect 3 staff members assigned in the units as they never had more than 2 staff working in the unit. Staff N stated when the CCDI line of the 10:00 p.m. to 6:00 a.m. line blank, that meant the nurse listed on the line of the 2:00 p.m. to 10:00 p.m. slot the only staff member assigned to cover the unit. Review of the daily staffing assignments from 11/1/18 through 3/4/19 revealed no major changes made to the level of staffing assigned to the CCDI unit during that time frame. Many of the days reflected the absence of 2 staff members on the unit during the day and afternoon shifts and the overnights at times only staffed with 1 staff member. At no time did the sheets reflect more than 2 staff members assigned to the unit. The following days documented only 1 staff member assigned to the CCDI unit on the overnight shift 10:00 p.m. to 6:00 a.m.: a. November 2018 - 11/2, 11/3, 11/4, 11/5, 11/9, 11/10, 11/11, 11/12, 11/16, 11/17, 11/18, 11/21, 11/22, 11/23, 11/24, 11/25, 11/26, 11/27, 11/28, 11/29, 11/30	F 725		

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F 725	Continued From page 143 b. December 2018 - 12/1, 12/2, 12/3, 12/4, 12/5, 12/7, 12/8, 12/9, 12/10, 12/11, 12/12, 12/13, 12/14, 12/15, 12/17, 12/21, 12/22, 12/23, 12/25, 12/27, 12/28, 12/29, 12/30, 12/31 c. January 2019 - 1/1, 1/5, 1/7, 1/9, 1/10, 1/11, 1/12, 1/13, 1/14, 1/15, 1/17, 1/18, 1/19, 1/20, 1/23, 1/24, 1/26, d. February 2019 - 2/1, 2/5, 2/7, 2/13, 2/15, 2/16, 2/18, 2/21, 2/22, 2/23, 2/24, 2/25, 2/27, 2/28 e. March 2019 - 3/3 The following days documented only 1 staff member assigned to the CCDI unit on the afternoon shift 2:00 p.m. to 10:00 p.m. for either part or all of the shift: a. November 2018 - 11/17, 11/23 b. December 2018 - 12/1, 12/2, 12/4, 12/10, 12/11, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18, 12/19, 12/20, 12/21, 12/23, 12/24, 12/26, 12/27, c. January 2019 - 1/2, 1/3, 1/4, 1/7, 1/8, 1/10, 1/11, 1/12, 1/13, 1/14, 1/15, 1/17, 1/18, 1/19, 1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/27, 1/28, 1/29, 1/31 d. February 2019 - 2/1, 2/2, 2/4, 2/5, 2/10, 2/13, 2/21 e. March 2019 - 3/1, 3/3	F 725		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		

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F 757	Continued From page 144 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility record review, the facility failed to attempt to analyze a resident's behavior to create non-pharmalogical and behavioral interventions prior to the use of or in conjunction with antipsychotic medication use for one of six residents reviewed for unnecessary medications (Resident #55). The facility reported a census of 67 residents. Findings include: The admission Minimum Data Set (MDS) assessment dated 11/21/18 for Resident #55 documented an admit date of 11/12/18. The MDS identified a Brief Interview for Mental Status (BIMS) score of 03 and signs of delirium with fluctuating behavior of disorganized thinking. A score of 03 indicated severely impaired cognition. The MDS recorded the resident exhibited behaviors of delusions and physical and verbal behavioral symptoms directed toward others on 1 to 3 days of the 7-day look back period. The MDS recorded the resident wandered on 4 to 6	F 757		

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F 757	Continued From page 145 days of the 7-day look back period. The MDS revealed the resident as independent with transfer, walk in room, and required supervision with walking in corridor and locomotion on the unit. The MDS documented diagnoses that included non-Alzheimer's dementia, schizophrenia, and unspecified altered mental status. The MDS coded the use of antipsychotic, antianxiety, and antidepressant medication all on 7 out of 7 days of the assessment reference period. The care plan focus area dated 11/14/18 identified the potential for an ADL (Activities of Daily Living) self-care deficit related to diagnoses of dementia with behavioral disturbances and schizoaffective disorder. The care plan informed staff the resident ambulated independently on the CCDI unit (Chronic Confusion Dementing Illness). The care plan focus area dated 11/14/18 identified psychotropic medication use related to dementia with behavioral disturbances and schizoaffective disorder. The care plan directed staff to review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. The care plan focus area dated 11/14/18 identified an elopement risk/wanderer and would set off alarms on doors, exit seek, and pack up his belongings, kicking/pulling on doors, pacing, voices he was getting out of there related to diagnosis of dementia. The care plan directed staff to identify patterns of wandering such as: is wandering purposeful, aimless, or escapist?; is the resident looking for something?; does it indicate the need for more exercise?; and intervene as appropriate. The care plan directed staff to provide structured activities such as: toileting; walking inside and outside; and	F 757		

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reorientation strategies including signs, pictures, and memory boxes. The care plan focus area dated 11/15/18 identified a behavior deficit and the resident would make sexual comments, rub staff arms and back related to dementia. The care plan informed staff the resident with a history of barricading self in room, pressing body against staff trapping them against cart and rubbing staff arms. The care plan directed staff: if reasonable, to discuss the resident's behaviors, explain/reinforce why behavior inappropriate and or unacceptable to the resident; intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner, divert attention; and remove from situation to an alternate location; and provide a program of activities of interest and accommodates the resident's status. The care plan intervention revised 11/27/18 directed staff to provide the opportunity for positive interaction, attention, and to stop and talk with the resident as passing by. The care plan focus area dated 11/27/18 identified the potential to be physically and verbally aggressive and the resident would curse, hit, kick, grab, push/shove staff related to diagnosis of dementia. The care plan directed staff to: analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document; assess and anticipate the resident's needs of food, thirst, toileting, comfort level, body positioning, and pain; and when the resident became agitated, intervene before agitation escalated guiding away from the source of distress, engaging calmly in conversation but if response aggressive staff to walk calmly away and approach later. The care plan focus area dated 11/27/18 identified the potential for delirium/confusional episodes related to fluctuating episodes of disorganized thinking.

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F 757	Continued From page 147 The care plan directed staff to monitor, record, report new onset signs/symptoms of delirium such as: changes in behavior; altered mental status; wide variation in cognitive function throughout day; communication decline; disorientation; lethargy; restlessness and agitation; altered sleep cycle; and dehydration, infection, delusions, and hallucinations. The Order Recap Report printed 2/28/19 documented orders for the following medications: a. Lorazepam (an antianxiety medication also known as Ativan) tablet 1 mg; give 1 tablet by mouth 2 times a day (BID) for anxiety; initiated 11/12/18 ended 12/4/18 b. Lorazepam tablet 1 mg; give 1 tablet by mouth 3 times a day (TID) for anxiety; initiated 12/4/18 ended 12/31/18 c. Ativan tablet 1 mg; give 1 mg by mouth 3 times a day related to anxiety disorder unspecified; initiated 1/1/19 d. Lorazepam tablet 1 mg; give 1 mg by mouth as needed for agitation until 11/29/18; initiated 11/20/18 ended 11/29/18 e. Ativan solution 2 mg/ml (milligrams/milliliter); inject 2 mg intramuscularly (IM) every 24 hours as needed (PRN) for agitation for 14 days; initiated 11/16/18 and ended 11/30/18. f. Ativan 2 mg/ml; inject 2 mg IM 1 time only for agitation/restlessness; initiated 11/26/18 g. Ativan 2 mg/ml; inject 2 mg IM 1 time only for increased anxiety for 1 day mix with Ativan initiated 12/7/18 h. Ativan tablet 1 mg; give 1 mg by mouth as needed for agitation/restlessness for 14 days, may administer 1 mg by mouth daily PRN; initiated 12/11/18 and ended 12/25/18. i. Haldol (an antipsychotic medication) solution; inject 2 mg IM every 24 hours as needed for	F 757		

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F 757	Continued From page 148 agitation for 14 days; initiated 11/16/18 and ended 11/30/18 j. Haldol solution 5 mg/ml; inject 2 mg IM 1 time only for agitation/restlessness for 1 day; initiated 11/26/18 k. Haldol solution 5 mg/ml; inject 2 mg IM 1 time only for increased behavior for 1 day mix with Ativan 2 mg; initiated 12/7/18 l. Quetiapine fumarate (an antipsychotic medication also known as Seroquel) 25 mg tablet; give 1 tablet by mouth 2 times a day related to schizoaffective disorder unspecified; initiated 11/12/18 ended 11/16/18 m. Quetiapine fumarate 25 mg tablet; give 1 tablet by mouth 3 times a day related to schizoaffective disorder unspecified; initiated 11/16/18 ended 11/19/18 n. Seroquel tablet; give 50 mg; give 1 tablet by mouth 2 times a day related to altered mental status unspecified; initiated 11/19/18 ended 11/21/18 o. Seroquel tablet; give 62.5 mg orally every morning and at bedtime related to schizoaffective disorder unspecified; initiated 11/21/18 ended 11/28/18 p. Seroquel tablet; give 75 mg orally every morning and at bedtime related to schizoaffective disorder unspecified; initiated 11/28/18 The Progress Notes dated 11/13/18 at 12:20 a.m. documented the resident admitted to the facility with no wandering or agitation noted during that shift. At 1:20 p.m. the notes documented the Resident #55 at the yard door attempting to get the door open with another resident. At 6:29 p.m. the notes documented the resident redirected several times from the doors at the end of the hall, alarm sounded, and he backed away from them laughing.	F 757		

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F 757	Continued From page 149 The Progress Notes dated 11/14/18 at 9:29 p.m. documented Resident #55 became increasingly more anxious since the beginning of the shift. The note recorded the resident sought exit, pulled on doors, and argued with staff because he wanted to leave. The entry documented the resident pulled on the nurse's arms and legs to try to get her to let him out. The nurse wrote as she stood at the (medication) cart charting, Resident #55 came up from behind, pressed his anterior body against her posterior body, trapped her in between him and the cart, grabbed her arms and rubbed them. The note recorded the nurse moved away from the resident and distracted him. The Progress Notes dated 11/16/18 at 1:33 p.m. documented the resident with increased behaviors in the afternoon and exit seeking all day. The note recorded the resident hit doors, tried to take the window apart so he could escape through it, thought the staff held him hostage, redirected without success, and very fixated on going home to see his mom. At 3:46 p.m. the notes documented a new verbal order for IM Haldol everyday as needed and IM Ativan as needed everyday with an end date of 14 days. At 4:39 p.m. the notes documented a new order to increase his Seroquel to 3 times a day. The Progress Notes dated 11/16/18 at 5:09 p.m. documented the resident noted to be anxious and paced the hallway. The entry recorded as a housekeeper opened the door go into the CCDI unit, the resident hurried through the double doors out into the hallway. Three staff members approached the resident to bring him back to the locked unit with the resident stating he had to get	F 757		

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out of there as he didn't belong locked up. The entry recorded staff assisted resident #25 outside to the fenced in courtyard where the resident repeatedly stated he was going to leave, made several attempts to pull on the gate to get out, and the resident redirected with conversation and calmed down. The entry documented after approximately 20 minutes outside the resident agreed to go back in and chatted for awhile. The note documented the resident remained calm the rest of this shift with no more attempts to leave the facility. The entry recorded the nurse talked with resident about his experience in the Air Force and his family which he seemed to enjoy talking about.

The Progress Notes dated 11/18/18 at 1:39 p.m. documented Resident #25 paced up and down hallway pushing on front door attempting to get out as well as pushing the numbers on the keypad. The entry recorded he required redirection to leave another resident's room and although visibly upset, able to be redirected to the hallway. The resident's family member redirected the resident out of their room 4 times in order to visit with their loved one. The entry documented the resident then went back to front door and attempted to push on it and when the nurse tried to redirect, he started to get loud telling the nurse to, shut up and cursed at her. The nurse attempted to redirect the resident back to his room as other residents present but he refused, Another nurse talked to him about calling his wife, walked him to the TV room to talk to him about his phone call, and engaged him in conversation. At 3:12 p.m. the notes documented the resident paced the halls, hit doors, packed his suitcase, and carried it around. The entry recorded staff attempted to redirect and distract with TV, food,

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fluids, cards, picture albums, conversation, and phoned his wife, but escalated and started to get physical. The note recorded the resident received as needed Ativan and he slowly started to calm down. At 8:01 p.m. the resident had behavior issues early in the shift, meds given at 7:00 p.m., and quietly watched TV with other residents.

The Progress Notes dated 11/19/18 at 4:17 p.m. documented a new order received to increase Seroquel to 50 mg by mouth 2 times a day.

The Progress Notes dated 11/20/18 at 12:57 p.m. documented the resident continued to exit seek related to wanted to see his mom and appeared very agitated with trying to explain what he needed. At 10:00 p.m. the notes documented the resident agitated, kicked the doors, and wandered around the unit with his personal belongings. The entry recorded staff tried redirection 2 times, offered drink, snack, and as needed Ativan given with positive effect.

The Progress Notes dated 11/21/18 at 4:10 p.m. documented the resident requested to call his wife at 10:40 a.m. with no answer. The notes recorded the resident became agitated, exhibited increased exiting attempts, and seen by the physician that day who increased the dosage of Seroquel. At 9:38 p.m. the notes documented the resident anxious following others around the unit. The notes documented the resident redirected but then would kick the bottom of doors. Staff offered the bathroom, fluids, and snacks without distraction or success so PRN medication given with success.

The Progress Notes dated 11/23/18 at 6:13 a.m.

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documented the resident attempted to leave the unit by sticking his foot in the door to prevent it from closing when a staff member exited. The entry recorded when 2 more staff redirected the resident, he pushed staff member when in between him and the door, the 3rd staff member able to distract just long enough to close door, after which the resident able to be distracted away.

The Progress Notes dated 11/26/19 at 11:20 a.m. documented a Plan of Care Note. The note recorded staff reported the resident on occasion had delusions, voiced he waited on his mom to come get him; had verbal behaviors as would yell/curse at staff; had physical behaviors as would hit, kick, garb at staff when agitated and could get handsy trying to rub female staff's arms, back. The note documented the resident wandered most days and would pack up his belongings carried in a suit case, pace the halls, pull/kick exit doors, set off door alarms, and stand by door waiting for someone to enter or exit.

The Progress Notes dated 11/26/18 at 12:20 p.m. documented staff paged for assistance to the CCDI at 11:15 p.m. The note recorded the resident forced his way past staff and stood outside the door with all his belongings stacked on a laundry basket and attempts to redirect him back into unit unsuccessful as he wanted to go home. The entry documented all staff members present walked with resident down the hall and could not redirect him from the emergency exit at end of east hall. Staff called his wife who reported she didn't think it did any good to speak to her. Staff informed his wife of the verbal order to administer IM Haldol and Ativan 1 time PRN. The entry recorded after speaking to the

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F 757	Continued From page 153 wife the resident de-escalated from attempting to exit from door and sat to talk. The entry documented the resident continued to be restless and slightly agitated refusing to return to the CCDI unit so the nurse administered Haldol 5 mg/ml, 1 time injection of 2 mg for agitation/restlessness with Ativan 2 mg/ml, 1 time injection of 2 mg for agitation/restlessness. The entry recorded the DON spoke with resident about IM medications and what they were for, the resident agreed to administration, assisted with removing his coat and long sleeve for medication, and both medications were administered as ordered. The note documented the resident remained in chair talking about feeling sad of not being able to go home and the selling of his home with his wife moving. The resident eventually agreed to return to his room. The entry noted medications were discussed while on the phone with the physician's office, recent increase to Seroquel, and would review medications with physician when on the premises that week. The Progress Notes dated 11/26/18 at 4:14 p.m. documented the resident slept until 3:30 p.m. then up packing clothes again but able to be redirected to put them back without behaviors. The Progress Notes dated 11/28/18 at 3:08 p.m. documented the resident developed increased anxiety in the afternoon wanting to leave the facility. The resident packed his clothes, took them to the entrance, stated he was leaving, and that made it very difficult for anyone entering or exiting the unit. The entry recorded IM dose of lorazepam given to help with anxiety and redirection provided by talking to the resident about his work in the Air Force. At 4:43 p.m. the notes recorded a new order from the physician to	F 757		

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F 757	Continued From page 154 increase Seroquel to 75 mg, 2 times a day. The Progress Notes dated 11/29/18 at 3:31 p.m. documented the resident anxious, wanted to leave the facility, and stood by the door the majority of the shift trying to get out whenever anyone entered or left the facility. The resident carried his clothes with him, stated he didn't understand why he couldn't leave, and attempted to push door open pressing the keypad to get out. The entry recorded the resident received a shot of Haldol earlier that seemed to distract the resident briefly but not for long. The entry documented the resident had shown no verbal or physical aggression but very persistent on getting out of the doors to leave with redirection very hard and ineffective that day. The Progress Notes dated 12/2/18 at 7:58 a.m. documented the resident walked up behind the nurse, swung a T-shirt over his head, struck the nurse in the eye, pulled it back and struck the writer a 2nd time before he stopped. The nurse documented the resident did not back up when asked and she had to escape from him. At 4:43 p.m. the notes documented the resident much calmer and conversational after a.m. meds. By noon, the resident paced, more anxious, and blocked the exit doors. At 12:07 a.m. the notes documented a fax received from the physician that ordered an increase in Ativan to 1 mg 3 times a day. The Progress Notes dated 12/6/18 at 10:05 p.m. documented the resident had a few exit seeking behaviors that night as he tried the front door and shook it. The notes recorded the 4:30 p.m. Ativan did not seem to have any effect on his anxiety or exit seeking behavior, and once	F 757		

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F 757	Continued From page 155 bedtime meds administered, the resident calmed and decided to go to bed with no more incidents of exit seeking. The Progress Notes dated 12/7/18 at 2:49 p.m. documented the CCDI nurse paged for assistance with the ADON (Assistant Director of Nursing) responding to find the resident on the floor, on his back with legs stretched out, empty coffee cup with spill around him. The entry recorded the resident very calm, not upset, and stated, I must have ran into the wrong one I guess. Resident #55 unable to voice details of what occurred, but the nurse witnessed another resident push Resident #55 from doorway, and Resident #55 fell backwards to ground landing on his buttock. The nurse documented assessment of a skin tear to Resident #55's right elbow and provided treatment of steri-strip in place. The Progress Notes dated 12/7/18 at 10:50 p.m., created by the MDS Coordinator, documented the resident ambulated in the hallway waving dollar bills and being extremely loud with Staff O, Registered Nurse (RN). Staff O informed Resident #55 others tried to sleep but the resident responded he, didn't give a damn, then walked up to the MDS Coordinator, and pushed her in the chest. Staff O got between the resident and the MDS Coordinator to which the resident responded, hey now stop that. The MDS Coordinator told the resident he shouldn't put his hands on anyone and Resident #55 responded he didn't do anything. Staff O ran to the East station to get assistance from Staff P, CNA, and Staff Q, RN. The MDS Coordinator went into the nurses office, closed the door, and Resident #55 pounded on the door and attempted to get in. Staff Q, Staff P, and Staff O arrived and Staff P	F 757		

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F 757	Continued From page 156 able to distract Resident #55 enough to get him down the hall. The MDS Coordinator called the physician to ask for an order of 2 mg Haldol, 2 mg Ativan IM injection for behaviors and Staff Q gave the injection. The MDS Coordinator documented she continued to give cares as Resident #55 did not have cognition intact enough to remember that he initiated aggression towards her. At 11:13 p.m. the notes documented the resident in and out of room after receiving Haldol and Ativan with 1 somewhat aggressive episode where he tried to read paper the RN going through but easily redirected. The Progress Notes dated 12/11/18 at 11:00 a.m., created by the ADON, documented discussed the resident's trend of behaviors and how they were continuing less in numbers and less in content. The entry recorded an order received for Ativan 1 mg by mouth PRN daily for 14 days and would re-evaluate resident's needs again at that time. The Progress Notes dated 12/14/18 at 12:19 a.m. documented exit seeking behavior occurred. At 4:15 p.m. the notes documented follow up for PRN Ativan use continued with the resident noted to have a slow staggering gait after breakfast but steady with ambulation the rest of shift. The entry recorded 1 episode of exit seeking behavior. Review of the clinical record revealed a lack of documentation of detailed analysis of behaviors for root cause prior to use of pharmalogical interventions. The clinical record did not reflect implementation of the care plan interventions as listed above.	F 757		

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F 757	Continued From page 157 On 2/28/19 at 11:30 a.m., the DON stated she knew they had done things for Resident #55's behaviors like having activities bring the resident out of the unit. The DON clarified that any assessment or analysis of behaviors, or follow up for care plan interventions, would be documented in the progress notes. The DON acknowledged the facility had no formal behavioral analysis as listed in the care plan.	F 757		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition	F 801		

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F 801	Continued From page 158 professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers,	F 801		

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F 801	Continued From page 159 meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interviews, the facility failed to ensure the facility's Dietary Service Manager had the required qualifications in the absence of a full-time dietitian. The facility reported a census of 67 residents. Findings include: During an interview 2/25/19 at 9:52 AM, the Dietary Manager (DM) reported he has been the dietary manager since 12/17. The DM reported he had taken a course with the Community College and had completed the Dietary Management course 12/17/18, but he had not taken the Dietary Manager Certification (CDM) examination. The DM reported the Dietician came to the facility one day a week. The DM provided a copy of his DM certificate received from the Community College 12/17/18. During an interview on 2/26/19 at 4:01 PM, the Administrator confirmed the DM did not have the CDM certification when hired 12/17. The Administrator confirmed the DM had recently completed the DM course and thought the DM was scheduled to take the certification exam soon. A document titled "Job Description - Food Service Supervisor" dated 12/27/17 revealed the Dietary Supervisor qualifications required completion of a	F 801		

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F 801	Continued From page 160 State Approved food service supervisor course. On 2/27/19 at 8:00 AM, the DM provided documentation of approval for him to take the CDM credentialing exam but he stated he still needed to set up an appointment to take the exam within 90 days.	F 801		
F 803 SS=B	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 803		

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F 803	Continued From page 161 Based on review of the planned menu, observation, staff interviews and facility record review, facility staff failed to follow the planned menu for residents on regular, mechanical soft and pureed texture diets. The facility identified a census of 67 residents. Findings include: The facility's Week 1 menu identified the following items as part of the planned menu for the lunch meal on 2/26/19 for residents with orders for general, mechanical soft and puree diets: Raspberry BBQ glazed ribs, Maple mashed sweet potatoes, sauteed green beans with bacon & red onions, a Flaky biscuit, margarine and vine ripened watermelon. Observation on 2/26/19 at 9:30 AM, revealed Staff A, cook, assigned to prepare the pureed texture items for the noon meal and stated he would puree 7 servings. Staff A pureed the ribs, green beans and watermelon but did not puree biscuits as ordered on the puree menu. Observation on 2/26/19 from 11:00 to 12:20 PM revealed Staff A served the meals to all of the residents but did serve any biscuits. On 2/26/19 at 12:31 PM, the Dietary Manager confirmed the biscuit were not served and stated he didn't catch that. The Dietary Manager confirmed biscuits were on the menu and he would expect them to be served. On 2/26/19 at 12:43 PM, Staff A, confirmed he forgot to puree the biscuits and forgot to serve them. Staff A stated he is aware the menu is to be followed.	F 803		

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F 803	Continued From page 162 The job description for Cook, revised 10/23/17, directed under Point #2 - Must be able to understand and able to prepare therapeutic diets - Follows written menus and recipes.	F 803		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that	F 838		

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F 838	Continued From page 163 may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interviews, the facility failed to develop a comprehensive facility wide assessment to include and analyze the CCDI (Chronic Confusion Dementing Illness) unit for acuity level of residents, staffing needs, and staff competency. Fourteen residents resided on the CCDI unit. The facility reported a total census of 67 residents.	F 838		

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F 838	Continued From page 164 Findings include: 1. The admission Minimum Data Set (MDS) assessment dated 11/2/18 for Resident #2 documented an admit date of 10/22/18. The MDS identified a BIMS score of 3 with sign/symptom of delirium with fluctuating presence of inattention; a score of 3 indicated severe memory and cognitive impairment. The MDS documented the resident exhibited physical and verbal behavioral symptoms directed toward others and wandering on 1 to 3 days of the 7-day look back period. The MDS recorded the resident's behaviors impacted others putting others at significant risk for physical injury and significantly disrupted care or the living environment. The MDS recorded he was independent with transfers, walking in the room and corridor, and locomotion on the unit. The MDS documented diagnoses that included Non-Alzheimer's dementia, depression, delirium due to known physiological condition, unspecified/uncomplicated nicotine dependence, other uncomplicated psychoactive substance abuse, and metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood). The care plan focus area dated 11/5/18 identified an elopement risk/wanderer with behaviors of exit seeking, kicking exit doors, pacing, and going into other residents' rooms related to increased agitation when he did not have cigarettes and could not go out to smoke when he wanted; he resided on the CCDI unit. The care plan focus area dated 11/5/18 identified a behavior deficits of physical and verbal behaviors towards others, hitting others, shoving a resident, increased	F 838		

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agitation related to smoking and the refrigerator , throwing items, pushing doors and breakage. The care plan identified Resident #2 had diagnoses of vascular dementia, delusional disorder, depression, metabolic encephalopathy, and had a long history of substance abuse with nicotine dependence.

The Progress Notes dated 12/7/18 at 3:01 p.m. documented the CCDI unit nurse paged to the unit and the ADON (Assistant DON) found another resident lying on the floor with spilled coffee around him and a skin tear. Resident # 2 made contact with the other resident, resulting in a fall. Resident # 2 said he wanted in to the other room to make a phone call and the other resident stood in the doorway so he asked him to move but he didn't move. Resident # 2 said he didn't push him, he moved him, and would never push another man. The entry documented Resident # 2 placed on 15 minute checks. At 3:06 p.m., another nurse documented Resident # 2 had approached the nurses station, shoved another resident at the doorway at the same time he told that resident to get out of his way as he wanted to call his sister.

The Progress Notes dated 12/28/18 at 2:42 p.m. documented a late entry for 12/22/18. The entry recorded a CNA reported after breakfast Resident # 2 walked past another resident and smacked them on the bottom. The entry documented the other resident swung at Resident # 2 and hit him in the left shoulder, staff separated both immediately and noted no injury.

The Progress Notes dated 12/29/18 at 2:50 a.m. documented Resident # 2 had 2 unpleasant interactions with Resident #24 about the TV. The

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entry recorded Resident # 2 as difficult to redirect.

The Progress Notes dated 12/30/18 at 4:14 a.m. documented Resident # 2 had 3 episodes of using abusive language towards Resident #24 early in the shift; the nurse intervened with limited success.

The Progress Notes dated 1/2/19 at 2:03 a.m. documented Resident # 2 had 1 episode with Resident #24 at snack time.

The late entry Progress Notes dated 1/2/19 at 8:14 a.m. documented Resident # 2 refused his meds and wanted to smoke. Resident # 2 pushed past the nurse cursing and stating, he could do whatever he wanted at the facility, could smoke whenever he wanted and staff couldn't stop him or tell him what to do. Resident # 2 went into the nurses office, threw a side table down the hall and grabbed his cigarettes and lighter. Staff I, CNA, took him out to smoke. Resident # 2 refused to return the lighter and stated he didn't mind going back to jail because the food better and he hadn't eaten in 3 days, and that he could do what he wanted because the state paid for him to stay at the facility. The nurse contacted the Administrator who informed staff the resident was no longer allowed to light his own cigarettes and staff must maintain possession of the lighter and keep the nursing office door closed at all times.

The Progress Notes dated 1/4/19 at 10:45 p.m., created by the MDS Coordinator, documented at approximately 8:15 p.m. she spoke with another staff member on the phone while Resident # 2 stood 2.5 feet behind her asking to go smoke in a loud voice. The MDS Coordinator informed

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F 838	Continued From page 167 Resident # 2 she was the only staff member in the unit and no one could take him outside. Resident # 2 yelled he wanted to go f***ing smoke and they better get staff back here to take me. The MDS Coordinator locked the medication cart, went into the nurses station, and shut the door. The MDS Coordinator documented she was not going to cater to Resident # 2's temper tantrum. The MDS Coordinator documented Resident # 2 ripped the computer from the wall plug, threw it down the hallway, and cleared the medication cart of every single item on it. The MDS Coordinator called 911 then a code red for help and a nurse from the west side of the facility arrived within a few minutes to find Resident # 2 standing up against the railing and within 2 more minutes, the police arrived. The MDS Coordinator informed the Administrator and then police and EMS (Emergency Medical Services) who escorted the resident from the premises. The Progress Notes dated 2/24/19 at 1:00 a.m. documented staff educated Resident # 2 after he jumped around in hallway in front of others yelling, Hi-Ya, and kicking his leg and waving his arms. Resident # 2 said he was just showing them his karate moves and repeated his actions in front of the nurse. They educated Resident # 2 on inappropriate behavior. At 12:57 p.m. Resident # 2 continued 15 with minute checks and he had been very demanding that day. Resident # 2 waved a paper in a female resident's face and antagonizing her. When staff attempted to redirect him, Resident # 2 was slow to respond and stared at that person in a defiant manner. Observation on 2/25/19 at 12:45 p.m. revealed Resident #2 walked up the hallway from the TV	F 838		

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F 838	Continued From page 168 room by the nurse's station passing Resident #47. A loud slap could be heard and Resident #47 yelled "Ouch; I'm tired of you hitting me". Resident #2 made eye contact with surveyor and quickly walked into room 20. Resident #47 turned and walked back down to the TV room. Another resident (#36) walked up the hall to the nurses station from the TV room at the same time and informed Staff K that Resident #2 just slapped him. The surveyor reported the slap on Resident #47's buttocks immediately to Staff J, CNA, and Staff K. Staff J called for management help in the unit immediately. 2. The MDS assessment dated 11/21/18 for Resident #55 recorded the resident exhibited behaviors of delusions and physical and verbal behavioral symptoms directed toward others on 1 to 3 days of the 7-day look back period. The MDS recorded the resident wandered on 4 to 6 days of the 7-day look back period. The MDS documented diagnoses that included Non-Alzheimer's dementia, schizophrenia, and unspecified altered mental status. The care plan focus area dated 11/14/18 identified the potential for an ADL (Activities of Daily Living) self-care deficit related to diagnoses of dementia with behavioral disturbances and schizoaffective disorder; the resident walked independently on the CCDI unit. The care plan focus area dated 11/14/18 identified an elopement risk/wanderer and would set off alarms on doors, exit seek, and pack up his belongings, kicking/pulling on doors, pacing, voices he was getting out of there related to diagnosis of dementia. The care plan focus area dated 11/15/18 identified a behavior deficit , he would make sexual comments, rub staff arms	F 838		

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F 838	Continued From page 169 and back, barricaded himself in room. The care plan directed staff to discuss the resident's behaviors (if reasonable), explain/reinforce why behavior inappropriate and or unacceptable to the resident, intervene as necessary, approach/speak in a calm manner, divert attention, remove from situation and provide a program of activities of interest and accommodates the resident's status. The Progress Notes dated 11/26/19 at 11:20 a.m. documented a Plan of Care Note. The note recorded staff reported the resident on occasion had delusions, voiced he waited on his mom to come get him, had verbal behaviors and would yell/curse at staff, had physical behaviors and would hit, kick, grab at staff when agitated and could get handsy trying to rub female staff's arms, back. The note documented the resident wandered most days and would pack up belongings carried in a suitcase, paced the halls, pulled/kicked on exit doors, sought exits, set off door alarms, and would stand by door waiting for someone to enter or exit. Review of the Facility Assessment revealed it did not contain any information related to the facility having a dedicated CCDI unit, any analysis of the acuity of residents, training of staff for dementia/behaviors or analysis of competency of staff to handle services of dementia. In an interview on 3/6/19 at 3:28 p.m., the Administrator confirmed the Facility Assessment lacked inclusion of the CCDI unit with analysis of the residents' acuity levels, staffing needs, and staffing competencies. The Administrator stated she used the template on file when she arrived to the facility when she completed the annual review of the assessment on 1/2/19.	F 838		

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 171 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to disinfect a glucose machine before and after testing one of three residents observered during blood sugar testings. Staff also failed to use a barrier for supplies that had been taken into a residents room. The facility reported a census of 67 residents. Finding include	F 880		

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F 880	Continued From page 172 During an observation on 02/26/19 at 7:55 a.m. Staff B, Licensed Practical nurse took the glucose machine from the top of the medication cart, placed it on a barrier tested a residents blood sugar, then replaced the glucose machine directly onto the medication cart. Staff A did not clean the glucose machine before or after use. During an observation on 02/26/19 at 10:44 a.m., Staff C Certified Medication Aide took a plastic carrier from the medication cart with glucose testing supplies into a residents room, and placed it directly on the residents dresser. During an interview on 2/26/19 at 10:55 a.m. Staff B, Certified Medication Aide reported that she would clean the glucose machine after each use. During an interview on 2/27/19 at 8:40 a.m. Staff D, Registered Nurse reported that she cleans the glucometer machine after using it each time that way she knows it's ready to go every time she goes to take a residents blood sugar. Staff D reported that they use the 2 minute wipes for disinfecting the glucose machines. The Glucometer Cleaning Policy without a date directed staff as follows; After using a glucometer for a patient, the glucometer shall be wiped for one minute using a "minute wipe" specifically designed for patient care equipment such as "microdot minute wipes:. According to manufacturer's recommendations, the surface (glucometer) must remain visible wet for one minute and allowed to air dry before using the glocometer for the next patient. .	F 880		

the building five days a week and is available to assist at any time. She averages about 25 hours per week in the kitchen and is under the guidance of our certified corporate dietitian who is available anytime and on the Carlisle campus 3 days per week.

Facility will ensure formal training has been completed prior to hire by requiring a copy of the candidates CDM license.

F803:

A mini in-service on following menus was initiated on 3/29/2019 and completed on 3/31/2019.

Audits while serving 3x/week until continued compliance.

Audits began 3/29/2019.

F838:

Facility assessment was reviewed.

Changes were on 4/1/2019 made to ensure it was a more comprehensive document.

The facility assessment now appropriately assesses the needs of the CCDI residents.

F880:

DON to provide staff education on proper process of blood sugar monitoring on 4/1/2019.

DON put out staff education on the importance of infection control on 4/4/2019.

Audits will be conducted 3x/week on blood sugar checks until staff in continued compliance.

Audits to being 4/1/2019.

headache; lethargy/fatigue; tremors; seizure activity; lung sounds/shortness of breath; edema; urine output; level of consciousness; sweating.

Weight parameters added to resident #25's MARs on 4/8/2019 per physicians' orders, weight will be taken post dialysis. If there has been an 8lb loss or gain from the previous dialysis appointment, the physician is to be notified.

Dialysis port monitoring located on resident TARs.

Contract with Fresenius Kidney Care Mercy Des Moines was received and signed by facility on 4/4/2019.

F725:
Two staff members will be scheduled in the CCDI Unit from 6am-8pm daily. In compliance as of 4/2/2019.

If behaviors are noted after 8pm, the "Behavior Escalation Plan" as outlined in Attachment #1 will be followed by facility staff. This includes immediately placing the resident on 1:1 supervision and immediately notifying the DON or ADON so a proper assessment can be made regarding the residents' specific behavior episode. Upon this assessment, the "Behavior Escalation Plan" will be followed as long as nursing management deems necessary.

F757:
An in-service was held on 3/26/2019 to educate staff on the importance of providing non-pharmacological interventions prior to medications and to ensure they are properly documenting these interventions.

Social Services and DON will begin reviewing all care plans regarding behaviors and proper interventions.

We will continue to monitor through a care plan log

Implementation start date: 4/5/2019

F801:
As of 3/15/2019 the facility no longer employs the uncertified dietary manager.

The facility is actively seeking a certified dietary manager.

The facilities' Social Services department head with over 5 years of dietary management experience in the Carlisle building is overseeing the department on a temporary basis. She is in

F657:
MDS coordinator will ensure all residents noted to be on antibiotics will have a care plan reflecting infection.

Antibiotics are discussed in morning nursing huddles, these huddles are run by the DON and as of 4/1/2019 are also attended by the MDS Coordinator.

Resident #34 has a list of interventions to ensure staff remains diligent and aware of acute respiratory changes, resident's care plan was reviewed and modified to provide additional guidance on 4/8/2019 (Attachment #4).

Staff educated on 4/8/2019 on identifying signs of respiratory distress.

The DON keeps an active running infection log.

Implementation Date: 3/31/2019

F689:
Two staff members will be schedule in the CCDI Unit from 6am- 8pm daily. Implemented: 4/2/2019

If behaviors are noted after 8pm, the "Behavior Escalation Plan" (Attachment #1) will be followed by staff. This includes immediately placing the resident on 1:1 supervision and notifying the DON or ADON so a proper assessment can be made regarding the residents' specific behavior episode. Upon this assessment, the "Behavior Escalation Plan" will be followed as long as necessary.

Emergency Discharged of resident #2 on 2/25/2019

Education provided to staff on 3/5/2019 regarding care cards and transfer status.

Disciplinary action was given to staff member S on 3/5/19 for improper transferring of resident #25 resulting in a fall with a fracture.

F698:
Vital signs added to the resident's MARs to be completed upon pre and post dialysis. DON will continue to monitor to ensure continued compliance. Compliance effective 4/1/2019.

Education provided to nurses on proper assessment to be completed in nurse's notes pre and post dialysis on 3/29/2019. This head to toe assessment and nursing note can include the following assessments depending on residents' condition at the time of assessment: complaints of nausea/vomiting; complaints of diarrhea: complaints of muscle cramps; complaints of pain or

Implemented 3/1/2019

F625:

An in-service was held for the nursing staff on 3/26/2019 with education on bed holds. Bed hold forms and discharge checklist packets with education about both were placed at each nurse's station on 3/13/2019.

Education was provided again to nursing staff on 4/1/2019.

After every hospital discharge the DON follows up with staff to ensure the forms have been properly delivered, this is included in the working DON tracking form that was implemented on 4/1/2019.

F640:

Facility no longer has a PRN MDS Coordinator. As of 4/1/2019, the MDS Coordinator is a full-time position. Currently, the Director of Nursing will communicate all discharges/admissions/change in status to the MDS Coordinator. Once the DON determines the MDS Coordinator is completely oriented, this task will belong to the MDS Coordinator.

Implementation Date for DON taking over communication of discharged/admissions/changes in status to the MDS Coordinator: 3/7/2019

Discharges/Admissions/Change in status are discussed in daily morning meetings. These meetings are attended by both the DON and the full time MDS Coordinator to ensure the information is being communicated.

F644:

All PASRRs will be reviewed and resubmitted by social services if resident is identified to need a new PASRR.

The admissions coordinator and social services will work together to monitor pharmacy recommendations and nursing charting for any changes in medication that could indicate a need for a new PASRR. Update in care plans if a level II is needed.

Resident #40 had his level II PASRR re-submitted on 3/19/2019

Residents #49,#37,#15 and# 52 have all had their level II PASRRs resubmitted as of 4/5/2019

Resident #2 was Emergency Involuntarily Discharged from the facility on 2/25/2019.

On 12/28/2018 disciplinary action was given to a staff member who failed to report a resident to resident contact on 12/22/2018.

Nursing staff was educated on the importance of proper reporting on 12/29/2018 and the education was presented to the nursing staff again on 4/1/2019.

Staffing ratios adjusted in the CCDI Unit, as of 4/2/2019. There will be two staff members will be scheduled from 6am-8pm daily.

If behaviors are noted in the CCDI unit, the "Behavior Escalation Plan" (Attachment #1) will be followed by facility staff. This includes immediately placing the resident on 1:1 supervision and immediately notifying the DON or ADON so a proper assessment can be made regarding the residents' specific behavior episode. Upon this assessment, the "Behavior Escalation Plan" will be followed as long as nursing management deems necessary, this plan includes a thorough plan to investigate and monitor disruptive behavioral issues.

If 1:1 supervision is not an adequate intervention to protect other residents, as indicated in the "Behavior Escalation Plan", the resident exhibiting the behaviors will be transferred or discharged to an appropriate level of care.

Nursing staff was presented with a flowchart on reporting on 4/9/2019 and instructed to follow the flowchart when a resident to resident contact occurs. When an incident occurs, staff has been educated to immediately notify the on-call nurse manager. The nurse manager will document the incident on the Incident Log and determine if it's reportable. If an incident is reportable, the on-call manger will notify the DON and/or Administrator immediately.

F622:
An in-service was held on 3/26/2019 educating nursing staff on proper information/documentation to provide when transferring a resident to the hospital.

Education and a discharge checklist were provided to staff on 3/13/2019 and again on 4/1/2019.

DON has a working document to track all hospital transfers. Effective 4/1/2019.

F623:
Business office manager will notify ombudsman monthly of resident transfers.

The form for the previous month will be sent within the first working week of the current month.

Business office manager will copy Administrator on the monthly resident transfer emails and keep an electronic file and a hard copy record of the sent documentation, including time stamped email.

This Plan of Correction constitutes the facilities written allegation of compliances for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

F600:
Carlisle Center for Wellness and Rehab (CCWR) submitted a mitigation plan on 2/27/2019, which was accepted by the department and abated effective the same date.

Resident #2 was Emergency Involuntary Discharged from the facility on 2/25/2019.

All staff was educated with written education "Strategies to De-escalate Aggressive Behaviors" prepared for the proper employee designation (ie. RN/LPN; CNA; Non-nursing staff) beginning 2/27/2019. This education has also been added to the new staff orientation beginning 2/27/2019.

Should a similar situation arise, staff will immediately implement the "Behavior Escalation Plan" as outlined in Attachment #1. Resident will immediately be places on 1:1 supervision and the Director of Nursing or Assistant Director of Nursing will determine the duration and if continuance with the Behavior Escalation Plan is necessary.

F609:
Resident #2 was Emergency Involuntary Discharged from the facility on 2/25/2019.

Nursing staff was given mini in-service. They were educated and signed off on the importance of reporting potential abuse on 4/5/2019.

Facility will include abuse reporting as part of our annual in-service rotation.

The on-call member of nursing management to be called if abuse suspected, on-call staff will have Incident Log (Attachment #2) in Call Book. The criteria for reporting, Chapter 50.11, has been placed in Call Book, on-call managers have been educated on reporting criteria on 4/9/2019. A flowchart for reporting (Attachment #3) is also in the Call Book. All incidents (reportable or not) will be recorded on Incident Log. If the member of management deems an incident reportable, the DON and/or Administrator will be notified immediately.

F610:
CCWR abated IJ on 2/27/2019.

Resident #2 was Emergency Involuntary Discharged from the facility on 2/25/2019.