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	345126	A. BUILDING _____ B. WING _____	C 05/06/2022

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F 000	INITIAL COMMENTS A compaint investigation was conducted from 5/4/2022 to 5/6/2022. Event ID# OHLL11. The following intakes were investigated: NC00187858 and NC00187869. One of the 8 complaint allegations was substantiated resulting in a deficiency. Past-noncompliance was identfied at: CFR 483.12 at tag F600 at a scope and severity (J) The tag F600 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 600 SS=J	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:	F 600		5/12/22

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

Electronically Signed | 05/12/2022

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F 600	Continued From page 1 Based on record review, observation, psychiatric Nurse Practitioner, staff, and resident interviews, the facility failed to protect Resident #1 from physical abuse by Resident #2 who had a history of resident and staff altercations. On 3/26/22 Resident #2, who was assessed, and care planned as a supervised smoker, was in the smoking area without supervision. She asked Resident #1 for a light for her cigarette and when he refused, she "attacked" him punching him in the face causing both residents to fall to the ground. Resident #2 continued hitting Resident #1 while both residents were on the ground. Resident #1 sustained 3 scratches to his face with bleeding and an abrasion to his left knee. This abuse affected 1 of 2 residents reviewed for resident-to-resident altercations. Findings included: Resident #2 was admitted on 7/27/17 with diagnoses including dementia and bipolar disorder. The Annual Minimum Data Set (MDS) dated 4/16/22 indicated Resident #2 was moderately impaired for cognition and was ambulatory. The MDS indicated Resident #2 was a smoker. Resident #2's active care plan as of 3/25/22 noted she was a supervised smoker per the smoking assessment. Interventions included: Resident is a supervised smoker; Inform and remind resident of location of smoking areas and times; and Maintain resident's smoking materials at nurses' station. The active care plan also indicated Resident #2 exhibited physical behaviors related to cognitive loss/dementia (i.e., will charge or try to hit staff if she is told no.	F 600	Past noncompliance: no plan of correction required.	

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Interventions included: Observe for signs of physical aggression, e.g. (for example), rigid body position, clenched fists, etc. If resident becomes combative or resistive, postpone care/activity and allow time for her to regain composure.

Resident #2's active psychiatric medications as of 3/25/22 included Seroquel (antipsychotic medication) 25 milligrams (mg) by mouth two times daily.

A review of the facility's active smoking policy as of 3/25/22 revealed supervised smokers were allowed to smoke at designated times. The door to the smoking area was unlocked from 7:00 AM to 11:00 PM. During those hours, a staff member was assigned to observe smokers and assist them with smoking safely.

A nursing note completed by Nurse Supervisor #1 dated 3/27/22 revealed an altercation with Resident #2 and Resident #1 on 3/26/22, resulting in 3 scratches to Resident #1's face and an abrasion to his left knee. Resident #1 refused Emergency Room evaluation.
A review of the 5-day report completed by the Director of Nursing on 4/1/22 noted on 3/26/22 around 4:30 PM Nurse Supervisor #1 was called to the smoking area by Nurse #1. Resident #1 was noted with scratch marks and blood on his face and an abrasion to his knee with complaints of knee pain. Resident #1 was asked if he wanted an ambulance to go to the hospital or have Emergency Medical Services (EMS) assess him and he refused. Resident #2 was taken to Nurse Supervisor #1's office. When asked what happened with Resident #1, Resident #2 stated, "he started some s**t with me, so I finished it." Resident #2 confirmed she put her hands on

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Resident #1. Resident #2 was immediately started on 1 to 1 (1:1) supervision. The investigation noted the facility Medical Director was notified on 3/26/22 of the altercation between the two residents and of Resident #1's complaint of knee pain. The physician ordered an x-ray of the knee.

A review of the x-ray report dated 3/26/22 of Resident #1's knee revealed only normal degenerative changes, no acute abnormality.

On 5/4/22 at 10:00 AM Resident #1 was interviewed. Resident #1 indicated he was sitting outside in the smoking area on 3/26/22 minding his own business when Resident #2 came outside and asked him for a light. Resident #1 indicated he told her no and "she just punched me. I fell to the ground, and we rolled around, and she was still punching me until I got her off me" and that was when Nurse Supervisor #1 and Nurse #1 came.

On 5/4/22 at 12:00 PM Nurse Supervisor #1 was interviewed and stated after the incident on 3/26/22, Resident #1 and Resident #2 were interviewed separately. She stated she asked Resident #2 what happened, and Resident #2 stated Resident #1 started "s**t with her, so she finished it". Resident #2 was asked if she put her hands on Resident #1 and she stated "yes." Nurse Supervisor #1 indicated while Resident #1 was being assessed and treated, Resident #2 was put on 1:1 supervision, the Psychiatric Service nurse practitioner was notified and Resident #2's antipsychotic medication was increased back to the original dosing. She explained that Resident #2 recently had a Gradual Dose Reduction (GDR) of her

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antipsychotic medication. Nurse Supervisor #1 stated Resident #1 was interviewed after he was given first aid for his injuries. (Resident #1 had refused an ambulance to go to the hospital and refused Emergency Medical Services to assess him.) She noted Resident #1 was alert and oriented to person, place, time, and situation. She reported that Resident #1 said, "she attacked me, I knew this was going to happen." Nurse Supervisor #1 revealed she did not assign a staff member to observe the smoking area on 3/26/22. She further revealed, "I didn't realize we needed someone to observe the smoking area at all times." She stated there were 8 or 9 Nursing Assistants (NAs) in the facility, and she would rather have people working the floor. She indicated Resident #1 and Resident #2 had not had a physical altercation prior to the one on 3/26/22, but she knew of two times those two residents had verbal altercations. Nurse Supervisor #1 noted the door to the smoking area was unlocked, and residents that do not smoke could go out there if they wanted. Nurse Supervisor #1 stated safe smokers and supervised smokers' assessments were in their electronic charts. Nurse Supervisor #1 reported she knew that Resident #2 was a supervised smoker.

In an interview on 5/5/22 at 3:30 PM, Nurse Supervisor #2 stated she knew Resident #2 to be verbally aggressive "most of the time" but had not seen physical behaviors from the resident.

On 5/5/22 at 4:00 PM, Nursing Assistant (NA) #1 stated Resident #2 was a supervised smoker because of her cognition. NA #1 stated, "she is very aggressive especially if she wants to do something, like smoke." NA #1 was not assigned

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to Resident #2 on 3/26/22 but had been assigned to her several times.

Resident #3, who was assessed as cognitively intact, was interviewed on 5/5/22 at 4:30 PM, and stated he had been threatened by Resident #2 with being hit with a metal chair. He could not state a date or time. He further stated that a few months ago Resident #2 had spit on him.

On 5/6/22 at 3:10 PM, the Social Worker stated Resident #2 did not like to be told no. She explained that when she was told no she would become aggressive, especially when it was about smoking. The Social Worker also indicated that some staff were better at re-directing Resident #2, because you needed to approach her in a way that was not demanding or negative.

A review of notes of a psychiatry telehealth visit with the Nurse Practitioner on 4/1/22 revealed the physical altercation with Resident #2 and Resident #1 on 3/26/22 was completely instigated by Resident #2. The note indicated Resident #2 was prescribed an antipsychotic medication and that she had a history of previous physical altercations and has had aggressive episodes toward staff.

In an interview with the psychiatric Nurse Practitioner (NP) on 5/5/22 at 4:30 PM, the NP stated she was called on 3/26/22 after the altercation between the two residents occurred. The NP stated she changed the Seroquel back to 50 mg by mouth at bedtime, which was the dose Resident #2 was getting prior to a gradual dose reduction on 3/11/22. The NP stated Resident #2 had always been outspoken and noted Resident #2 had a challenging life and the NP felt that was

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part of the reason Resident #2 was so aggressive.

On 5/4/22 at 4:45 PM in an interview, the Administrator stated Resident #2 was assessed to be a supervised smoker. The smoking assessment indicated Resident #2 was observed sharing smoking materials with other residents and that was why she was a supervised smoker. She was unable to explain why Nurse Supervisor #1 was unaware the facility protocol was to assign a staff member to the smoking area between the times of 7:00 AM and 11:00 PM.

The facility provided the following corrective action plan with a completion date of 3/28/22.

1. Resident #2 had a history of resident-to-resident altercations. She was involved in a resident-to-resident altercation on 3/26/22 with another resident (Resident #1), resulting in minor injuries to the other resident. Resident #2 was assessed to be a Supervised Smoker; she has a care planned history of going to smoking area and looking for cigarette butts and asking other residents for smoking materials. Facility had a plan in place to have all smoking activities supervised by staff, however, on the date of this event, the supervisor (Nurse Supervisor #1) failed to assign someone to the smoking area, and Resident #2 went to the smoking area where she got into a resident-to-resident altercation with a male resident (Resident #1). Staff responded to the event and an immediate investigation was initiated. Resident #1 received first-aid care for the scratches he sustained on his face and an x-ray to rule-out injury to his knee, which was bruised during the altercation. The police were

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notified and responded to the facility without additional action taken.

Resident #2 was placed on 1:1 and has continued 1:1 supervision since 03/26/22. Resident #2 had a Gradual Dose Reduction on 3/11/22 for her Seroquel (antipsychotic medication). Psychiatric Service provider notified and increased her Seroquel back to original dosing on 03/26/22. Social Service Director is actively working on finding alternative placement for resident that is appropriate for her level of care. The resident will not be transferred or discharged without the agreement of the responsible party.

2. All residents have the potential to be affected. Interviews were conducted with staff and residents to determine if there are any concerns with resident's behaviors. Interviews were conducted by nursing management and the Social Services Director commencing on 03/26/22 and completed on 03/28/22; no other issues were identified.

3. Education on Abuse Prevention and resident to resident altercations was initiated on 3/26/22 for all staff, including full time, part time, PRN (as needed) and Agency staff. No staff shall work without education provided; education was provided by the Clinical Management team. Weekend Supervisor was educated by the Center Nurse Executive to ensure that staff are scheduled for the Smoking Area for monitoring.

4. Nursing will monitor resident smoking areas for appropriate supervision from 7 am - 11 pm and will monitor Resident #2 1:1 daily to ensure compliance and safety for all; 1:1 monitoring

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continues for Resident #2. Results of these monitoring audits will be brought to the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. QAPI Committee Members Responsible: Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Infection Preventionist, Social Services Director and the Activity Director.

Onsite validation was completed on 5/6/22 through staff interviews, observation, and record review. Staff were interviewed to validate in-services completed on abuse intervention, reporting, notification, and action. In-services were also confirmed to be provided on resident-to-resident altercation intervention, reporting, notification, and action. Observation of 1:1 supervision for Resident #2 and a review of audits of 1:1 supervision verified 1:1 was implemented. Observation of the smoking area and review of audits of staff supervision of the smoking area validated supervision was implemented as indicated in the corrective action plan. Review of education conducted with the weekend supervisor (Nurse Supervisor #1) about assigning staff to observe smoking area verified education was completed. Review of residents audited for possible resident abuse and resident interviews verified no additional issues were identified. The facility's action plan was validated to be completed as of 3/28/22.