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F 000	INITIAL COMMENTS An onsite complaint investgation survey was conducted from 5/30/23 to 5/31/23. The following intakes were investigated NC00202670, NC 00201336, and NC00202033. Intake NC00202033 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity J. The tag F 600 constituted Substandard Quality of Care. Non-noncompliance began on 5/16/23. The facility came back in compliance effective 5/26/23. A Partial extended survey was conducted on 6/2/23. Therefore, the survey exit date was changed to 6/2/23.	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	F 600		

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

Electronically Signed | 06/07/2023

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F 600	Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, and staff interviews the facility failed to protect the rights of two residents (Resident # 5 and Resident # 6) to be free of abuse. Following a verbal altercation, Resident # 6, who was cognitively intact, reported feeling threatened by Resident # 5, who was cognitively impaired. Resident # 6 and Resident # 5 then became involved in a physical fight during which Resident # 6 held Resident # 5 down on his bed by Resident # 5's neck and hit him multiple times in the face. Resident # 5 sustained scratches to his neck and finger. This was for two of three sampled residents reviewed for abuse. The findings included: Record review revealed Resident # 5 was admitted to the facility on 3/7/22. Resident # 5's diagnoses in part included dementia, depression, diabetes, and history of right lower leg amputation and history of left foot amputation for which he used prosthetic devices. Resident # 5's annual Minimum Data Set assessment, dated 3/8/23, revealed Resident # 5 was severely cognitively impaired. He was coded as being independent in his locomotion around the unit on which he resided. Resident # 5 was not coded as having behavioral problems. Record review revealed Resident # 6 was admitted to the facility on 1/3/22. Resident # 6's diagnoses in part included cancer, chronic obstructive pulmonary disease, and a history of heart attack. Resident # 6's quarterly Minimum Data Set assessment, dated 5/17/23, coded	F 600	Past noncompliance: no plan of correction required.	

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Resident # 6 as cognitively intact. He was assessed to need oversight supervision for locomotion around the unit on which he resided. He was not assessed to have behavioral problems.

Review of Resident # 6 and Resident # 5's records revealed they shared a room together up until the date of 5/18/23.

On 5/18/23 at 10:19 PM Nurse # 1 made the following entry into Resident # 5's record. "Writer was attempting to give insulin. Resident stated 'No, I'm not taking that I just received that, get the (expletive) on.' Writer attempted to explain the type of insulin being given. Resident stated 'dumb (expletive) I'm not taking it.' Writer exited. Writer heard roommate state 'Stop talking to the nurses like that.' (Resident # 5) stated 'well if you don't like it come on over and do something about it.' (Resident # 5) then stated 'I'm sick of your mouth and theirs.' After that statement residents connected physically."

Review of the facility's investigative file regarding the 5/18/23 incident revealed the following written statement by Nurse # 1. "At around 8 PM writer was passing medication. Once I got to (Resident # 5's room) he allowed me to take his blood sugar. Insulin offered. Resident stated 'What the (expletive) are you giving me?' Writer explained what insulin it was, he then proceeded to say 'No I'm not taking that get the (expletive) on.' He again stated 'dumb (expletive) nurses I'm not taking that.' I then exited the room. I then started giving medication to (Resident #6). Once his medication was given, they proceeded to talk. Writer overheard (Resident # 6) state 'Stop talking to the nurses like that.' (Resident # 5)

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stated 'well if you don't like it come over and do something about it.' A few minutes later I could hear what sounded like hits landed. I walked in and noticed (Resident # 6) on top of (Resident # 5) with his left hand around his neck and the right hand punching him. (Resident # 5) did hit back. After a few minutes I was able to separate the two. (Resident # 5) was placed in TV room until police came into the facility."

According to Resident # 5's record and the facility's investigative file, Resident # 5 was moved to a private room and did not reside with Resident # 6 following the altercation.

On 5/18/23 at 10:16 AM Nurse # 3, who worked as the facility social worker, noted the following. On 5/18/23, she had talked to Resident # 5, who stated he did not recall anything about the altercation and did not know who Resident # 6 was. Resident # 5 also reported he did not recall talking to the police. He further reported to Nurse # 3 that "if everyone just leaves me alone everything will be fine." Nurse # 3 noted a referral was sent to for psychological services. Nurse # 3 noted she visited to check on Resident # 5 again on 5/22/23, 5/24/23, and 5/25/23. In Nurse # 3's 5/25/23 notation, she documented that Resident # 5 was "sick of being asked questions about the incident." He continued to deny he knew Resident # 6.

On 5/25/23 Resident # 5 was seen for a comprehensive psychotherapy assessment. Review of the therapist's report revealed Resident # 5 reported he did not recall any memory of an altercation. The psychotherapist further noted the following. He was alert to person and place, but not fully oriented to time or situation. He had

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cognitive decline. During the conversation with the therapist he would at times rock back and forth while sitting on his bed and crying. He answered some of the therapist's questions and then concluded with her by saying, 'I am through talking with you.' The therapist noted that his loss of independence and his environment were contributing to depression.

On 5/18/23 at 10:22 AM Nurse # 3 noted she also visited with Resident # 6 and spoke to him about the incident. Nurse # 3 documented that Resident # 6 reported the following to her. Resident # 5 was cursing at the staff, and he asked Resident # 5 to stop being ugly to the staff. Resident # 5 then told Resident # 6 to come over and make him stop. Words were exchanged between the two of them. Then Resident # 5 walked towards his (Resident #6's) bed and he (Resident # 6) felt endangered and stood up himself. Resident # 6 did not recall much following that. Nurse # 3 further noted that Resident # 6 was very soft spoken and appeared upset about the incident while stating, 'I don't want to get in trouble. He's (Resident # 5) mean to the staff.' Nurse # 3 concluded her notation by documenting that an emergency psychiatric referral was made for Resident # 6.

According to the facility's investigative file, Resident # 5 had sustained the following injuries: a small scratch to his neck, redness to both lateral sides of his neck , 3 small scratches to his left ring finger with some swelling. Resident # 6 had not sustained injuries.

Review of a police report noting the incident revealed the following information. The police officer had responded on 5/18/23 at 8:10 PM. The

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police officer noted he had spoken to Resident # 5 who stated he had gotten into a fight with Resident # 6 because "he was tired of hearing his mouth." The police officer also spoke to Resident # 6 and noted Resident # 6 reported Resident # 5 was being disrespectful to the nurses and he had told him to relax and let the nurses help him. Then Resident # 6 stated he had enough of Resident # 5's mouth and got into a fight with him. The officer noted Resident # 5 was bleeding from his neck and left pinky finger due to a scratch.

Nurse # 1 was interviewed on 5/31/23 at 4:25 PM and reported the following about the incident. Resident # 5 and Resident # 6 had no history of prior altercations of which she was aware. Resident # 5 could at times curse at staff, but not at residents. Resident # 6 had no history of aggressive behavior. Both the residents had been sitting on their own beds when she left the room on the night of the incident. After she left the room, she did hear them continue to talk from the hallway, but Resident # 6 used a rollator walker to move around and at times needed oxygen. Resident # 5 used prosthetic devices. She thought it "was just talk" between them. Then she heard a noise as if someone was hitting someone. She went immediately into the room. When she entered Resident # 6 was not physically on top of Resident # 5. Rather, Resident # 6 was standing over the top of Resident # 5 while Resident # 5 was in his bed. Resident # 6 was holding Resident # 5 down with his left hand. Resident # 6 had done this by cupping his left hand around Resident # 5's neck. It was clear to Nurse # 1 that Resident # 6 was not trying to strangle Resident # 5 but had positioned his left hand to hold him down. She

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(Nurse # 1) witnessed Resident # 6 use his right hand to punch Resident # 5 on the left side of Resident # 5's face. Resident # 6 did this about four times. Resident # 5 was also hitting back. She (Nurse # 1) witnessed Resident # 5 hitting Resident # 6 in the torso about two times. She yelled at them to stop, and it took about one minute and she was able to get them to stop. They were separated and the police were called. The police tried to ascertain who had hit who first, but could not determine that. At the time of the police arrival, Resident # 5 wanted to continue fighting. Following the altercation, Resident # 5 had some scratches to his finger and neck, with a "little" blood from his finger scratch. Resident # 6 had no injuries. According to the nurse, there was nothing that signified to her that the incident would have occurred before it actually did.

Nurse # 2 was interviewed on 5/31/23 at 12:30 PM. Nurse # 2 had routinely cared for both Resident # 5 and Resident # 6 prior to the incident and was familiar with them. She reported the two residents had no history of altercations prior to the incident of 5/18/23.

Resident # 6 was interviewed on 5/31/23 at 1:00 PM and again at 4:15 PM. Resident # 6 reported the following. On the night of the incident, Resident # 5 was cursing the nurses and he (Resident # 6) asked him to stop. Then Resident # 5 came over to his (Resident # 6's) side of the room and threatened him. Resident # 5 hit him first. He (Resident # 6) then went to Resident # 5's side of the room and held him on the bed and hit him. They had never had an altercation before that date.

Nurse # 3 was interviewed on 5/31/23 at 1:15 PM

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and reported the following. She was employed as the facility social worker. There had been no altercations between Resident # 5 and Resident # 6 prior to the incident. They were immediately separated, and psychological referrals were placed for both residents. Resident # 5 reported he had had no recall of the incident.

On 5/31/23 at 3:45 PM the Administrator, Director of Nursing (DON) and facility corporate Nurse Consultant were interviewed. They reported the following. They had investigated the incident and found no evidence the altercation could have been anticipated by their staff. Immediately following the incident, the police and Director of Nursing were called. The DON came to the facility the night of the incident to assure safety for Residents # 5, Resident # 6, and other residents. Resident # 5 was placed in a private room where he currently remained. The facility completed a review of incident reports to assure there were no other residents at risk for altercations that could lead to abuse. They talked to residents to assure compatibility between roommates. They also completed education training for their staff regarding abuse and dealing with challenging behaviors in residents. They had a system in place to monitor for future occurrences by discussing clinical needs in daily meetings, reviewing grievance reports, and monitoring clinical records for behavioral issues. They had reviewed the care plans and updated as needed.

On 5/31/23 at 5:55 PM the Administrator was notified of immediate jeopardy. The Administrator presented the following corrective action plan.

Date of Incident was 5/18/2023. Residents

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involved were Resident #5 in A Bed and Resident #6 in B Bed. Resident #5 has a Brief Interview for Mental Status (BIMS) of 7 and Resident #6 has a BIMs of 15. There were no staff involved.

Initial Report
Why Investigation Was Needed: Resident on Resident Altercation reported by staff. Resident 5 obtained scratches from altercation with roommate Resident #6. A 24 hour report was submitted. The police were notified on 5/18/2023 and came out to interview Residents #5 and #6. There were no employees involved. Notifications to family and physician were made for both Residents #5 and #6. Skin assessments by assigned nurse were completed for Residents #5 and #6 on 5/18/2023.
First aide was rendered as follows: assigned nurse cleansed scratches for Resident #5 with normal saline, applied with an antibiotic ointment and left opened to air. Head to toe assessments were completed for Residents #5 and #6. Both residents were assessed for pain and signs/symptoms of injuries with no other signs or symptoms of injuries noted.

Final Investigation
The following documents were completed: Witness statements, audits education, quality assurance. The timeline of events is as follows: At 8:50pm Residents #5 and #6 were separated immediately and Resident #5 was moved to another hall. Body audits were completed on Residents #5 and #6 and both residents were assessed for injuries. Police were called and interviewed Residents #5 and #6. Physician and Responsible Parties were notified for both Residents #5 and #6. Adult Protective Services was notified of incident.

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The root cause of the event was: Resident to resident altercation due to both residents having poor impulse control. The root cause analysis statement is as follows: Resident to resident altercation is related to unanticipated poor impulse control.

Plan for Correcting specific area of concern identified, including the process that led to the concern:
Corrective action for resident involved: On 5/18/2023 the assigned nurses assessed the residents for any noted change in condition or signs/symptoms of injuries. Residents were immediately separated and Resident #5 was moved to another room on another hallway. Both residents were monitored by floor nurses and nurse aides assigned to respective halls (200 and 500) for any further behaviors or signs/symptoms of injuries. Resident #5 sustained some scratches on his left hand. Root cause of injury was resident to resident altercation related to poor impulse control. Resident #5 does not currently have a roommate. Resident #6 does have a roommate. Interventions to address root cause of poor impulse control and to prevent further incidents are as follows: Both Resident #5 and Resident #6 were referred for psychological evaluations. Evaluation has been completed on Resident #5 on 5/ 25 /2023. Resident #6 has been referred for psych services but was out of the building at the time psych services visited on 5/25/23 and will be seen on their next visit.

Corrective action for potentially impacted residents: On 5/19/2023 the Director of Nursing audited incident reports for the last 14 days for any incidents of resident altercations with none

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found. On 5/19/2023 the social worker interviewed alert and oriented residents on the 200 Hall with no room compatibility issues identified.

Systemic changes: On 5/18/2023 the Director of Nursing and Assistant Director of Nursing began an in-service of all staff (including agency) on Resident to Resident Abuse and Handling Challenging Behaviors. As of 5/26/2023, 100% of staff have attended the in-service. The Director of Nursing will ensure that any of the above mentioned staff who do not complete the in-service by 5/26/2023 will not be allowed to work until the training is completed.

Quality Assurance: Quality assurance monitoring will be completed by the Administrator/Director of Nursing on an ongoing basis utilizing facility processes related to the Daily Clinical Review Process for change in condition, the Daily Standup Meeting with the interdisciplinary team, which includes a review of incident reports and applicable interventions; an ongoing review of grievances and a monthly review of Resident Council Minutes. The Daily Clinical Review is separate and distinct from the Daily Standup Meeting. Daily Clinical Review process for a change in condition is: Review of the Real Time Report, the 24 hour report from the electronic health record system, search of key words by clinical staff, and review of staff 24 hour reports collected from clinical floor staff. (Key word search is the process of looking for words anywhere in the record utilizing the search engine). The interdisciplinary team members include: Administrator, Director of Nursing, Minimum Data Set Coordinator, Activities Director, Assistant Director of Nursing, Social

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Worker, Dietary Manager, and Rehab Director. The Social worker will complete ongoing monitoring through interviews of 25 alert and oriented residents on various halls weekly x 2 for any concerns with roommate compatibility. Reports will be presented to the weekly QA Committee by the Administrator or Director of Nursing to ensure corrective action is initiated as appropriate. The Administrator and Director of Nursing are responsible for this plan of correction. Compliance will be monitored and ongoing auditing reviewed at the weekly QA meeting. The weekly QA meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Rehab Director, Health Information Manager, and Dietary Manager.

Corrective Action Completion Date: 5/26/2023

On 5/31/23 the facility's plan of correction was validated by the following.

Resident # 5 was observed residing in a private room on 5/30/23 at 11:05 AM. The resident appeared without any signs of injury and was able to report he had no complaints about care and treatment.

Resident # 6's care plan was updated on 5/19/23 to reflect he had the potential for physical behaviors related to poor impulse control. Multiple interventions were listed on Resident # 6's care plan which included but were not limited to monitoring his behavior and if he became agitated then staff were to intervene before things escalated.

The facility presented documented evidence of education for their staff regarding abuse and

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F 600	Continued From page 12 dealing with residents who displayed challenging behavior. Staff interviews were conducted on 5/31/23 on multiple units which validated education had been provided for staff. Staff also reported in the interviews that they were no residents they felt displayed behaviors that might endanger other residents or place other residents at risk for abuse. On 5/31/23 the facility presented evidence they had audited their incident reports to assure other residents were not in altercations that could lead to abuse. This had been done on 5/19/23. On 5/31/23, the facility's correction date of 5/26/23 was validated.	F 600		