STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065246	A. BUILDING _____ B. WING _____	09/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAUREL MANOR CARE CENTER, INC	920 S CHELTON RD COLORADO SPRINGS, CO 80910

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to prevent abuse for two (#1, and #3) out of six sample residents. Specifically, the facility failed to: -Protect Resident #5 from physical abuse by Resident #1 who had a history of [REDACTED].#4 from physical abuse by Resident #3 who had a history of [REDACTED]. Cross-reference to F744 (Treatment/Services for Dementia), the facility failed to implement person-centered care planned interventions for residents with dementia to prevent an altercation between Residents #1 and #5 and Residents #3 and #4. Findings include: I. Facility policy The Resident/Client/Participant Protection/Freedom From Abuse, Neglect and Misappropriation Policy and Procedure, last revised 12/19, was provided by the nursing home administrator (NHA) via email on 9/8/2020. It read in pertinent part: -Resident/Client/Participant Assessment: The population of the facility/service includes individuals who meet the criteria for skilled care under the Medicaid and Medicare guidelines as well as specialty programs including short term rehabilitation, post-acute care, dementia care, ventilation program and transitional care. Every resident/client/participant is unique and may be subject to maltreatment based on a variety of circumstances, including facility/service physical plant, environment, the resident/client/participant's health, behavior or cognitive level. -Population (See Specific Facility/Service Prevention Plan): a. The facility/service's population presents the following factors, (May include, but not limited to) which could result in maltreatment of [REDACTED]. behaviors, resident/client/participants with self-injurious behaviors, socially inappropriate behaviors, verbal outbursts, resident/client/participants with communication disorders, those who are nonverbal and those that require heavy care and/or are totally dependent on staff. -Protection: a. Immediately upon receiving a report, the ED (executive director), DON (director of nursing), Social services or designee, and delegated IDT (interdisciplinary team) members will coordinate delivery of appropriate medical and/or psychological care and attention. Ensuring safety and well-being for the vulnerable adult is of utmost priority. Safety, security and support of the resident/client/participant, their roommate, if applicable and other resident/client/participants with the potential to be affected will be provided. This should include as appropriate: Remove resident/client/participant/patient from situation. Examine and interview the resident/client/participant immediately to ensure there is no injury. Restrict visitors as appropriate (particularly an alleged perpetrator or cohort). Notification of law enforcement and/or State Agency, Crisis Response, Poison Control. Hospital admission for safety monitoring and adequate care. A medical, evidentiary, or sexual assault exam should be completed as soon as possible, as appropriate. Consider room change or roommate change. II. Altercation Resident #1 and Resident #5 A physical altercation took place between Resident #1 and #5 on 8/4/2020 where as Resident #1 kicked Resident #5 in the shin, however this was not witnessed. Resident #5 yelled out He kicked me and continued to yell at Resident #1 that he had stolen something of hers. Licensed practical nurse (LPN) #1 attended to the altercation and moved Resident #5 away from Resident #1. LPN #1 documented in her witness statement that the altercation took place in the lobby of the facility. She reported the incident to registered nurse (RN) #1 who was the charge nurse. The RN did not complete an assessment of Resident #5 who was kicked by Resident #1 until after Resident #5 had blood on her shin and the LPN notified the RN again. The RN treated the skin tear to Resident #5's shin however did not document the incident or the treatment. The investigation revealed that the RN did not report the incident or develop the investigation report so it was not reported or investigated by the facility until 8/17/2020 when the skin tear treatment was discovered during a routine skin assessment. During the investigation the facility interviewed the RN to understand the reason for not acting upon the incident, but the RN did not feel as though she did anything wrong and felt she had made the appropropriate notifications, however the facility was not able to find the notifications the RN made. The RN and LPN were interviewed by the police to determine if criminal action should be taken but since the act was not intentional, no criminal charges were filed. The facility fired the RN and reported her to the licensure agency. The IDT determined the cause of the altercation was due to the resident's reaction to perceived violations into his personal space. The facility completed the investigation and notifications by 8/20/2020. On 8/20/2020 the facility conducted staff training with all employees about the reporting and acting upon allegations of abuse. The training consisted of identifying abuse situations, reporting, documenting and acting on allegations of abuse. It included the meaning of being a First Responder and the legal obligations associated with not reporting and acting timely to allegations of abuse. A. Resident #1's status Resident #1, age 71, admitted on [DATE]. According to the September 2020 computerized physician order [REDACTED]. The 7/28/2020 minimum data set (MDS) assessment revealed the resident had short and long-term memory problems. Resident #1 had severely impaired cognitive skills for daily decision-making. The resident experienced inattention, which fluctuated in severity and disorganized thinking continuously without fluctuation. Resident #1 was rarely understood. The resident had physical and verbal behaviors. Resident #1 required supervision to limited assistance of one person with activities of daily living (ADL). B. Resident #5's status Resident #5, older than 89 was admitted on [DATE] and discharged on [DATE]. According to the CPO [DIAGNOSES REDACTED]. The 6/26/2020 MDS assessment revealed the resident was cognitively impaired with a BIMS score of six out of 15. She required extensive two-person assistance with ADLs. The resident wandered; however, she did not exhibit behaviors or resist care. C. Staff interviews The director of nursing (DON) was interviewed on 9/9/2020 at 9:30 a.m. She said the resident did not have a history of being aggressive instead he struggled to understand. She said it would take a while for the staff to help navigate his space because he had to be guided with hands. He was in advanced stages of dementia so he did not understand others and his environment. She said in this incident with Resident #5, Resident #5 approached Resident #1 in the chair. The incident was not witnessed and since he was the only around when Resident #5 yelled at him about being hurt, it was assumed he was involved. She said he got frustrated if someone was sitting in his chair and he had a specific chair that he sat in daily. She said in the past if anyone sat in his chair he would pace in front of them until they moved. He did not get aggressive. She said he had a favorite chair in the dining room as well. She said the staff knew to keep residents out of his chair. She said since this incident Resident #1 got an illness and was moved to another area of the building for treatment so the residents were kept away from each other. III. Altercation between Resident #3 and Resident #4 A. Altercations 1.7/16/2020 On 7/16/2020 a resident-to-resident altercation occurred when Resident #3 went into the wrong room and held another resident's wrist, no injury. The 7/17/2020 IDT/Fall Team First Post Investigative Review read, The interdisciplinary/fall team reviewed the Individual to Individual Altercation incident and after reviewing the investigation noted the root cause to be Resident thought that another resident was in his room/bed and was attempting to pull this other resident out of the bed by the wrist. Resident just had his atorvastatin discontinued and recent changes were made to [MEDICATION NAME]. Will reach out to (physician name) for further review and suggestions/recommendations. The 7/23/2020 IDT Final Post Review Follow Up (SNF) read, The interdisciplinary team reviewed the Individual to Individual

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Altercation incident and determined the effectiveness of the interventions put into place are IDT recommending for resident to have a mental health evaluation in patient center, waiting for acceptance. 2. 8/17/2020 On 8/17/2020 a resident-to-resident altercation occurred between Residents #3 and #4 where as Resident #3 pushed Resident #4 to the ground. The investigation revealed the incident was unwitnessed and the nurse found Resident #4 on the ground and Resident #3 standing nearby, saying that he pushed him. The IDT implemented every 15 minute checks on Resident #3. The 8/20/2020 IDT/Fall Team First Post Investigative Review read, The interdisciplinary/fall team reviewed the Individual to Individual Altercation incident and after reviewing the investigation noted the root cause to be Resident was attempting to enter another resident's room. Residents separated. 3. 9/4/2020 On 9/4/2020 there was a resident-to-resident altercation that took place between Residents #3 and #4. Resident #3 used a cup to hit Resident #4 in the head. The investigation revealed CNA #2's witness statement read that she heard Resident #4 crying out and saw Resident #3 hitting him in the head with a plastic cup. She pulled Resident #4 out of the way. CNA #3's witness statement read that she saw Resident #3 kicking and hitting with a cup as Resident #4 yelled out. The determination by the interdisciplinary team (IDT) was that the resident escalated into aggressive behavior because of feeling agitated by the 1:1 person assigned to the resident after the last incident. The determination by the IDT was to implement an activity person on the unit during awake times of Resident #3. The activity person did not cause stress for the resident since the person was usually on the unit to provide interaction with the residents. B. Resident #3's status Resident #3, age 76, admitted on [DATE]. According to the CPOs [DIAGNOSES REDACTED]. The 6/23/2020 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. Resident #3 experienced physical and verbal behavioral symptoms towards others. He required supervision to extensive assistance of one person with ADLs. C. Resident #4's status Resident #4, age 89, admitted on [DATE]. According to the September 2020 CPOs [DIAGNOSES REDACTED]. The 6/2/2020 MDS assessment revealed that Resident #4 was rarely understood. The resident experienced physical behavioral symptoms directed towards others daily. He rejected evaluation or care. He required supervision to extensive assistance of two persons with ADLs. D. Staff interviews The director of nursing (DON) was interviewed on 9/9/2020 at 11:39 a.m. She said that the interdisciplinary team (IDT) reviewed the investigations and determined cause in order to implement interventions. She said the facility conducted another review a few days later for effectiveness of the implemented interventions. She said another week or two later they did a final review of the interventions. She said the reviews were documented under the assessments tab in the medical record. The DON said that Resident #3 failed 1:1 so they implemented after the 9/4/2020 event an activity assistant on the unit assigned to him during his waking hours. He felt threatened by having a person assigned to him however the activity assistant was usually on the unit so it was not alarming to him and he had accepted it so far. The DON said that after the 9/1/2020 altercation Resident #3's [MEDICAL CONDITION] medications were adjusted. The DON said that since the facility announced it was closing and it had a COVID-19 outbreak around the same time so they lost numerous staff. She said there were struggles in the past with staffing shortages but currently the resident census was 17 and they had two staff members per unit, four units. She said that she felt some of the reasons for the altercations taking place prior to August were due to staff shortages.
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to provide dementia treatment and services to maintain their highest practicable physical, mental, and psychosocial well-being for two (#1 and #4) out of six sample residents. Specifically, the facility failed to: -Implement care planned interventions to prevent Resident #1's poor coping ability when other residents sat in his chair resulting in a physical altercation which resulted in Resident #1 kicking and causing a skin tear to another resident; and, -Implement care planned interventions to prevent Resident #3's poor coping ability with perceived threats resulting in a physical altercation which resulted in Resident #3 becoming physically aggressive with other residents. Findings include: I. Facility policy and procedure The Guidelines for Memory Support Programs and Services policy, revised February 2015, was provided by the director of nursing (DON) via email on 9/9/2020. It documented in pertinent part, -The memory support program/services operates under a person-centered model, with emphasis on the whole person. The model recognizes that all persons have physical, social, emotional, intellectual, occupational and spiritual needs, regardless of their level of cognitive function. The memory support program/services will meet the needs of persons with dementia in a safe, nurturing environment in which the program is determined by the needs of residents. Programming is flexible, responsive to meeting changing needs. Staff are instructed on the philosophy of carte the shapes policies and procedures. -Caregivers may struggle with interpreting the actions of the disoriented individual. The focus then turns to stopping the behaviors rather than determining what is causing the action. The validation method teaches caregivers practical ways to change the way they communicate with those in their care, allowing for a deeper, more meaningful level of connection. The staff are proactive vs. reactive. The individual with Alzheimer's more likely feels heard, their anxiety decreases and the behaviors decline. II. Facility census and condition The 9/8/2020 Census and Conditions form read that the resident census was 17 and 17 residents had a [DIAGNOSES REDACTED]. The facility had a secured unit with eight residents. III. Resident #1 A. Resident status Resident #1, age 71, admitted on [DATE]. According to the September 2020 computerized physician order [REDACTED]. The 7/28/2020 minimum data set (MDS) assessment revealed the resident had short and long-term memory problems. Resident #1 had severely impaired cognitive skills for daily decision-making. The resident experienced inattention, which fluctuated in severity and disorganized thinking continuously without fluctuation. Resident #1 was rarely understood. The resident had physical and verbal behaviors. Resident #1 required supervision to limited assistance of one person with activities of daily living. B. Care plans The dementia care plan last revised on 7/6/2020 read that the resident had a [DIAGNOSES REDACTED]. He could become threatened when other residents' entered his personal space. He also had a compulsive behavior of picking up trash and tiny pieces of paper off the carpets. He would become distressed if this compulsion was interrupted or discouraged. Since COVID-19 precautions, (resident's name) has had increased agitation, anxiety and confusion due to not understanding the changes in his environment. [MEDICATION NAME] (antidepressant) was increased and this seemed to help however he has begun urinating/defecating in his bathroom sink and had an episode of drinking hand sanitizer. Interventions included having the resident write down information and have staff assist him to write reminders for things such as dining schedule, bath schedule etc. Ensure he can read it. Communicate with the resident at eye level when able. Establish a daily routine with the resident. Explain each activity/care procedure to the resident prior to beginning it. Give the resident simple choices that would not be overwhelming. Give the resident two choices when presenting decisions. Provide opportunity for uninterrupted sleep. The communication care plan last revised on 7/6/2020 read that the resident had adequate hearing ability and was able to make his needs known, however due to his cognitive status he was not always able to understand how to convey his needs. Staff needed to anticipate his needs. The resident's speech was slightly slurred due to edentulousness and had some of his tongue removed due [MEDICAL CONDITION]. The resident was shy and did not initiate conversations but would answer and nod greetings. Interventions included greeting the resident with friendly disposition. Staff to be aware of his surroundings. The resident was shy due to not having teeth and a lisp. Include the resident in group conversations. C. Progress notes and behavior documentation The 4/14/2020 nurses note read, Monthly summary: Resident has remained stable the past 30 days: Requires verbal cues to dress, change clothes and perform personal care: feeds self after set up remains on a reg/puree diet,tolerates medications, OCD ([MEDICAL CONDITION]) remains active with behaviors occurring if he feels his space is being violated. VS (vital signs) are WNL (within normal limits) for this resident, no ? (complaint of) or s/s (signs and symptoms) of pain are noted and no acute distress is noted. The 4/22/2020 Social Services General Notes (SSGN) read, Resident suspected to be involved in resident v (versus) resident altercation with injury on 4/4 (2020). Another resident was in the lobby with this resident and reported to staff that he kicked her in the shin. No other residents' were present. There was a visible injury; skin tear that had to be treated. Notifications and occurrence reporting done. This resident has had an escalation in anxious and paranoid behaviors since the facility began quarantine. Increased pacing, increased disorientation, confusion, frigidity and not being able to follow 1 (one) step commands. Documented history of striking out at other residents that he feels have intruded on his personal space which is suspected to have preceded the aggression in the 4/4 incident. The 4/24/2020 nurse note read, while dispensing a.m. meds this shift the 100/200 hall CNA (certified nurse aide) came and reported to me that this resident had a paper towel cleaning out the inside of the toilet bowl while b/m (bowel movement) was present, when she attempted to redirect his behavior she stated he became angry and

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F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) refused to stop, attempted to get resident to wash his hands but he stated no and became verbally combative, this nurse also attempted to get resident to wash his hands and was met with the same results. The 6/14/2020 nurse note read, Call from resident's POA (power of attorney) nephew, (name of nephew), responding to voice mail left regarding resident consuming hand sanitizer. Author reviewed notes with (nephey name), verified Poison Control was contacted and advice followed. Assured (nephew) that resident is stable now and in no distress; staff will continue to monitor closely and the author will notify (nephew) if changes occur today. The 6/23/2020 nurse note read, Resident urinated and defecated in the sink again. Resident's roommate is unable to wash his hands or brush his teeth due to this. Signs were posted in the resident's room to guide him to the bathroom and toilet. The 7/25/19 Social Services General Notes (SSGN) read, SS had discussion w/ (with) this resident guardian (nephew) today. Discussed current interventions in place after the last resident-to-resident altercation. Guardian indicated that he would like the resident to be on something stronger for his behaviors and indicated dissatisfaction w/current psych ([MEDICAL CONDITION]) med (medication) regimen. SS (social service) discussed this concern to be addressed by a psychiatrist on the next visit. The resident is expected to see the psychiatrist at the next NF (nursing facility) visit. The 7/31/2020 nurse noteread in pertinent part, Patient ambulates up and down the unit throughout the entire shift. D. Physician documentation The 4/25/2020 Medical Professional Visit Note read, Late entry: Received message from Nursing on 4/21/2020, re: this resident's increased agitation. His progress notes were reviewed and no significant behaviors have been documented for the past few weeks. When the unit was called, the nurse reporting his behaviors had left for the day. Charge nurse was only aware of an incident a few weeks ago, so no orders were written. Received message from SSD who clarified and elaborated upon his recent behaviors. He seems to thrive on routines, such as sitting in the day room and watching TV (television). With Covid-19 precautions, his routine has been seriously disrupted and any attempts to redirect him are not well received. He is also unaware as to why he is being told he is unable to continue some parts of his routine, as he seems not to appreciate that there is a pandemic. Given his increased stress levels, which are contributing to him becoming more easily agitated, and resistant to redirection, [MEDICATION NAME] was increased from 25 mg (milligrams) TID (three times a day) to 50 mg a.m., 25 mg p.m. and 50 mg evening. He has responded to [MEDICATION NAME] at low doses for the past year, but has required an increased dosage in recent weeks. E. Resident altercation The resident had been involved in at least one previous resident-to-resident altercation (see above) when other residents were in his personal space. Another physical altercation took place with Resident #1 8/4/2020 where as Resident #1 kicked a resident in the shin, however this was not witnessed. Cross-reference F600 for freedom from abuse. The IDT determined the cause of the altercation was due to the resident's reaction to perceived violations into his personal space. The facility completed the investigation and notifications by 8/20/2020. F. Staff interviews CNA #1 and RN #2 were interviewed on 9/8/2020 at 10:18 a.m. CNA #1 said that she received training on how to handle residents with behavioral issues from recent training she received. She said currently there was no one on the unit that had behavioral issues since they were sick, in bed and not active. CNA #1 said she was not instructed on interventions for Resident #1 when agitated. RN #2 said that she was recently trained on how to handle residents with behavioral issues. She said she was aware that Resident #1 could become agitated and non-compliant with staying in his room when feeling better. She said she and the staff would reapproach and try to keep other residents away from him. The director of nursing (DON) was interviewed on 9/9/2020 at 9:30 a.m. She said the resident did not have a history of being aggressive instead he struggled to understand. She said it would take a while for the staff to help navigate his space because he had to be guided with hands. He was in advanced stages of dementia so he did not understand others and his environment. She said in this incident on 8/4/2020, another resident approached Resident #1 in his chair. The DON said Resident #1 got frustrated if someone was sitting in his chair and he had a specific chair that he sat in daily. She said in the past if anyone sat in his chair he would pace in front of them until they moved. He did not get aggressive. She said he had a favorite chair in the dining room as well. She said the staff knew to keep residents out of his chair. She said since this incident Resident #1 got an illness and was moved to another area of the building for treatment so the residents were kept away from each other. She said that after the communal dining was stopped, the resident was confused because he could not maintain his routine and sit in his favorite chair. IV. Resident #3 A. Resident status Resident #3, age 76, admitted on [DATE]. According to the CPOs [DIAGNOSES REDACTED]. The 6/23/2020 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. Resident #3 experienced physical and verbal behavioral symptoms towards others. He required supervision to extensive assistance of one person with ADLs. B. Care plan The last revised on 6/30/2020 care plan revealed the resident was placed on a secured unit due to impaired cognition and would benefit from programming on the unit. The resident had a history of [REDACTED]. The resident stated that he needed to get home or work. He could get verbally and at times physically agitated with redirection. Calls to his family during these times are not always helpful as he may get angry with them. Interventions included, Appropriateness of secure unit placement to be assessed per protocol. Staff will observe for changes in mood/behavior and intervene PRN (as needed). The last revised on 7/2/2020 care plan revealed the resident had cognitive loss/behavior due to [DIAGNOSES REDACTED]. The resident could become verbally aggressive and threaten staff if he perceives they are not treating others appropriately. (i.e if providing care, will perceive they are harming them and will threaten to take it outside). He is not always responsive to direction for location, room, etc. (i.e if told where his room/bed is may respond I know and shut the door forcefully. (Resident's name) also has a history of getting upset if others take his things. (Resident's name) does not always understand others (staff and residents) and can at times feel that he is being scolded so will react with name calling. (Resident's name) is a proud Veteran and acknowledging that is a positive intervention/interaction. (thank him for his service). Interventions included: Assist the resident in conversing with others as he at times has difficulty being understood and understanding others, resulting in increased confusion and agitation. The resident enjoyed burgers, offering this choice if he seemed undecided about meal choice. The resident enjoyed coffee, especially in the morning - offer as possible. The resident enjoyed talking about the Broncos, going for walks, music, talking about cars (he owned a used car dealership). Attempt engagement in these activities to divert from negative behaviors as needed. Establish daily routine with the resident. Explain each activity/care procedure to the resident prior to beginning it. Give the resident simple choices that would not be overwhelming. Identify and report issues that create a worsening ability to process information. Provide one-on-one (1:1), distraction, remove other residents from the area when the resident became agitated. Provide opportunity for uninterrupted sleep. The last revised 6/27/2020 care plan revealed the resident was taking antipsychotic and antidepressant medications for dementia. The resident had aggressive behaviors at home. Decrease [MEDICATION NAME] (antipsychotic) 10/19/19, increase 2/6/20, increase 6/27/20. [MEDICATION NAME] & [MEDICATION NAME] changed to [MEDICATION NAME] r/t (related to) (resident's name) spitting out meds (medications). He clears his throat and spits frequently after medication administration, possibly to remove [MEDICATION NAME] residue from mouth. (Resident's name) has shown aggressive behaviors related to misunderstanding, causing resident-to-resident altercations or aggressiveness towards staff. Interventions included: - Offer short walk to de-escalate; - 9/4/2020-(Resident's name) was the initiator of physical aggression toward another resident, separated and placed on Q (every) 15 minute safety checks as per facility protocol. - Redirect to a new/quiet environment; - Evaluate medical cause for changes in behavior, mood or anxiety level prior to use of or dose change for psychoactive medication; - Evaluate pain as a contributing factor of anxiety, depression, [MEDICAL CONDITION] or behavior; - Inform resident/decision-maker of FDA side effect warnings for antipsychotic medication; - Monitor and document target behaviors/symptoms; - Monitor for adverse effects of medication. Report symptoms to MD (medical doctor)/NP (nurse practitioner); - Notify MD of recommendations for dose reduction trials or other pharmacist findings. - Refer to Psychologist as needed; - Provide comfort and support; and, - Re-orient patient to environment, equipment, routines, staff and roommate. C. Progress and behavior notes The 6/7/2020 Nurse Weekly Skin Check note read, (resident name) skin check completed by the nurse today. Unable to give the resident a bath/shower. Called the wife to coach the resident and was agreeable on the phone but when the wife hung-up, the resident refused and became angry for a short time. The 6/10/2020 nurses note read, Resident slept most of the night. Refused every attempt to supervise toileting; redirection,when he tried pulling a female resident to his room before bedtime and monitoring during nightly rounds with verbal aggression to staff. Resident came to the dining room at approximately 0515 (5:15 a.m.) with an angry look, offered snacks and fluid and he went back to his room. No respiratory distress, fever, cough noted during this shift. Will monitor. The 6/11/2020 nurses note read that the resident refused to wear or be approached by staff regarding wearing a mask. The 6/13/2020 nurse note read, Resident hollering and cursing at another resident who was sitting on the spare bed in his room. Removed the other resident without any difficulty. The 6/13/2020 nurse note read, Stated he wanted to talk to his wife and call placed to her. He hung up shortly afterward. Daughter called back and stated he was angry with his wife and wanted to know why she left him there,

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F 0744

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 3)

that she was there 15 minutes before. His daughter spoke to him and stated that his wife told him that she was not there - that she was not able to come because she was sick. After he hung up from speaking to his daughter, he then became more agitated and wanted to leave to go take care of his wife. Refused to take medication and remained agitated. The 6/18/2020 nurse note read, This resident was in the hall trying to get away from another resident who had struck out toward him. This resident was struck with an open hand on his right arm. Skin check done and no injuries noted, no complaints offered. (Physician's name) aware at 3:55 p.m. Resident's responsible party made aware at 3:50 p.m. Resident placed on 15 minute checks. The 6/20/2020 nurse note read, Resident continues on 15 minutes check. Resident noted with verbal aggression with staff especially when redirected.Resident attempted to push another resident that intruded to his room but was averted due to timely interception of staff, no direct altercation noted. Slept around 2200 (10:00 p.m.) and woke up around 0430 (4:30 a.m.), offered snacks, stayed up for about an hour and went to bed. No respiratory concerns noted during this shift. Will continue to monitor. The 6/22/2020 nurse note read, Resident physically aggressive with another resident who entered his room. Staff heard him hollering at the other resident who was on the floor in the bathroom. He was shouting that the other resident called him a (expletive). Removed the other resident from the room and have been monitoring both closely. The 6/27/2020 at 6:12 a.m. nurse note read, At the onset of this shift Resident was seen carrying another resident walker and pulling same resident alongside with him through the east door, putting both to risk of falling, the other resident appears not resisting.This writer attempted to redirect resident, to avoid risk of falling. Resident became aggressive, screamed and physically pushed writer twice to almost falling, then stomped angrily away. Resident again pushed the aide during this shift. 30 minutes later resident came, extended handshake and apologized to writer and aide. When asked reason for behavior, resident explained, he had to protect himself, writer advised resident to try to control himself in future.Resident said I am sorry it won't happen again. Resident was most calm for the rest of this shift. Will monitor. The 6/27/2020 at 5:22 p.m. nurse note read, Resident was sitting in the dining room with a female resident when another resident began talking to her. The other resident was confused and (resident's name) began hollering and cursing at him. This writer got between them and attempted to remove the other man from the situation. Then (resident's name) took the female by the hand and attempted to go outside with her. The CNA tried to get her to use her walker but he continued to be aggressive and took her outside. The CNA followed them to make sure she was safe.They walked around to the back door by his room and he brought her into his room and was hollering and cursing when the CNA tried to stop him. He picked up a chair that was in the hall and attempted to throw it at him; hit and pushed him as well. This writer arrived at that time and tried to assist the female out of the room and he got verbally aggressive with me - the female was upset and kept asking him why he was doing This. We let them close the door of the room to de escalate. They stayed in afew minutes and then came and walked in the patio area afterward for a while and then he came in and sat in the dining room. He remained agitated for a while afterward and still appears to be acting like he can get agitated. The 7/2/2020 IDT note read, IDT Review of Resident because of Resident Altercations: Contacted daughter-Wife is unable to do video chat but daughter spoke with resident. Female resident was moved from his wing that he had an attraction to. Resident with recent psychoactive medication adjustment and has a crush medication order, and he does take medication better crushed. Nurse assessment and request for labs. Resident care plan reviewed and updated by the team. Resident with escalation of behavior does verbalize negative response to prior to becoming aggressive. 1 intervention that has helped is offering food/snacks. Care Planned. Will do a hearing evaluation as the resident thinks other residents call him names. Will ask family if they would be able to bring in pillow/blanket etc. with his spouses picture on it. The 7/10/2020 nurse note read, CNA heard this resident arguing with another resident. CNA was approaching the residents when this resident pushed the other resident. Per CNA the other resident wasn't in the residents personal space, but was just looking out of the window. CNA stated that this resident got up out of his chair and pushed the resident down. Nurse reported to the Supervisor and also reported to the Doctor and Psychiatrist. Will continue to monitor. The 7/18/2020 nurse note read, Resident stated to nurse They are talking about me. Resident proceeded to follow other residents and stated If you hit me, I ' ll hit back. You punch me, I'll punch back. Nurse redirected. Resident proceeded to follow the other two residents thru out the unit. Resident then stated that they called me a (expletive). Nurse reoriented resident. One resident was opening the doors to other rooms and opened this residents room door. This resident got aggressive with the other resident because the resident bumped him. Nurse broke it up and CNA redirected residents to get ice cream. Nurse was with residents the whole time. Will continue to monitor. The 7/22/2020 Social Services General Notes read, Spoke with family with update on behaviors. Informed of possibility of looking for alternate placement due to aggressive behaviors. Family understands, and appreciative of care we do provide. Resident is on close monitoring of behaviors and has had a recent medication change related to increase in behaviors. Will continue to monitor, assess and intervene as needed. Will keep family informed of plan of care. The 8/17/2020 nurse note read, Nurse found resident and two other residents in his room. Nurse instructed them to come out. This resident stated to CNA I'll kill him with my bare hands. CNA separated everyone. Resident then stated They called me a (expletive). Resident said the actual word. CNA tried to separate the other resident from him but he won't separate from them. Resident stated that the CNA called him a (expletive) also. There was no physical aggression but a lot of verbal aggression. D. Physician documentation The 7/2/2020 Provider Progress Note read, called regarding concern about metabolic cause for increased behaviors. Check laboratory results and heart status with increasing [MEDICATION NAME]. I do not think that a UA (urinalysis) is indicated. No other signs/symptoms of UTI (urinary tract infection). I suspect advancing dementia as the cause. Reassess after labs return. The 7/12/2020 Provider Progress Note read, Received a call from Nursing on 07/10/20 re: patient's worsening behaviors and lack of response to current medication treatment. This resident has had gradually increasing doses if [MEDICATION NAME] in response to escalating agitation and aggression. The last increase was ordered by Attending about 2 weeks ago. When he arrived here nearly a year ago, he was taking [MEDICATION NAME] 2.5 mg per day which was prescribed by the Psychiatric Consultant at (hospital). [MEDICATION NAME] (antidepressant) was also prescribed at 15 mg HS (hour of sleep). As he was quite calm, soft-spoken and without any agitation or aggression at that time, his dosage of [MEDICATION NAME] was lowered. He was down to 1mg daily shortly after his admission, and seemed to do well for the next 5 months, when his dosage was increased to 1.5 mg daily. Nearly 5 months after this, which was 2 weeks ago, his dosage was increased to 2 mg per day. He apparently had been doing fairly well with the 2 mg per day dosage. However, he then pushed another resident to the floor for no apparent reason after having stared at that resident before he pushed. As this resident has a past history of aggressive behaviors, requiring [MEDICATION NAME] 2.5 mg per day as recently as one year ago, and since he has again become aggressive, this writer will increase his [MEDICATION NAME] further to 2.5 mg per day. As it is unclear if his [MEDICATION NAME] is adding anything therapeutically to his med regimen, will decrease [MEDICATION NAME] to 7.5 mg HS. When his labs from last week were reviewed, it was noticed that his B12 level was 191, with deficiency defined as <180. B12 was ordered for supplementation. Whether his B12 insufficiency is causally related to his recent aggressive outburst will never be known for certain. However, this writer has seen some significant behavioral changes as a result of B12 deficiency, including paranoid [MEDICAL CONDITION] which culminated with the patient firing a shotgun through the front door of her home. E. Resident altercations The resident was involved in resident-to-resident altercations on 7/16/2020, 8/17/2020, and 9/4/2020. Resident #3 was the aggressor in the altercations in which he wandered to other resident room's and thought they were in his room and was aggressive with another resident after his behaviors were not de-escalated. Cross-reference F600 for freedom from abuse. F. Staff interviews CNA #4 was interviewed on 9/8/2020 at 9:30 a.m. She said she worked at the facility for the past [AGE] years. She said since there was little restorative services happening since COVID-19 she worked the floor. She said she knew to prevent residents from getting close to Resident #3 since he misinterpreted conversation and felt that residents and staff were saying rude things to him. She said when he felt as though someone insulted him, then he would have a physical altercation. She said she received dementia care training and received specific training on residents that required interventions like Resident #3. She said the staff knew to keep other residents away from him especially if he was overheard getting angry. CNA #5 was interviewed on 9/8/2020 at 9:45 a.m. She said she worked for the facility for the past three months. She said she received training specific to the care needs of the residents residing on the secured unit. She said when Resident #3 got agitated she knew to get out of his way and keep other residents away as well. She said that he was proud and usually was redirectable when implementing interventions like food, drink and talking about his Veteran status. The director of nursing (DON) was interviewed on 9/9/2020 at 11:39 a.m. She said that the interdisciplinary team (IDT) reviewed the investigations and determined cause in order to implement interventions. She said the facility conducted another review a few days later for effectiveness of the implemented interventions. She said another week or two later they did a final review of the interventions. She said the reviews were documented under the assessments tab in the medical record. The DON said that Resident #3 failed to have one-on-one staff supervision so they implemented after the 9/4/2020 event an activity assistant on the unit assigned to him during his waking hours. He felt threatened by having a person assigned to him however the activity assistant was usually on the unit so it was not alarming to him and he had accepted it so far. The DON said that after the 9/1/2020 altercation Resident #3's [MEDICAL CONDITION] medications were adjusted. The DON said that since the facility announced it was closing and it had a COVID-19 outbreak around the same time so they lost numerous staff. She said there were struggles in the past with staffing shortages but currently the resident census was 17 and they had two staff members per unit and a total of four units. She said that she felt some of the reasons for the altercations taking place prior to August 2020 were due to staff shortages. V. Facility training for staff The in-service/training that was conducted on 1/16/2020 was provided on 9/9/2020 by the DON via email. The pertinent topics included Resident Protection and Dealing with Challenging Behaviors. The training was provided by the social service director (SSD) and the licensed social worker (LSW). The attached documentation pertinent to the in-service/training for Dealing with Challenging Personality Characteristics included examples of behaviors, causes of behaviors, environmental issues, task considerations, communication considerations, helpful techniques in managing behaviors. The in-service/training that was conducted on 1/20/2020 was provided on 9/9/2020 by the DON via email. The pertinent topics included Behaviors and Reporting Abuse. The training was provided by the social service director (SSD).