STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366122	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARY SCOTT NURSING CENTER	3109 CAMPUS DR DAYTON, OH 45406

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 -** Immediate jeopardy **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 review of a closed medical record, interviews with residents, staff, local law enforcement, and the Coroner, review of a Self-Reported Incident (SRI) and facility policy review, the facility failed to ensure one resident (#82) was free from physical abuse by another resident. This resulted in Immediate Jeopardy and subsequent death when Resident #83 placed a pillow over his roommate Resident #82's face and suffocated him. This affected one of seven residents reviewed for abuse. The facility census was 80. On [DATE] at 4:15 P.M., the Administrator was notified Immediate Jeopardy began on [DATE] during the morning shift change at approximately 7:00 A.M., when Resident #83 stated he had killed his roommate. Resident #82 was found lying in his bed, unresponsive, cool to touch and blue. Homicide Detective #101 stated the preliminary cause of Resident #82's death was identified as suffocation. She stated this was also confirmed by the statement she received from Resident #83. He gave a detailed statement of how he picked up a pillow from the wheelchair and held it over the face of Resident #82, suffocated, and killed him. He further stated to her Resident #82 had scratched Resident #83's neck and she confirmed Resident #83 had fresh scratches on his neck. She stated Resident #83 reported the devil made him do it. She stated nail scrapings were taken from Resident #82 and a Deoxyribonucleic Acid (DNA) swab was taken from Resident #83. She said the case was closed as a homicide. Finally, she stated there would be no trial as Resident #83 had hung himself in the local jail and expired. The Immediate Jeopardy was removed on [DATE] at 5:00 P.M., when the facility implemented the following corrective actions: On [DATE] at approximately 7:30 A.M., the local law enforcement removed Resident #83 from the facility. Resident #83 was placed into custody and taken to the local county jail. On [DATE], the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #64 reviewed both residents' records. There were no prior documented issues between the two residents. On [DATE] time unspecified, Licensed Practical Nurse (LPN) #61 notified Medical Director (MD) #106 of the alleged abuse by Resident #83. LPN #61 also notified MD #106 of Resident #82's death. On [DATE] at 9:00 A.M., the facility initiated an SRI for resident to resident abuse. On [DATE] at approximately 9:30 A.M., Social Service Director (SSD) #68 completed wellness checks of all residents to ensure they felt safe and were completed on [DATE] at 5:00 P.M. On [DATE] at approximately 5:00 P.M., the Administrator implemented a new procedure to no longer admit any resident with a history of homicidal ideation. On [DATE] at 5:00 P.M., ADON #64 and Unit Manager (UM) #62 began educating all staff on behaviors including homicidal ideation. Part time, as needed staff, and Agency nursing staff will be educated prior to working their next scheduled shift. All in house staff will be educated by [DATE] at 5:00 P.M. The Administrator, the DON and ADON #64 will continue to update and educate staff and residents on abuse monthly. The most recent abuse training was completed on [DATE] for all staff. On [DATE] at 5:00 P.M., SSD #68 completed an audit of current residents with a psychiatric [DIAGNOSES REDACTED]. No residents were found with homicidal ideation. One resident (#61) was identified with a history of suicidal ideation, but no current ideations. On [DATE], ADON #64, and UM #62 created a monitoring tool to review residents for signs and symptoms of abuse weekly, times four weeks, and then monthly thereafter. Interviews on [DATE] from 8:45 A.M. to 6:47 P.M. and on [DATE] from 9:00 A.M. to 4:00 P.M. with the Administrator, the DON, Registered Nurse (RN) #37 and #39, LPN #61, State tested Nursing Assistant (STNA) #38, STNA #103, STNA #104, STNA #60, STNA #66, Activity Director #22, and Housekeeper #19 revealed they were knowledgeable of the abuse policy and indicated they would immediately report any allegations of abuse to the Administrator and/or to the DON. On [DATE] at approximately 8:00 A.M., House Psychiatrist #100 completed a review all residents for homicidal ideation. No current residents were found with homicidal ideation. On [DATE], a special Quality Assurance Performance Improvement (QAPI) meeting was held with MD #106 and House Psychiatrist #100 to discuss the incident that occurred between Resident #82 and Resident #83. Although the Immediate Jeopardy was removed, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the closed medical record revealed Resident #82 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly assessment dated [DATE] revealed the resident had intact cognition, he required extensive assistance from one staff for bed mobility, transfer and ambulation. He had bilateral impairment of the upper and lower extremities and used a wheelchair. Review of the current plan of care revealed the resident had an alteration in mood and behavior related to anxiety and brain deterioration. The goal was to accept care and medication as ordered. Interventions included monitor mental status when new medications are added. Observe and report any changes in mental status. Review of the nurse notes dated [DATE] at 8:00 A.M., revealed the resident was found unresponsive at 7:05 A.M. Review of the closed medical record revealed Resident #83 was admitted to the facility on [DATE]. He was admitted from a local hospital where he had a stay in [DATE] due to bizarre behaviors, such as stripping naked and he expressed wanting to kill everyone at the homeless shelter. [DIAGNOSES REDACTED]. It may result in some combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning and can be disabling. People with [MEDICAL CONDITION] require lifelong treatment), [MEDICAL CONDITION] disorder, and diabetes. Review of the quarterly assessment dated [DATE] revealed the resident had moderate impaired cognition, he had trouble falling or staying asleep and he had not displayed any hallucinations or delusions. He required supervision for bed mobility, and transfer; however, he was independent in walking in his room. He also took antipsychotic medication. Review of the current plan of care revealed he had a potential to demonstrate physical behaviors related to poor impulse control and a history of suicidal and homicidal ideation. The goal was to not harm himself or others. Interventions included cognitive assessments, provide physical and verbal cues to alleviate anxiety, be able to verbalize the source of agitation, document observed behavior and attempted interventions in the behavior log. Monitor, document and report to the MD of danger to self and others. Review of the nurse notes revealed the last documented note was dated [DATE] which documented the resident had no behaviors. No further behavior documentation was in the progress notes from [DATE] to [DATE]. Review of a facility SRI, dated [DATE], and facility investigation revealed an allegation of physical abuse involving Resident #82 and Resident #83 occurred at 6:55 A.M., when Resident #83 claimed to have caused the passing of Resident #82. The local authorities were called and immediately arrived. Per the SRI, the local authorities and the facility management staff did not believe the allegation made by Resident #83. The investigation revealed the residents were immediately separated. As part of the facility's investigation, witness statements were taken from LPN #61, RN #37, Medical Records Staff #09, and UM #62 on [DATE]. LPN #61's witness statement documented she administered 5:00 A.M. medications and both residents were on their respective sides of the room. She checked Resident #83's blood sugar and noticed Resident #82 resting with his eyes closed and his chest was moving up and down. As she was completing her shift, Housekeeper #19 alerted her that Resident #83's head was hurting. Resident #83 was standing in the hallway. LPN #61 told the resident to wait so she could obtain equipment to check his

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** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) vital signs. LPN #61 called UM #62 and told her Resident #83 did not seem like himself. UM #62 instructed her to ask him if he felt like hurting himself or others. Resident #83 told LPN #61 he had hurt Resident #82. LPN #61 observed Resident #82 unresponsive. She indicated Medical Records Staff #09 initiated cardiopulmonary resuscitation (CPR) while she called for emergency services and checked Resident #82's code status. After LPN #61 called emergency services, she went to the room to assist with the code. RN #37's witness statement documented she heard the calls for help and she and Medical Records Staff #09 came to assist. RN #37 stayed outside of the room with Resident #83 while the code was started. Medical Records Staff #09's witness statement documented she and RN #37 ran down the hall toward the calls for help. RN #37 remained outside with Resident #83 while she began chest compressions until emergency services arrived. UM #62's witness statement documented she received a call from LPN #61 on [DATE] at 7:01 A.M. LPN #61 inquired if Resident #83 had recently been acting weird or had been sick. LPN #61 informed UM #62 the resident was complaining his head hurt and he didn't feel right. UM #62 instructed LPN #61 to ask Resident #83 if he felt like he was going to hurt himself or someone else. Further review of the facility investigation revealed there were no other witness statements or interviews from other staff members who had worked on [DATE]. Interview on [DATE] at 10:42 A.M., Homicide Detective #101 stated the preliminary cause of Resident #82's death was identified as suffocation. She said this was also confirmed by the statement she received from Resident #83. He gave a detailed statement of how he picked up a pillow from the wheelchair and held it over the face of Resident #82, suffocated and killed him. He further stated to her Resident #82 had scratched Resident #83's neck and she confirmed Resident #83 had fresh scratches on his neck. She said Resident #83 reported the devil made him do it. She said nail scrapings were taken from Resident #82 and a Deoxyribonucleic Acid (DNA) swab was taken from Resident #83. She said the case was closed as a homicide. She said there would be no trial as Resident #83 had hung himself in the local jail and expired. Interview on [DATE] at 11:19 A.M., Coroner's Office Staff #102 stated they would not release any information at this time due to the matter was a homicide. Interview on [DATE] at 11:45 A.M., Housekeeper #19 stated she came in on [DATE] around 7:00 A.M., and Resident #83 was standing in the hallway, which was unusual for him. He told her he didn't feel well so she alerted LPN #61 who was getting ready to clock off. She observed LPN #61 talking to Resident #83 but could not hear what they were saying. LPN #61 ran out of the room and yelled he's (Resident #82) 'expletive' dead. All the nurses were in the hallway and Housekeeper #19 called her supervisor at 7:09 A.M., and again at 7:16 A.M. She said Resident #83 was calm standing in the hallway. Interview on [DATE] at 12:00 P.M., RN #37 stated she heard the call for help from the night shift nurse LPN #61. RN #37 said she stayed out in the hallway with Resident #83. LPN #61 went to the top of the hallway to call emergency services. Agency LPN #105 went into the resident's room while RN #37 waited in the hallway with Resident #83. The police came and took Resident #83 away. She said she never saw this coming, Resident #83 did not socialize and did not come out of his room. Interview on [DATE] at 4:18 P.M., LPN #61 stated she had finished up her morning medication pass. She was called back to the 100-hall because Resident #83 had a headache and wasn't acting himself. She called UM #62 and asked if the resident had been having any problems since LPN #61 had not worked in a few days. At the direction of UM #62, she asked Resident #83 if he felt like hurting himself or others and he stated he had killed Resident #82. She went into the room and Resident #82 looked unresponsive. She did not initiate CPR, instead she called nine-one-one (911) and stayed on the phone with the dispatcher. Medical Records Staff #09 initiated CPR while RN #37 was in the hallway with Resident #83. Interview on [DATE] at 4:32 P.M., the DON, ADON #64 and the Administrator stated the staff were not going to go in the resident's room after Resident #83 had just killed his roommate. Interview on [DATE] at 5:25 P.M., Resident #51 stated she was a friend of Resident #82 and the only thing she noticed was a few days before the incident, she observed Resident #83 rummaging through Resident #82's drawers. She asked Resident #83 what he was doing, and he said nothing. She observed Resident #82 asking Resident #83 what he was carrying, but Resident #83 indicated he had nothing and refused to show Resident #82 what he had. Interview on [DATE] at 12:17 P.M., House Psychiatrist #100 stated when she previously saw Resident #83, he denied command auditory hallucinations and he could not recognize the voices he was hearing. There was no indication he would escalate to this level. Interview on [DATE] at 11:17 A.M., Medical Director #106 stated he was informed of the incident approximately 24 hours later. He said Resident #83 was very protective and fixated on being the best friend of Resident #82. He further reported when Resident #82 began spending time with Resident #51 this may have set Resident #83 off. Review of the facility policy entitled Abuse, Neglect, and/or Misappropriation of Resident Funds or Property with a revised date [DATE] revealed if the resident was injured as a result of the alleged or suspected abuse or neglect, the facility shall take immediate action to treat the resident. Staff are not to leave a victim unless it was necessary to summon assistance. This deficiency substantiates the allegations in Complaint Number OH 601, Complaint Number OH 573, Complaint Number OH 540 and Complaint Number OH 291.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a closed medical record, interviews with residents, staff, local law enforcement, and the Coroner, review of a Self-Reported Incident (SRI) and facility policy review, the facility failed to implement their abuse policy to ensure residents were free from physical abuse, victims treated immediately and allegations were investigated thoroughly. This affected one (#82) of seven residents reviewed for abuse. The facility census was 80. Findings include: Review of the closed medical record revealed Resident #82 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly assessment dated [DATE] revealed the resident had intact cognition, he required extensive assistance from one staff for bed mobility, transfer and ambulation. He had bilateral impairment of the upper and lower extremities and used a wheelchair. Review of the current plan of care revealed the resident had an alteration in mood and behavior related to anxiety and brain deterioration. The goal was to accept care and medication as ordered. Interventions included monitor mental status when new medications are added. Observe and report any changes in mental status. Review of the nurse notes dated [DATE] at 8:00 A.M., revealed the resident was found unresponsive at 7:05 A.M. Review of the closed medical record revealed Resident #83 was admitted to the facility on [DATE]. He was admitted from a local hospital where he had a stay in [DATE] due to bizarre behaviors, such as stripping naked and he expressed wanting to kill everyone at the homeless shelter. [DIAGNOSES REDACTED]. It may result in some combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning and can be disabling. People with [MEDICAL CONDITION] require lifelong treatment), [MEDICAL CONDITION] disorder, and diabetes. Review of the quarterly assessment dated [DATE] revealed the resident had moderate impaired cognition, he had trouble falling or staying asleep and he had not displayed any hallucinations or delusions. He required supervision for bed mobility, and transfer; however, he was independent in walking in his room. He also took antipsychotic medication. Review of the current plan of care revealed he had a potential to demonstrate physical behaviors related to poor impulse control and a history of suicidal and homicidal ideation. The goal was to not harm himself or others. Interventions included cognitive assessments, provide physical and verbal cues to alleviate anxiety, be able to verbalize the source of agitation, document observed behavior and attempted interventions in the behavior log. Monitor, document and report to the MD of danger to self and others. Review of the nurse notes revealed the last documented note was dated [DATE] which documented the resident had no behaviors. No further behavior documentation was in the progress notes from [DATE] to [DATE]. Review of a facility SRI, dated [DATE], and facility investigation revealed an allegation of physical abuse involving Resident #82 and Resident #83 occurred at 6:55 A.M., when Resident #83 claimed to have caused the passing of Resident #82. The local authorities were called and immediately arrived. Per the SRI, the local authorities and the facility management staff did not believe the allegation made by Resident #83. The investigation revealed the residents were immediately separated. As part of the facility's investigation, witness statements were taken from LPN #61, RN #37, Medical Records Staff #09, and UM #62 on [DATE]. LPN #61's witness statement documented she administered 5:00 A.M. medications and both residents were on their respective sides of the room. She checked Resident #83's blood sugar and noticed Resident #82 resting with his eyes closed and his chest was moving up and down. As she was completing her shift, Housekeeper #19 alerted her that Resident #83's head was hurting. Resident #83 was standing in the hallway. LPN #61 told the resident to wait so she could obtain equipment to check his vital signs. LPN #61 called UM #62 and told her Resident #83 did not seem like himself. UM #62 instructed her to ask him if he felt like hurting himself or others. Resident #83 told LPN #61 he had hurt Resident #82. LPN #61 observed Resident #82 unresponsive. She indicated Medical Records Staff #09 initiated cardiopulmonary resuscitation (CPR) while she called for emergency services and checked Resident #82's code status. After LPN #61 called emergency services, she went to the room to assist with the code. RN #37's witness statement documented she heard the calls for help and she and Medical Records Staff #09 came to assist. RN #37 stayed outside of the room with Resident #83 while the code was started. Medical Records Staff #09's witness statement documented she and RN #37 ran down the hall toward the calls for help. RN #37 remained outside with Resident #83

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) while she began chest compressions until emergency services arrived. UM #62's witness statement documented she received a call from LPN #61 on [DATE] at 7:01 A.M. LPN #61 inquired if Resident #83 had recently been acting weird or had been sick. LPN #61 informed UM #62 the resident was complaining his head hurt and he didn't feel right. UM #62 instructed LPN #61 to ask Resident #83 if he felt like he was going to hurt himself or someone else. Further review of the facility investigation revealed there were no other witness statements or interviews from other staff members who had worked on [DATE]. Interview on [DATE] at 10:42 A.M., Homicide Detective #101 stated the preliminary cause of Resident #82's death was identified as suffocation. She said this was also confirmed by the statement she received from Resident #83. He gave a detailed statement of how he picked up a pillow from the wheelchair and held it over the face of Resident #82, suffocated and killed him. He further stated to her Resident #82 had scratched Resident #83's neck and she confirmed Resident #83 had fresh scratches on his neck. She said Resident #83 reported the devil made him do it. She said nail scrapings were taken from Resident #82 and a Deoxyribonucleic Acid (DNA) swab was taken from Resident #83. She said the case was closed as a homicide. She said there would be no trial as Resident #83 had hung himself in the local jail and expired. Interview on [DATE] at 11:19 A.M., Coroner's Office Staff #102 stated they would not release any information at this time due to the matter was a homicide. Interview on [DATE] at 11:45 A.M., Housekeeper #19 stated she came in on [DATE] around 7:00 A.M., and Resident #83 was standing in the hallway, which was unusual for him. He told her he didn't feel well so she alerted LPN #61 who was getting ready to clock off. She observed LPN #61 talking to Resident #83 but could not hear what they were saying. LPN #61 ran out of the room and yelled he's (Resident #82) 'expletive' dead. All the nurses were in the hallway and Housekeeper #19 called her supervisor at 7:09 A.M., and again at 7:16 A.M. She said Resident #83 was calm standing in the hallway. Interview on [DATE] at 12:00 P.M., RN #37 stated she heard the call for help from the night shift nurse LPN #61. RN #37 said she stayed out in the hallway with Resident #83. LPN #61 went to the top of the hallway to call emergency services. Agency LPN #105 went into the resident's room while RN #37 waited in the hallway with Resident #83. The police came and took Resident #83 away. She said she never saw this coming, Resident #83 did not socialize and did not come out of his room. Interview on [DATE] at 4:18 P.M., LPN #61 stated she had finished up her morning medication pass. She was called back to the 100-hall because Resident #83 had a headache and wasn't acting himself. She called UM #62 and asked if the resident had been having any problems since LPN #61 had not worked in a few days. At the direction of UM #62, she asked Resident #83 if he felt like hurting himself or others and he stated he had killed Resident #82. She went into the room and Resident #82 looked unresponsive. She did not initiate CPR, instead she called nine-one-one (911) and stayed on the phone with the dispatcher. Medical Records Staff #09 initiated CPR while RN #37 was in the hallway with Resident #83. Interview on [DATE] at 4:32 P.M., the DON, ADON #64 and the Administrator stated the staff were not going to go in the resident's room after Resident #83 had just killed his roommate. Interview on [DATE] at 5:25 P.M., Resident #51 stated she was a friend of Resident #82 and the only thing she noticed was a few days before the incident, she observed Resident #83 rummaging through Resident #82's drawers. She asked Resident #83 what he was doing, and he said nothing. She observed Resident #82 asking Resident #83 what he was carrying, but Resident #83 indicated he had nothing and refused to show Resident #82 what he had. Interview on [DATE] at 12:17 P.M., House Psychiatrist #100 stated when she previously saw Resident #83, he denied command auditory hallucinations and he could not recognize the voices he was hearing. There was no indication he would escalate to this level. Interview on [DATE] at 11:00 A.M., agency LPN #105 stated she had just arrived at work, around 7:05 A.M., and LPN #61 came to the 100-hall nurses station and said she had just asked Resident #83 if he had wanted to hurt himself or anyone. He said he had killed Resident #82. LPN #61 stated she went in the resident's room and he was dead as a doorknob and he was blue. She said LPN #61 called 911 and it took about seven minutes for the emergency services to arrive. When emergency services arrived, they asked for the nurse on duty and worked on Resident #82 for about 20 minutes. Agency LPN #105 said she never went down the hallway or saw Resident #82. She confirmed she had not been called or asked to write a statement of what she witnessed. Interview on [DATE] at 11:17 A.M., Medical Director #106 stated he was informed of the incident approximately 24 hours later. He said Resident #83 was very protective and fixated on being the best friend of Resident #82. He further reported when Resident #82 began spending time with Resident #51 this may have set Resident #83 off. Interview on [DATE] at 12:40 P.M., the DON, ADON #64 and the Administrator stated they did not have access to all of the documentation to finish the investigation. They also reported they had time to get other interviews and to complete the investigation. Review of the facility policy entitled Abuse, Neglect, and/or Misappropriation of Resident Funds or Property with a revised date [DATE] revealed if the resident was injured as a result of the alleged or suspected abuse or neglect, the facility shall take immediate action to treat the resident. Staff are not to leave a victim unless it was necessary to summon assistance. Allegations of abuse will be investigated thoroughly. This deficiency was an incidental finding discovered in Complaint Number OH 5405 and Complaint Number OH 291.
F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the closed medical record, interviews with staff, review of the local fire department patient care record, review of the Self-Reported Incident (SRI) and facility policy review, the facility failed to assess, and immediately initiate Cardiopulmonary Resuscitation (CPR) for one Resident (#82) who was found unresponsive and was identified as a full code status. This resulted in Immediate Jeopardy and life-threatening harm when Resident #82 was not assessed nor provided timely CPR and expired in the nursing facility. This affected one of two residents reviewed for full code status and death. The facility identified five deaths in the facility. The facility census was 80. On [DATE] at 3:49 P.M., the Administrator, the Director of Nursing (DON), Assistant Director of Nursing (ADON) #64, Social Service Director (SSD) #68, Unit Manager (UM) #62, Admissions Coordinator #85, Dietary Manager #36, Activity Director #22, and Minimum Data Set (MDS) Nurse #34 were notified Immediate Jeopardy began on [DATE] during the morning shift change at approximately 7:00 A.M., when Resident #82 was found by Licensed Practical Nurse (LPN) #61 to be unresponsive and CPR was not immediately initiated. LPN #61 ran out of the room and yelled he's ' expletive ' dead. Homicide Detective #101 stated the preliminary cause of Resident #82's death was identified as suffocation. She stated this was also confirmed by the statement she received from Resident #83. He gave a detailed statement of how he picked up a pillow from the wheelchair and held it over the face of Resident #82, suffocated and killed him. Interview on [DATE] at 4:32 P.M., the DON, ADON #64 and the Administrator stated the staff were not going to go in the room after Resident #83 said he had killed someone. They were making sure the scene was safe and they were safe. The Immediate Jeopardy was removed on [DATE] at 5:00 P.M., when the facility implemented the following corrective actions: On [DATE] at approximately 9:00 A.M., ADON #64 and UM #62 began educating all nursing staff on what to do when finding a resident unresponsive, checking the code status, starting CPR immediately and having another person call nine-one-one (911) and to continue CPR until emergency services arrive. State tested Nursing Assistants (STNAs) were educated if a nurse yells for help they should respond to this type of event as anyone can get another nurse, check code status, or call 911. All full-time staff had completed education by [DATE] at 5:00 P.M. All part-time and as needed (PRN) staff will be educated by phone or in person prior to their next working shift by ADON #64 or UM #62. All training will be completed by [DATE]. All new employees will be trained on this procedure upon hire. On [DATE] at approximately 9:30 A.M., SSD #68 reviewed all resident records to ensure code status was properly placed in the medical record. She also interviewed residents to ensure they felt safe in the building. On [DATE] and [DATE] the DON, ADON #64 and SSD #68 held a town hall meeting (a meeting with staff and residents) to debrief residents and staff about the incident/alleged murder and the passing of two of their residents. On [DATE] at approximately 8:00 A.M., Medical Director (MD) #106 was notified of the death of Resident #82. The Administrator, the DON, ADON #64 and UM #62 will audit charts for code status and monitor any future deaths of residents who were full code status if they expired in the facility. This will be completed weekly times four weeks and then monthly thereafter. On [DATE], a special Quality Assurance Performance Improvement (QAPI) meeting will be held with Medical Director #106 and House Psychiatrist #100 to discuss the incident in the building. Although the Immediate Jeopardy was removed, the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and were monitoring to ensure continued compliance. Findings include: Review of the closed medical record revealed Resident #82 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the face sheet revealed he was a full code. He expired in the facility on [DATE]. Review of the quarterly assessment dated [DATE] revealed the resident had intact cognition, and he required extensive assistance from one

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) staff for bed mobility, transfer and ambulation. He had bilateral impairment of the upper and lower extremities and used a wheelchair. Review of the current plan of care revealed the resident had an alteration in mood and behavior related to anxiety and brain deterioration. The goal was to accept care and medication as ordered. Interventions included monitor mental status when new medications were added. Observe and report any changes in mental status. He was a full code. Review of the local fire department patient care record dated [DATE] documented the emergency services were called to the facility at 7:07 A.M., they were dispatched at 7:09 A.M., they arrived at the facility at 7:17 A.M., and they were at Resident #82 at 7:19 A.M. The engine crew made contact with Resident #82 who was lying supine (on his back) in bed. It was reported Resident #82 was strangled by another resident who occupied the same room. The crew reported CPR was not initiated prior to their arrival and there was another (unknown) resident sitting on the other bed in the room with the door shut. The crew reported Resident #82 was pulseless, apneic (cessation of breathing), and warm to touch. CPR was initiated and the Automated External Defibrillator (AED) was applied as well as oxygen. They established an airway, an intravenous (IV) line and administered lifesaving medications. The resident was pronounced dead at 7:39 A.M., in the facility. The coroner's office was contacted and would be out to investigate. Review of the nurses notes dated [DATE] at 8:00 A.M. revealed the resident was found unresponsive at 7:05 A.M. Code was started at 7:05 A.M., and 911 was called. Review of a facility SRI dated [DATE] at 9:00 A.M. revealed the facility investigated an allegation of resident to resident physical abuse involving Resident #82 and #83 that occurred on [DATE] at 6:55 A.M., when Resident #83 claimed to have caused the passing of Resident #82. As part of the facility investigation, witness statements were taken from LPN #61, RN #37, Medical Records Staff #09, and UM #62 on [DATE]. LPN #61's witness statement documented she administered 5:00 A.M. medications and both residents were on their respective sides of the room. She checked Resident #83's blood sugar and noticed Resident #82 resting with his eyes closed and his chest was moving up and down. As she was completing her shift, Housekeeper #19 alerted her that Resident #83's head was hurting. Resident #83 was standing in the hallway. LPN #61 told the resident to wait so she could obtain equipment to check his vital signs. LPN #61 called UM #62 and told her Resident #83 did not seem like himself. UM #62 instructed her to ask him if he felt like hurting himself or others. Resident #83 told LPN #61 he had hurt Resident #82. LPN #61 observed Resident #82 unresponsive. She indicated Medical Records Staff #09 initiated CPR while she called for emergency services and checked Resident #82's code status. After LPN #61 called emergency services, she went to the room to assist with the code. RN #37's witness statement documented she heard the calls for help and her and Medical Records Staff #09 came to assist. RN #37 stayed outside of the room with Resident #83 while the code was started. Medical Records Staff #09's witness statement documented she and RN #37 ran down the hall toward the calls for help. RN #37 remained outside with Resident #83 while she began chest compressions until emergency services arrived. UM #62's witness statement documented she received a call from LPN #61 on [DATE] at 7:01 A.M. LPN #61 inquired if Resident #83 had recently been acting weird or had been sick. LPN #61 informed UM #62 the resident was complaining his head hurt and he didn't feel right. UM #62 instructed LPN #61 to ask Resident #83 if he felt like he was going to hurt himself or someone else. Further review of the facility investigation revealed there were no other witness statements provided or follow-up interviews with other staff who had worked on [DATE]. Interview on [DATE] at 11:45 A.M., Housekeeper #19 stated she came in on [DATE] around 7:00 A.M., and Resident #83 was standing in the hallway, which was unusual for him. He told her he didn't feel well so she alerted LPN #61 who was getting ready to clock out. She observed LPN #61 talking to Resident #83 but could not hear what they were saying. LPN #61 ran out of the room and yelled he's (Resident #82), 'expletive' dead. All the nurses were in the hallway and Housekeeper #19 called her supervisor at 7:09 A.M., and again at 7:16 A.M. She said Resident #83 was calm standing in the hallway. Interview on [DATE] at 12:00 P.M., RN #37 stated she heard the call for help from the night shift nurse LPN #61. RN #37 said she stayed out in the hallway with Resident #83. LPN #61 went to the top of the hallway to call emergency services. Agency LPN #105 went into the resident's room while RN #37 waited in the hallway with Resident #83. The police came and took Resident #83 away. She said she never saw this coming, Resident #83 did not socialize and did not come out of his room. Interview on [DATE] at 12:15 P.M., Medical Records Staff #09 stated she was in the building and heard screaming and saw LPN #61 was distraught. She walked briskly down to the area where she heard screaming, ran in the room and started chest compressions. She said she was the only person in the room, she knew LPN #61 was on the phone and RN #37 was outside of the room watching Resident #83. She reported Resident #82 was cool to the touch and his lips and face were blue. Interview on [DATE] at 4:18 P.M., LPN #61 stated she had finished her morning medication pass. She was called back to the 100-hall because Resident #83 had a headache and wasn't acting himself. She called UM #62 and asked if the resident had been having any problems since LPN #61 had not worked in a few days. At the direction of UM #62, she asked Resident #83 if he felt like hurting himself or others and he stated he had killed Resident #82. She went into the room and Resident #82 looked unresponsive. She did not initiate CPR, instead she called 911 and stayed on the phone with the dispatcher. Medical Records Staff #09 initiated CPR while RN #37 was in the hallway with Resident #83. Interview on [DATE] at 4:32 P.M., the DON, ADON #64 and the Administrator stated the staff were not going to go in the room after Resident #83 said he had killed someone. They were making sure the scene was safe and they were safe. Interview on [DATE] at 11:00 A.M., agency LPN #105 stated she had just arrived at work, around 7:05 A.M., and LPN #61 came to the 100-hall nurses station and said she had just asked Resident #83 if he had wanted to hurt himself or anyone. He said he had killed Resident #82. LPN #61 stated she went in the resident's room and he was dead as a doorknob and he was blue. She said LPN #61 called 911 and it took about seven minutes for the emergency services to arrive. When emergency services arrived, they asked for the nurse on duty and worked on Resident #82 for about 20 minutes. Agency LPN #105 said she never went down the hallway or saw Resident #82. Interview on [DATE] at 8:38 A.M., Environmental Manager #50 stated he received two phone calls from Housekeeper #19 on [DATE] and both were a little after 7:00 A.M. He said she called and reported to him that Resident #83 had killed Resident #82. He kept asking her what and to repeat herself, as he couldn't believe what she was saying. He arrived to work a few minutes after the calls, and the police had already taken Resident #83 into custody and the emergency personnel were working on Resident #82. During a follow-up interview on [DATE] at 8:05 A.M., Medical Records Staff #09 stated she was in the residents room completing chest compressions and she was told by RN #37 the emergency services personnel had arrived, so she stopped compressions and ran out of the room to the bathroom, because she was upset. She verified the emergency service personnel had not relieved her prior to her stopping chest compressions. Follow-up interview on [DATE] at 8:12 A.M., RN #37 verified she did not go in the residents ' room, she only kept her eyes on Resident #83. She did not recall alerting Medical Records Staff #09 of the arrival of the squad nor did she see her run out of the room. Her eyes were on Resident #83. Interview on [DATE] at 11:17 A.M., Medical Director #106 stated he was aware of the incident approximately 24 hours later. He stated he would expect the staff to call 911 and start CPR immediately if the resident was a full code. The only exception would be if they had clear clinical signs of death without reversal. Review of the facility policy titled Performance Guidelines of Cardiopulmonary Resuscitation (CPR) revised date [DATE] revealed the requirements to be met regarding CPR: Cardiac or respiratory arrest occurs for a resident who does not show obvious signs of irreversible death. A resident who has requested CPR in his/her advance directives. A resident who has not formulated an advance directive. A resident who does not have a valid Do Not Resuscitate (DNR) order. Procedure: Initial respondent reaches out to staff members for assistance, CPR is initiated based on Resident Code Status, staff member simultaneously calls 911/Emergency Medical Technicians (EMT's). This deficiency is an incidental finding discovered during Master Complaint Number OH 601, Complaint Number OH 573, Complaint Number OH 540 and Complaint Number OH 291.
F 0742 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, interviews with staff, review of the Self-Reported incident (SRI) and facility policy review, the facility failed to ensure one resident (#83) who was diagnosed with [REDACTED]. This resulted in Immediate Jeopardy and life-threatening harm when Resident #83, who had a known history of homicidal ideation, reported he had killed his roommate (Resident #82), who was subsequently found unresponsive in his bed after being suffocated by Resident #83. On [DATE] at 3:49 P.M., the Administrator, the Director of Nursing (DON), Assistant Director of Nursing (ADON) #64, Social Service Director (SSD) #68, Unit Manager (UM) #62, Admissions Coordinator #85, Dietary Manager #36, Activity Director #22, and Minimum Data Set (MDS) Nurse #34 were notified Immediate Jeopardy began on [DATE] during the

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	366122	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARY SCOTT NURSING CENTER	3109 CAMPUS DR DAYTON, OH 45406

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

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F 0742 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) morning shift change at approximately 7:00 A.M., when Resident #82 was found by Licensed Practical Nurse (LPN) #61 to be unresponsive and Resident #83 reported he had killed Resident #82. Homicide Detective #101 stated the preliminary cause of Resident #82's death was identified as suffocation. She stated this was also confirmed by the statement she received from Resident #83. He gave a detailed statement of how he picked up a pillow from the wheelchair and held it over the face of Resident #82, suffocated and killed him. He further stated to her Resident #82 had scratched Resident #83's neck and she confirmed Resident #83 had fresh scratches on his neck. She stated Resident #83 reported the devil made him do it. She said nail scrapings were taken from Resident #82 and a Deoxyribonucleic Acid (DNA) swab was taken from Resident #83. She said the case was closed as a homicide. Finally, she stated there would be no trial as Resident #83 had hung himself in the local jail and expired. The Immediate Jeopardy was removed on [DATE] at 5:00 P.M., when the facility implemented the following corrective actions: On [DATE] at approximately 7:30 A.M., the local law enforcement removed Resident #83 from the facility. Resident #83 was placed into custody and taken to the local county jail. On [DATE] the DON and ADON #64 reviewed both residents ' records. There were no prior documented issues between the two residents. On [DATE] time unspecified, Licensed Practical Nurse (LPN) #61 notified Medical Director (MD) #106 of the alleged abuse by Resident #83. LPN #61 also notified MD #106 of Resident #82's death. On [DATE] at 9:00 A.M., the facility initiated an SRI for resident to resident abuse. On [DATE] at approximately 9:00 A.M., SSD #68 began wellness checks of all residents and anyone who saw a counselor she notified the case manager of the incident. This was completed on [DATE] at approximately 9:45 A.M. On [DATE] at approximately 5:00 P.M., the Administrator implemented a new procedure to no longer admit any resident with a history of homicidal ideation. On [DATE] at 5:00 P.M., ADON #64 and UM #62 began educating all staff on behaviors including homicidal ideation. Part time, as needed staff, and Agency nursing staff will be educated prior to working their next scheduled shift. All in house staff will be educated by [DATE] at 5:00 P.M. The Administrator, the DON and ADON #64 will continue to update and educate staff and residents on abuse monthly. The most recent abuse training was completed on [DATE] for all staff. On [DATE] at 5:00 P.M., SSD #68 completed an audit of current residents with a psychiatric [DIAGNOSES REDACTED]. No residents were assessed with [REDACTED].#61) was identified with a history of suicidal ideation, but no current ideations. On [DATE] at 5:00 P.M., ADON #64, and UM #62 created a monitoring tool, to review residents for signs and symptoms of abuse/behaviors weekly times four weeks and then monthly thereafter. Interviews on [DATE] from 8:45 A.M. to 6:47 P.M. and on [DATE] from 9:00 A.M. to 4:00 P.M. with the Administrator, the DON, Registered Nurse (RN) #37 and #39, LPN #61, State tested Nursing Assistant (STNA) #38, STNA #103, STNA #104, STNA #60, STNA #66, Activity Director #22, and Housekeeper #19 revealed they were knowledgeable of resident behaviors and knew what to do in the case of homicidal ideation and suicidal ideation. On [DATE] at approximately 8:00 A.M., House Psychiatrist #100 completed a review all residents for homicidal ideation. No current residents were found with homicidal ideation. On [DATE], a special Quality Assurance Performance Improvement (QAPI) meeting is scheduled to be held with MD #106 and House Psychiatrist #100 to discuss the incident that occurred between Resident #82 and Resident #83. Although the Immediate Jeopardy was removed, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the closed medical record revealed Resident #83 was admitted to the facility on [DATE]. He was admitted from a local hospital where he had a stay in [DATE] due to bizarre behaviors, such as stripping naked and he expressed wanting to kill everyone at the homeless shelter. [DIAGNOSES REDACTED]. It may result in some combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning and can be disabling. People with [MEDICAL CONDITION] require lifelong treatment), [MEDICAL CONDITION] disorder, and diabetes. Review of the counseling referral dated [DATE] revealed he had been offered counseling due to being depressed, being withdrawn, psychotic thinking, thought distortion, worries and history of homicidal ideation (which he reasonably denied at the time of the consult). He declined the offer for counseling and there was no other documented follow-up request for counseling services for the resident. Review of the psychiatric consultation dated [DATE] revealed he was seen due to history of mental illness and unable to care for himself, he had auditory hallucinations (hearing voices), anxiety, depression, and difficulty coping with the new placement. His mental status examination included that he was suspicious, had paranoia, delusions, he had fair insight and limited judgement. He was ordered an antipsychotic medication. He was to follow up in one to three months. Review of the psychiatric consultation dated [DATE] revealed a follow-up was requested by the medical doctor due to behavioral symptoms, and psychotic signs and symptoms. He was feeling persecuted and paranoid. He was suspicious, withdrawn, dysphoric, delusions, preoccupation, he reliably denied suicidal and homicidal thoughts. He was slowly responding with increased quality of life. He was to have follow-up in three months. Review of the psychiatric consultation dated [DATE] revealed a follow-up was requested by the medical doctor due to behavior symptoms, psychotic symptoms and depressive mood and therapeutic efficiency of medication. He reliably denied suicidal and homicidal thoughts and continued the same medication regimen. Review of the psychiatric consultation dated [DATE] revealed he had presented to the hospital for out of control blood sugar; however, he continued with paranoid thinking, feeling persecuted, delusions, auditory hallucinations, dysphoric and anxious. He reliably denied suicidal and homicidal thoughts. His antipsychotic medication was decreased at this time; however, the plan documented a gradual dose reduction was clinically contraindicated at this time. He was to follow-up in three months. Review of the behavior/intervention monthly flow record dated from ,[DATE] through ,[DATE] revealed the behavior being monitored was refusing medications and refusing care. The behavior monitoring was not documented consistently on each shift. There were no other specific targeted behavior monitoring for delusions, auditory hallucinations, or homicidal ideation. Review of the quarterly assessment dated [DATE] revealed the resident had moderate impaired cognition, he had trouble falling or staying asleep and he had not displayed any hallucinations or delusions. He required supervision for bed mobility, and transfer; however, he was independent in walking in his room. He also took antipsychotic medication. Review of the current plan of care revealed he had a potential to demonstrate physical behaviors related to poor impulse control and a history of suicidal and homicidal ideation. The goal was to not harm himself or others. Interventions included cognitive assessments, provide physical and verbal cues to alleviate anxiety, be able to verbalize the source of agitation, document observed behavior and attempted interventions in the behavior log. Monitor, document and report to the MD of danger to self and others. Review of the nurse notes revealed the last documented note was dated [DATE] which documented the resident had no behaviors. No further behavior documentation was in the progress notes from [DATE] to [DATE]. Review of a facility's SRI dated [DATE] and the facility investigation revealed an allegation of physical abuse involving Resident #82 and Resident #83 occurred at 6:55 A.M., when Resident #83 claimed to have caused the passing of Resident #82. The local authorities were called and immediately arrived. Per the SRI, the local authorities and the facility management staff did not believe the allegation made by Resident #83. The investigation revealed the residents were immediately separated. As part of the facility investigation, witness statements were taken from LPN #61, RN #37, Medical Records Staff #09, and UM #62 on [DATE]. LPN #61's witness statement documented she administered 5:00 A.M. medications and both residents were on their respective sides of the room. She checked Resident #83's blood sugar and noticed Resident #82 resting with his eyes closed and his chest was moving up and down. As she was completing her shift, Housekeeper #19 alerted her that Resident #83's head was hurting. Resident #83 was standing in the hallway. LPN #61 told the resident to wait so she could obtain equipment to check his vital signs. LPN #61 called UM #62 and told her Resident #83 did not seem like himself. UM #62 instructed her to ask him if he felt like hurting himself or others. Resident #83 told LPN #61 he had hurt Resident #82. LPN #61 observed Resident #82 unresponsive. She indicated Medical Records Staff #09 initiated cardiopulmonary resuscitation (CPR) while she called for emergency services and checked Resident #82's code status. After LPN #61 called emergency services, she went to the room to assist with the code. RN #37's witness statement documented she heard the calls for help and her and Medical Records Staff #09 came to assist. RN #37 stayed outside of the room with Resident #83 while the code was started. Medical Records Staff #09's witness statement documented she and RN #37 ran down the hall toward the calls for help. RN #37 remained outside with Resident #83 while she began chest compressions until emergency services arrived. UM #62's witness statement documented she received a call from LPN #61 on [DATE] at 7:01 A.M. LPN #61 inquired if Resident #83 had recently been acting weird or had been sick. LPN #61 informed UM #62 the resident was complaining his head hurt and he didn't feel right. UM #62 instructed LPN #61 to ask Resident #83 if he felt like he was going to hurt himself or someone else. Further review of the facility investigation revealed there were no other witness statements or interviews from other staff members who had worked on [DATE]. Interview on [DATE] at 10:42 A.M., Homicide Detective #101 stated the preliminary cause of Resident #82's death was identified as suffocation. She said this was also confirmed by the statement she received from Resident #83. He gave a detailed statement of how he picked up a pillow from the wheelchair and held it over the face of Resident #82, suffocated, and killed him. He

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F 0742 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) further stated to her Resident #82 had scratched Resident #83's neck and she confirmed Resident #83 had fresh scratches on his neck. She said Resident #83 reported the devil made him do it. She stated nail scrapings were taken from Resident #82 and a Deoxyribonucleic Acid (DNA) swab was taken from Resident #83. She said the case was closed as a homicide. Finally, she stated there would be no trial as Resident #83 had hung himself in the local jail and expired. Interview on [DATE] at 12:00 P.M., RN #37 stated she heard the call for help from the night shift nurse LPN #61. RN #37 said she stayed out in the hallway with Resident #83. LPN #61 went to the top of the hallway to call emergency services. Agency LPN #105 went into the resident's room while RN #37 waited in the hallway with Resident #83. The police came and took Resident #83 away. She said she never saw this coming, Resident #83 did not socialize and did not come out of his room. Interview on [DATE] at 12:55 P.M., SSD #68 stated he had a history of [REDACTED]. She stated he had a psychiatric stay in May/[DATE] when he was running around the homeless shelter naked and acting bizarre. When they asked him if he wanted to hurt himself or others, he responded everyone. She verified there was no other attempt for counseling, and they did not monitor specific behavior daily of hearing voices, or homicidal ideation, because he just said it in the homeless shelter. He said he had seen the psychiatrist and reliably denied homicidal ideation. She further stated Resident #83 was protective of Resident #82 as he thought of him as a best friend. Interview on [DATE] at 4:18 P.M., LPN #61 stated she had finished up her morning medication pass. She was called back to the 100-hall because Resident #83 had a headache and wasn't acting himself. She called UM #62 and asked if the resident had been having any problems since LPN #61 had not worked in a few days. At the direction of UM #62, she asked Resident #83 if he felt like hurting himself or others and he stated he had killed Resident #82. She went into the room and Resident #82 looked unresponsive. Interview on [DATE] at 4:32 P.M., the DON, ADON #64 and the Administrator stated the staff were not going to go in the resident's room after Resident #83 had just killed his roommate. Interview on [DATE] at 5:25 P.M., Resident #51 stated she was a friend of Resident #82 and the only thing she noticed was a few days before the incident she observed Resident #83 rummaging through Resident #82's drawers. She asked Resident #83 what he was doing, and he said nothing. She observed Resident #82 asking Resident #83 what he was carrying, but Resident #83 indicated he had nothing and refused to show Resident #82 what he had. Interview on [DATE] at 12:17 P.M., House Psychiatrist #100 stated when she previously saw Resident #83, he denied command auditory hallucinations and he could not recognize the voices he was hearing. There was no indication he would escalate to this level. She further stated she decreased the antipsychotic medication due to him having [MEDICAL CONDITION]. She said she did not take him off completely and she decreased it slowly. She did not report why she had documented a gradual dose reduction was contraindicated on the [DATE] consultation when she decreased the medication. She also discussed the behavior plan with the nursing staff. She said for counseling they would attempt two times before they do not refer them again. Interview on [DATE] at 11:17 A.M., Medical Director #106 stated when Resident #82 started spending time with Resident #51 he thought this may have set off Resident #83. Resident #83 thought of Resident #82 as his best friend and fixated on this. Review of the facility policy titled Mental Health Services dated [DATE] revealed the facility will help residents maintain or improve their psychosocial conditions and will provide or arrange counseling, psychotherapy, or other mental health services when indicated. Monitor behavior using behavior monitoring tool on the Medication Administration Record [REDACTED]. This deficiency is an incidental finding discovered during Master Complaint Number OH 601, Complaint Number OH 573, Complaint Number OH 540 and Complaint Number OH 291.
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, review of the manufacturers recommendation and policy review, the facility failed to ensure a resident was free from a significant medication error. This affected one (#63) of four residents reviewed for medication administration. The facility census was 80. Findings include: Review of the medical record for Resident #63 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the physician orders dated 12/07/19 revealed duloxetine (antidepressant) 30 milligram (mg) one capsule by mouth one time a day. There were no documented orders to open the capsules prior to administration. Observation on 03/04/20 at 9:40 A.M., Licensed Practical Nurse (LPN) #62 opened the duloxetine 30 mg capsule and emptied the contents into a small plastic medication administration cup. LPN #62 then added vanilla pudding into the plastic medication cup mixing contents and administered medications to resident. Interview on 03/04/20 10:31 A.M., with LPN #62 verified the duloxetine was opened and the content of the capsule was added to the medication cup and administered together to Resident #63. Interview on 03/04/20 at 10:31 A.M., with Assistant Director of Nursing (ADON) #64 verified Resident #63 had no orders to open the capsules for administration. Review of the manufacturer recommendation for duloxetine, dated 10/2019, revealed to swallow the capsule whole, do not chew, crush or open the capsule and sprinkle its contents on food or mix with liquids. This may affect the [MEDICATION NAME] coating. Review of the facility policy titled Administrating Medication Policy, dated 01/06/20, revealed the policy does not address opening medication capsules for administration. This deficiency was an incidental finding discovered during investigation of Complaint Number OH 601, Complaint Number OH 573, Complaint Number OH 540 and Complaint Number OH 291.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and policy review, the facility failed to ensure expired medication was removed from the medication cart. This had the potential to affect 37 of 37 residents who resided on the the 100 and 200 halls. The facility census was 80. Findings include: Observation on [DATE] at 10:59 A.M. of the 200 hall medication cart revealed 22 individual [MEDICATION NAME] (a medication to open the lungs) inhalation solutions individual packs 2.25% with an expiration date of [DATE] and two opened bottles of multi-dose Vitamin B-12 with an expiration date of ,[DATE] being stored in the medication cart. Interview on [DATE] at 11:00 A.M., with Licensed Practical Nurse (LPN) #64 verified the medications had expired and should have been removed from the cart and disposed of. Observation on [DATE] at 11:30 A.M. of the 100 hall medication cart revealed one opened multi-dose Vitamin B-12 bottle with an expiration date of ,[DATE], a [MEDICATION NAME] (an injectable medication to treat very low blood glucose levels), for injection 1 milligram (mg) per vial expired ,[DATE], an unlabeled and opened [MEDICATION NAME] 220 microgram (mcg) inhaler with an expiration date of [DATE] and one multi-dose bottle of acidophilus [MEDICATION NAME][MEDICATION NAME] that had a written note on the cap of the bottle which revealed the medication should be kept in the refrigerator after opened. The bottle of [MEDICATION NAME] was located in the medication cart and expired ,[DATE]. Interview on [DATE] at 11:45 A.M., with LPN # 5 verified the medication identified was expired and should have been removed from the cart and disposed of. Review of facility policy titled Storage of Medication, dated ,[DATE], revealed the policy indicated the facility shall not use discontinued, outdated or deteriorated drugs or biological and all such drugs shall be returned to the pharmacy or destroyed. This deficiency substantiated allegations contained in Complaint Number OH 291.