STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175332	A. BUILDING _____ B. WING _____	**10/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCK CREEK OF OTTAWA	**1100 W 15TH STREET OTTAWA, KS 66067**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 71 residents. Based on record review and interviews, the facility failed to report a resident to resident altercation to the state agency, between Resident (R)1 and R2, as required. R1 grabbed R2 on both arms. Findings included: - The signed Physician order [REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], documented the resident admitted [DATE], and revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7, indicating he had moderately impaired cognition. The resident received anti-[MEDICAL CONDITION], anti-anxiety, and anti-depressant medications. The [MEDICAL CONDITION] Drug Use Care Area Assessment (CAA), dated 04/18/20, revealed the resident was at risk for adverse effects related to the use of anti-psychotic, anti-anxiety and anti-depressant medication. The care plan, dated 04/07/20, revealed the resident used [MEDICAL CONDITION] medications related to [MEDICAL CONDITION] and behavior management. Staff should consult with counselors for behaviors health as needed. Staff were to approach the resident in a calm manner, reposition him, offer him a snack, assess him for pain, provide a quiet environment, encourage him to express his feelings, attend an activity, and provide him reassurance. On 08/06/2020, the clinical records lacked documentation of a resident to resident altercation. Review of the facility's Internal Investigation, revealed on 08/06/2020 at 05:30 PM, a resident altercation occurred between R1 and R2. Staff heard R1 and R2 yelling out at each other. R2 reported R1 grabbed her arms in the altercation. R2 reported she expressed feelings of fear from R1. Observation, on 10/15/20 at 10:25 AM, revealed R1 without behaviors. On 10/15/20 at 10:42 AM, Certified Nurse Aide (CNA) P, provided cares on R1. R1 was compliant with his cares. On 10/15/20 at 02:11 PM, R1 was calm, and had no negative behaviors. On 10/19/20 at 08:48 AM, R1 rested in his bed, without behaviors. On 10/16/20 at 08:18 AM, Licensed Nurse (LN) G stated she was in the medication room and heard R1 yelling loudly. R1 was in R2's bedroom doorway. R2 reported R1 grabbed both of her arms in the altercation. On 10/16/2020 at 10:27 AM, R2 verbalized she did not want to discuss the incident. On 10/16/20 at 11:41 AM, LN I stated that she was in her office, located on the west hall, when she heard someone yell on the east hall. She witnessed R1 in his wheelchair at R2's doorway, with R2 standing behind him, however, when she approached the residents, she was unable to determine if either of the residents had physical contact. She reported R2 as alert and oriented. On 10/15/20 at 08:43 AM, Administrative Staff A verified she did not report the incident to the State agency. The facility's policy Reporting Alleged Violations of Abuse and Neglect, dated 11/15/2018, documented the resident has the right to be free from abuse and must not be subjected to abuse from other residents in the facility. The facility failed to report to the state agency, a resident to resident altercation when one resident grabbed another residents arm, which placed R1 at fearful for this resident's physical aggression.

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.