STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015120	A. Building B. Wing	10/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Anniston	2300 Coleman Rd Anniston, AL 36207

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record review, review of a Facility Reported Incident (FRI) received by the State Agency, the facility's investigative file, and review of a facility policy titled PATIENT'S RIGHTS, the facility failed to ensure Resident Identifier (RI) #237's rights were honored on 05/22/2023 when RI #237 told facility staff he/she had been attacked and wanted to notify the police. Facility staff witnessed RI #239 grab RI #237's wrists, pull RI #237 out of a recliner onto the floor, and RI #239 threw punches at RI #237. The police were not notified of RI #237's request. This deficient practice affected one of 26 residents sampled and was cited as a result of the investigation of complaint/report number AL00044297. Findings include: On 05/22/2023 the State Agency received an Online Incident Report (FRI) from the facility alleging staff witnessed RI #239 grab RI #237 by the wrists, pull RI #237 onto the floor from a recliner, RI #239 was throwing punches at RI #237, and RI #237 had a bruise to the right wrist. A facility policy titled PATIENT'S RIGHTS dated 03/2024 documented: . we support the patient's right to live in an environment which is individualized for them. We strive to cultivate and sustain an excellent quality of life for each individual with person-centered care and services, by honoring and supporting each patient's preferences, choices, values and beliefs. RI #237 was admitted to the facility on [DATE], with diagnoses to include Cerebrovascular Disease, Vascular Dementia with Severe Agitation and History of Falling RI #237's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/08/2023 documented a Brief Interview for Mental Status (BIMS) score of six of 15 which indicated severely impaired cognition. RI #239 was admitted to the facility on [DATE] with diagnoses to include History of Traumatic Brain Injury, Disorders of Brain-Encephalomalacia, Depression, and History of Transient Ischemic Attack. The facility investigative file contained a handwritten statement signed by Registered Nurse (RN) #5 dated 05/22/2023 that documented: On May 22, 2023 at 0340 (3:40 AM), Nurse from memory care unit called me down . due to rehab patient dragging memory care/long term patient to the floor from recliner and punching (him/her) multiple (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times up until 4 members of staff were able to get (him/her) off of them. I did not witness any of this. Upon speaking . (with) patient that was allegedly hit, patient states, I was pulled out my chair and attacked. I want the police. On 10/23/2024 at 2:23 PM RN #5 was asked about the incident with RI #237. RN #5 said, she had been called over to help with a resident who had pulled another resident to the floor, RI #237 was sitting in a chair, and she asked RI #237 what happened. RN #5 stated, RI #237 told her I was pulled out of a chair and attacked, I want the police. RN #5 said, she tried to call the abuse coordinator/Social Service Director (SSD) and could not reach her so she notified the Director of Nursing who said to separate the residents. RN #5 said, she then notified RN #4 to continue to try to notify the SSD, Administrator, physician, and families; and then RN #5 returned to her own hall. RN #5 said, she did not call the police, but tried to call the abuse coordinator. RN #5 said, the abuse coordinator and the Administrator were responsible for calling the police if warranted. The Abuse Coordinator (AC)/SSD was interviewed on 10/25/2024 at 3:15 PM. She stated, she did not recall any staff reporting that RI #237 requested the police. The AC said, anyone could have called the police for RI #237, including the Administrator and DON. The AC said, RI #237's rights were not honored if he/she requested the police be notified and the facility did not notify the police. On 10/26/2024 at 2:48 PM the Administrator (ADM) was asked about the incident involving RI #237. The Administrator said, the facility communicates with law enforcement by calling the police department directly or calling 911. The ADM said, the police were not notified of the incident between RI #237 and RI #239 on 05/22/2023 and she was not made aware RI #237 asked for the police.

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F 0600 Level of Harm - 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 interviews, record review, review of a facility policy titled Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, review of Facility Reported Incidents (FRIs) received by the State Agency, and review of the facility's investigative files, the facility failed to protect the rights of residents to be free from abuse perpetrated by other residents of the facility. Specifically, on 05/22/2023 Resident Identifier (RI) #237 was physically abused by RI #239 when facility staff witnessed RI #239 grab RI #237's wrists and pull RI #237 from a recliner onto the floor and punch RI #237 multiple times. The facility failed to prevent this from occurring as staff members were aware RI #239 was annoyed with RI #237 yelling and RI #239 had already told RI #237 to shut up, earlier in the night. RI #237 was assessed with redness and bruising to the right wrist. RI #237 told staff after the incident, he/she had been attacked and wanted the police. Facility staff said, the abuse against RI #237 would have made someone in that situation feel hurt, scared, and upset. Further, on 08/15/2023 RI #288 was physically abused by RI #290 when RI #290 struck RI #288 in the face and chest. After the incident RI #288 was seen crying and told staff he/she had been hit. Witnesses of the incident said it was physical abuse and someone in that situation would have felt terrified, upset, angry, and hurt. The facility failed to prevent this from occurring when just minutes prior to this incident RI #290 had used an electronic hand sanitizer as a weapon to swing at staff and had aggressively pushed a rollator (rolling walker) into staff and toward another resident. The facility further failed to substantiate RI #288 was physically abused by RI #290. This deficient practice was cited as a result of the investigation of complaint/report numbers AL00044297 and AL00045279 and affected RI #237 and RI #288, two of five residents sampled for abuse. Findings include: A facility policy titled Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, with a revision date of 02/01/2023, documented the following: . DEFINITION POLICY Abuse, Neglect, Misappropriation of Patient Property and exploitation . will not be tolerated by anyone, including . patients . The patient has the right to be free from abuse, neglect, . The center administrator is responsible for assuring that patient safety, including freedom from risk of abuse or neglect, holds the highest priority. DEFINITIONS: Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	injury or harm. Physical Abuse: includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. PREVENTION POLICY . A. The center will provide supervision and support services designed to reduce the likelihood of abusive behaviors. All supervisory partners who receive reports of and/or identify inappropriate behaviors will take immediate steps to correct such behaviors. C. Patients with needs and behaviors that might lead to conflict with partners or other patients will be identified by the Care Planning team, with interventions and follow through designed to minimize the risk of conflict. The interventions designed to meet the needs of such patients will include but will not be limited to 1. Identification of patients whose personal histories render them at risk for abusing other patients or partners, 2. Assessment of appropriate intervention strategies to prevent occurrences, 3. Monitoring the patient for any changes that would trigger abusive behavior, . 1) On 05/22/2023 the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse when staff witnessed RI #239 grab RI #237 by the wrists and pull RI #237 onto the floor from a recliner and RI #239 punched at RI #237. RI #237 was admitted to the facility on [DATE] with diagnoses to include Cerebrovascular Disease, Vascular Dementia with Severe Agitation and History of Falling. RI #237's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/08/2023 documented a Brief Interview for Mental Status (BIMS) score of six of 15, which indicated severely impaired cognition. RI #239 was admitted to the facility on [DATE] with diagnoses to include History of Traumatic Brain Injury, Disorders of Brain-Encephalomalacia, Depression, and History of Transient Ischemic Attack. The facility's investigative file included a report titled Opening Statement that documented: . On 5/22/23 at approximately 3:30am, . (RI #237) and (RI #239) were both up in the dayroom and had an altercation, and (RI #239) pulled (RI #237) out of the recliner and began hitting at (RI #237). Staff responded immediately and separated the two patients and took (RI #239) back to (his/her) room with staff supervision. MD (physician) was notified and orders were received to transfer (RI #239) to the adult . (psychiatric) unit . Calls were made to both patient's families and an immediate investigation was initiated. (RI #237) was assessed and it was noted that (he/she) had redness to (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	(his/her) right ear and right wrist. The facility's investigative file also contained a form titled Incident Investigation Summary, dated 05/25/2023 signed by the Administrator (ADM) that documented: . Conclusion Summary: Physical abuse was substantiated . The facility investigative file contained a handwritten statement signed by Registered Nurse (RN) #5 dated 05/22/2023 that documented: On May 22, 2023 at 0340 (3:40 AM), Nurse from memory care unit called me down . due to rehab patient dragging memory care/long term patient to the floor from recliner and punching (him/her) multiple times up until 4 members of staff were able to get (him/her) off of them. I did not witness any of this. Upon speaking . (with) patient that was allegedly hit, patient states, I was pulled out my chair and attacked. I want the police. Upon speaking (with) patient that allegedly hit the other patient, patient states, I told (him) to shut up. I told y'all I can not take all this noise here. On 10/23/2024 at 2:23 PM RN #5 was asked about the incident with RI #237. RN #5 said, she had been called over to help with a resident who had pulled another resident to the floor, RI #237 was sitting in a chair, and she asked RI #237 what happened. RN #5 stated, RI #237 told her I was pulled out of a chair and attacked, I want the police. RN #5 said, she tried to call the abuse coordinator/Social Service Director (SSD) and could not reach her so she notified the Director of Nursing who said to separate the residents. RN #5 said, she then notified RN #4 to continue to try to notify the SSD, Administrator, physician, and families; and then RN #5 returned to her own hall. The facility's investigative file contained an undated handwritten statement signed by CNA #6 that documented: (RI #239) was in the day area and I saw (him/her) drag (RI #237) out of the recliner and start punching (RI #237) repeatedly. The Nurse, CNAs and I immediately went over and removed (RI #239) away from (RI #237) . On 10/23/2024 at 9:24 AM CNA #6 was asked what she remembered about the incident on 05/22/2023. CNA #6 said, she witnessed RI #239 rolling up to RI #237 and pulling RI #237 out of a recliner and RI #239 hit RI #237. CNA #6 said, she did not remember where RI #237 was hit but they separated the residents and took RI #239 to his/her room. CNA #6 said, what she witnessed would make someone in that situation feel hurt or scared. The facility's investigative file contained an undated handwritten statement signed by CNA #7 that documented: (RI #237) . was in the day area, and I seen (RI #239) pulled (RI #237) out of the recliner and start punching (him/her) repeatedly. It took all of us to pull (RI #239) off of (RI #237) and remove (him/her) from the room. We took (RI #239) to (his/her) room where a CNA had to sit with (him/her). On 109/23/2024 at 10:17 AM CNA #7 was asked what she remembered about the incident on 05/22/2023. CNA #7 said, both residents were in the dayroom and she saw (RI #237) on the floor and RI #239 was leaning over RI #237. CNA #7 said, staff immediately separated the residents. CNA #7 said, RI #237 did not complain of pain but wanted the staff to call the police. CNA #7 said what she witnessed was physical abuse and someone in that situation would feel upset. The facility's investigative file contained an undated handwritten statement signed by CNA #8 that documented: I witnessed (RI #237) was sitting in the day room in the recliner when (RI #239) pulled (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	(him/her) out the recliner and proceeded to punch (him/her) multiple times me and other staff pulled (him/her) off and redirected patient . (RI #239) stated (RI #237) was annoying and I quote The Shit out of him. CNA #8 was unavailable for interview. The facility's investigative file contained an undated handwritten statement signed by CNA #9 that documented: I witnessed (RI #239) pull (RI #237) out of (his/her) chair and proceeded to punch (him/her) multiple times. It took 4 CNAs to pull (RI #239) off of (RI #237). CNA #9 was unavailable for interview. RI #237's nursing progress note dated 05/22/2023 electronically signed by RN #4 documented: . Pt (patient) had been in day room in recliner for most of this shift. Pt yelling out but when asked what (he/she) needs (he/she) states (he/she) doesn't know or that (he/she) needs to urinate, . Another patient rolled over to (RI #237) . My CNAS (Certified Nursing Assistant) reported to me that the patient pulled (RI #237) from recliner when I came around the corner I seen the patient punching (RI #237). Pt was stopped and separated . assessed for injuries. Redness noted to (R/right) wrist and Ear. A handwritten statement signed by RN #4 and dated 05/22/2023 documented: . (RI #237) was in recliner in the day room. Pt yells out often and was this night. (RI #239) told pt to shut up and stated the yelling was annoying. Moments later . (RI #239) was sitting in wheelchair speaking in normal tones to (RI #237). I was behind my (medication) cart when I heard my CNAs say Oh no and rushed out to day room. When I came around the corner I witnessed (RI #239) punching (RI #237) and (RI #237) was on the floor. CNAs stated to me that (RI #237) was pulled out of the chair by (RI #239). (RI #239) was removed and taken to room . Notified (physician/social services) and DON . verbal order to send pt (RI #239) out. On 10/23/2024 at 10:45 AM RN #4 was asked about the incident occurring on 05/22/2023 involving RI #237 and RI #239. RN #4 said, RI #237 who typically slept in the recliner started yelling out as he/she had a history of doing. RI #239 self propelled in wheelchair and yelled at RI #237 to shut up and RI #237 was annoying. RI #239 was re-directed to his/her room and a little while later, about an hour and a half, RI #239 came up the hall to the dayroom back toward RI #237, close to RI #237's chair. RN #4 said, the next thing she remembered was CNA #6 and CNA #8 jumped up from the desk and said, Oh no. RN #4 continued, she ran with them and saw RI #237 down on the floor and RI #239 leaning over RI #237 from the wheelchair punching at RI #237. RN #4 said, the incident she observed was physical abuse that would make someone in that situation feel upset and scared. The Abuse Coordinator (AC) was interviewed on 10/23/2024 at 3:19 PM. She stated RN #4 had reported the 05/22/2023 resident-on-resident altercation involving RI #237 and RI #239. The AC said, RN #4 had reported the incident to her, that the two residents had an altercation and RI #239 hit RI #237. The AC further concluded the incident was substantiated due to resident-on-resident abuse. On 10/26/2024 at 7:03 PM a follow up interview was conducted with the Abuse Coordinator and she was asked her professional opinion about what could have been done to prevent the abuse from occurring. The AC said, the nurse or the CNAs could have assessed for toileting needs, hunger, thirst, pain, or they could have offered quiet time in bed. The AC also said, the physician could have been (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	notified or they could have called the family. The AC said, these things were not done. The Director of Nursing, (DON), was interviewed on 10/23/2024 at 4:30 PM. When asked if she recalled the resident-on resident altercation on 05/22/2023 involving RI #237 and RI #239, she said, yes. The DON confirmed the nurse had reported the incident to her, and that the two residents had an altercation and RI #239 hit RI #237. The DON stated this conclusion was physical abuse. On 10/26/2024 at 6:47 PM a follow up interview was conducted with the DON and she was asked her professional opinion about what could have been done to prevent the abuse from occurring. The DON said, the physician could have been notified of RI#237's behaviors and they could have taken RI #237 to his/her room for quiet time. The DON also said, the staff also could have assessed RI #237 for pain, hunger, thirst, toileting needs, or they could have called the family. The DON said, these things were not done. 2) On 08/15/2023 the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse when RI #290 struck RI #288 on the left side of the face and upper stomach. RI #288 was readmitted to the facility on [DATE] and had diagnosis to include: Epilepsy and Dementia. RI #290 was admitted to the facility on [DATE] and had diagnosis to include: Parkinson's Disease and Dementia. Review of the facility investigative file revealed a report titled Opening Statement that documented: . At approximately 11:30am . (RI #290) . came out of (his/her) room . became difficult to redirect and proceeded to nurses station picked up the hand sanitizer and was trying to swing at partners (employees) and then wanted (his/her) phone. was given (his/her) phone . At approximately 12:30pm . (RI #290) . walked over to the day area where lunch was being served. (RI #288), stood from where (he/she) was seated and . (RI #290) walked over and struck (RI #288) on the cheek and then in the abdomen area. Staff was able to intervene and assist (RI #290) back to (his/her) room until the MD (physician) could be notified and was given orders to send (him/her) to the ER (emergency department) for evaluation. (RI #288) was assessed for injury and no injuries were noted other than a red area to (his/her) face . The facility's investigative file contained an undated report titled Conclusion which documented: . it was determined that physical abuse could not be substantiated. (RI #288) may have gotten up to hug (RI #290) . (he/she) reacted with physical aggression. A Witness Statement Form dated 08/15/2023 for RI #288, the victim, documented an incident type of physical and RI #288's statement as follows: . (RI #288) stated (he/she) hit me. (He/she) knew better . (RI #288) was crying. A facility . Body Audit Form . dated 08/15/2023 at 12:40 PM documented . Slight Redness to (L/left) Cheek . with a line drawn on the left side of the face on the figure on the form. A Witness Statement Form dated 08/15/2023, signed by Certified Occupational Therapy Assistant (COTA) #13 documented an incident type of Physical and COTA #13's statement as follows: . I was walking to a . room, when (RI #290) was walking out. The CNAs were moving beds. So I tried to redirect (him/her), but (he/she) became aggressive. (RI #290) started running (his/her) walker into me (and) (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	pushing me away. (He/she) continues to be aggressive, so I backed away to let the CNAs handle it. During an interview on 10/24/2024 at 2:07 PM with COTA #13, she stated she did observe RI #290 push his/her rollator in the way of staff in the hall so they could not get by and when she tried to intervene, RI #290 pushed the rollator into her, so she stepped aside and reported to the nurse, but not sure which nurse. A Witness Statement Form dated 08/15/2023, signed by CNA #11 documented an incident type of Patient-on-Patient and CNA #11's statement as follows: . Between 11:30 am and 12:00 pm while the nurse and I were moving a patient . (in the patient's bed) through the hall . (RI #290) would not let us pass. A member of therapy tried to redirect (RI #290) and (RI #290) ramed (rammed) the bed with (his/her) walker and began to ram the therapist. (RI #290) grabbed the Sanitizer dispenser from the desk . and began to swing it. When we got it away from (RI #290), (he/she) asked for (his/her) phone. (He/she) calmed down and stood at the desk for awhile. (He/she) walked over to the Dayroom and stood for a few minutes. (RI #288) stood up to go to the table to eat lunch. When (RI #288) stood up, (RI #290) punched (RI #288) in the chest area and then again in the face. On 10/23/2024 at 4:20 PM CNA) #11 was asked about the incident on 08/15/2023. CNA #11 stated, a short time prior to the incident between RI #290 and RI #288, RI #290 displayed aggressive behavior by using an electronic hand sanitizer dispenser as a weapon against the staff when RI #290 was mad for some reason and began to swing the dispenser at her and a nurse. CNA #11 said, it took several staff to take the dispenser away from RI #290. CNA #11 said, then RI #290 appeared to calm down and went over to the dayroom where RI #288 was. CNA #11 said, this was about 30 minutes later and they were singing in the watch area and RI #288 came up an started talking loudly (RI #288 is deaf) and RI #290 stood up and punched RI #288 in RI #288's face and chest. CNA #11 said, this was physical abuse and it would make someone in that situation feel terrified, upset, and angry. A Witness Statement Form dated 08/15/2023, signed by CNA #12 documented an incident type of physical and CNA #12's statement as follows: . I was in the watch .(area) sitting in between (another resident and RI #288). (RI #290) came and sat beside (RI #288). (RI #288) may have thought (RI #290) was a friend and went in to hug (RI #290). (He/she) punched (RI #288) in the upper right side of (his/her) face and upper right side of chest. (RI #288) was taken to safety and (RI #290) was taken to room. On 10/23/2024 at 3:53 PM CNA #12 was asked about the incident on 08/15/2023. CNA #12 stated, while on the unit assisting with activities RI #288 came up to RI #290 and tried to give RI #290 a hug. CNA #12 stated, RI #290 hit RI #288 in the face and upper chest. CNA #12 said, this was physical abuse and it would make someone in that situation feel angry. A Witness Statement Form dated 08/15/2023, signed by Licensed Practical Nurse (LPN) #14 documented an incident type of assault and LPN #15's statement as follows: . Resident was standing with (his/her) walker in front of (him/her). The nurse . (with a cart) . the CNA needed to pass. The resident began using (his/her) wheelchair to stop the . nurse and CNA . The resident then attempted to us (his/her) walker to stop PT person (physical therapist). The resident used (his/her) walker to attempt to stop the stretcher (resident being moved to another room). When that did not work, the resident picked up a metal hand sanitizer object (that was at the desk) to throw. Staff was able to get the object from the resident. (The resident was continuing to stop the stretcher . the stretcher had a resident on it as well). There was the potential to hurt the other resident and staff. The next thing was the resident had remained in the day area hit another resident twice. Once in the face and once in (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	the chest. We all came to assist in stopping any further problems. The resident with the walker continued to walk towards the hit resident. Resident sat in chair yet still was wanting to hit at staff and the other resident. The resident continued attempting to hit at, punch at, grimace at. We phoned for help . assisted to (his/her) room until transport came. On 10/24/2024 at 2:30 PM LPN #14 was asked about the incident on 08/15/2023. LPN #14 reviewed and agreed, that was her written statement, and said, the incident was physical abuse. During an interview on 10/24/2024 at 3:55 PM with Director of Nursing (DON), she stated she was called to the unit by nursing staff who reported RI #290 had hit RI #288 in the left side of the face and chest. The DON stated, after the incident RI #288 was crying and saying RI #290 had hit him/her and RI #290 knew better. The DON said, she asked RI #290 what happened and RI #290 just shook his/her head and mumbled. The DON said, the physician was notified, RI #290 was sent to the hospital for evaluation, was admitted and returned to the facility on [DATE]. The DON stated, she was not aware of the behaviors RI #290 displayed prior to the incident. The DON was asked what the facility could have done to prevent this from happening since RI #290 had displayed behaviors prior to the incident. The DON replied, they could have called the doctor for medication or could have sent to the hospital sooner or called the family to come sit with resident. The DON stated, the staff should have kept RI #290 away from other residents when he/she started having behaviors and the physician should have been notified when the behavior pattern began. The DON said, the incident was physical abuse and someone in that situation would feel upset, angry, and have hurt feelings.

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	015120	A. Building B. Wing	10/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Anniston	2300 Coleman Rd Anniston, AL 36207

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(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** Based on resident record review, interviews, review of a facility policy titled Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, and review of the facility investigative files, the facility failed to report reasonable suspicion of a crime against residents who were physically abused to Local Law Enforcement for Resident Identifier (RI) #237 and RI #288. Specifically, on 05/22/2023 facility staff witnessed Resident Identifier (RI) #237 being pulled from a recliner by the wrists onto the floor and punched by RI #239. RI #237 was assessed with redness and bruising to the right wrist after the incident and RI #237 told staff who witnessed the physical abuse occur, he/she had been attacked and wanted the police. This incident was reported to the Director of Nursing (DON), Administrator (ADM) and Social Services Director/Abuse Coordinator (AC) but was not reported to the Local Law Enforcement. Further the facility failed to ensure the abuse policy specified: who was required to report the reasonable suspicion of crimes to law enforcement agencies; what crimes must be reported to law enforcement agencies; what constitutes serious bodily injury; and what the timeframe would be for reporting suspicion of crimes to law enforcement agencies. These deficient practices affected RI #237, one of five residents sampled for abuse. Findings include: Cross-reference F 550 and F 600. A facility policy titled Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, revised 02/01/2023, documented the following: . 6. REPORTING POLICY . It is the policy of this facility that abuse allegations . are reported per Federal and State law. The facility will ensure that all alleged violations involving abuse, . are reported immediately, . to the administrator of the facility. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. The facility policy did not specify any of the following information about reporting suspicion of crimes against residents in the facility to local law enforcement agencies: who in the facility was required to report; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what crimes must be reported; what constitutes serious bodily injury; and what the timeframe was for reporting suspicion of crimes against residents of the facility to local law enforcement. On 05/22/2023 the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse had occurred when staff witnessed RI #239 grab RI #237 by both wrists pulling RI #237 onto the floor from a recliner and then RI #239 was witnessed throwing punches at RI #237 as staff tried to intervene. The FRI also documented upon physical assessment RI #237 had bruises to the right wrist and a local law enforcement agency had not been notified of the incident. RI #237 was admitted to the facility on [DATE], with diagnoses to include Cerebrovascular Disease, Vascular Dementia with Severe Agitation and History of Falling RI #237's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/08/2023 documented a Brief Interview for Mental Status (BIMS) score of six of 15, which indicated severely impaired cognition. RI #239 was admitted to the facility on [DATE] with diagnoses to include Personal History of Traumatic Brain Injury, Disorders of Brain-Encephalomalacia, Depression, and Personal History of Transient Ischemic Attack. The facility's investigative file also contained a form titled Incident Investigation Summary, dated 05/25/2023 and signed by the Administrator (ADM) that documented: . Conclusion Summary: Physical abuse was substantiated . RI #237's nursing progress note dated 05/22/2023 electronically signed by RN #4 documented: . Pt (patient) had been in day room in recliner for most of this shift. Another patient rolled over to (RI #237) . CNAS (Certified Nursing Assistant) reported to me that the patient pulled (RI #237) from recliner when I came around the corner I seen the patient punching (RI #237). Pt was stopped and separated . assessed for injuries. Redness noted to (R/right) wrist and Ear. During an interview on 10/23/2024 at 10:45 AM, RN #4 was asked if she recalled the incident on 05/22/2023 when RI #239 pulled RI #237 from a recliner onto the floor and began punching RI #237 multiple times. RN #4 said yes, she did recall that day, and that CNA #6 saw the altercation between RI #237 and RI #239. RN #4 said, the incident was reported to the Director of Nursing, the Administrator, and Abuse Coordinator/SSD. The Director of Nursing, (DON), was interviewed on 10/23/2024 at 4:30 PM. When asked if she recalled the resident-on resident altercation on 05/22/2023 involving RI #237 and RI #239, she said, yes. The DON confirmed the nurse had reported the incident to her, the two residents had an altercation, and the conclusion was physical abuse. The DON was asked when the facility notified the police of an incident of abuse. The DON replied, that was handled through the Administrator. On 10/26/2024 at 10:33 AM the Abuse Coordinator (AC) was asked about criminal reports to law enforcement. The AC said, the police would determine what a crime was. The AC said, the chief at the local police department would be the person to contact for reporting crimes. The AC said, the facility (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had not made any criminal reports to local law enforcement in the last year. When asked what types of abuse would be reported to law enforcement, the AC stated, any that involve reasonable suspicion of a crime against a resident. On 10/26/2024 at 8:39 PM in a follow up interview with the AC said, she had not communicated with local law enforcement about what a crime was and what incidents should be reported to law enforcement. The Administrator (ADM) was interviewed on 10/23/2024 at 5:18 PM and was asked about the conclusion of the investigation of the incident involving RI #237 and RI #239. The ADM said, physical abuse did occur. The ADM, said, law enforcement was not notified of the incident. In a follow up interview with the ADM on 10/26/2024 at 2:48 PM she was asked about criminal reports to law enforcement. The ADM said, anybody could determine what a crime was. The ADM was asked about communication with law enforcement for reporting and she replied, 911 could be called or the police department could be called directly to talk with police or the chief. The ADM said, the facility had not made any reports to local law enforcement in the last year. When asked what types of abuse would be reported, the ADM said, any suspicions of a crime. The ADM said, in this case the police had not been called and the concern of not calling the police to report suspicion of a crime was the police would not have the opportunity to determine if a crime occurred. In second follow up interview with the ADM on 10/26/2024 at 7:12 PM, she was asked when she had communicated with local law enforcement about what a crime was and what incidents at the facility should be reported. The ADM said, last year she had spoke with the chief. The ADM said, the communication with the chief was not documented. The facility did not have evidence of communication with local law enforcement about what was considered a crime and what was to be reported to local law enforcement.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record review, review of facility polices titled, Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation and INCIDENT AND ACCIDENT PROCESS, and review of the facility investigative files, the facility failed to thoroughly investigate incidents of resident-on-resident physical abuse for appropriate action to be taken to prevent further occurrences. On 05/22/2023 facility staff witnessed Resident Identifier (RI) #239 grab RI #237's wrists, pull RI #237 from a recliner onto the floor, and punch RI #237 multiple times. The facility failed to prevent this from occurring after RI #239 was annoyed with RI #237 yelling out and RI #239 had told RI #237 to shut up earlier in the night. RI #237 was assessed with redness and bruising to the right wrist. The facility investigation and witness statements the facility gathered from those present at the time the abuse occurred did not include any details describing how hard RI #237 was punched, how many times RI #237 was punched, where exactly RI #237 was punched, or how this could have been prevented. The investigative file also did not explain why it took four staff members to pull RI #239 off of RI #237, as explained by staff in their witness statements. Also, the investigative file did not explain why the local law enforcement were not notified of the abuse and of RI #237's wishes for the police to be notified. This failure had the potential to affect RI #237 and all residents residing on the facility's Memory Care Dementia Unit. This deficiency was cited as the result of the investigation of complaint/report #AL00044297. Findings include: Cross reference F 550, F 600, and F 609. 1.) A facility policy titled Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation with an effective date of 02/01/2023, documented: . DEFINITION POLICY Abuse, Neglect, Misappropriation of Patient Property and exploitation, . will not be tolerated by anyone, including staff, patients, . or any other individual in this center. The patient has the right to be free from abuse, neglect . The center administrator is responsible for assuring that patient safety, including freedom from risk of abuse or neglect, holds the highest priority. A. INTERNAL INVESTIGATION POLICY 1. Policy All events reported as possible abuse, neglect, . will be investigated to determine whether the alleged abuse, neglect, . did or did not take place. The Administrator or Director of Nurses will determine the direction of the investigation once notified of alleged incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse occurred on 05/22/2023 at 3:30 AM when facility staff witnessed RI #239 grab RI #237's wrists, pull RI #237 from a recliner onto the floor, and punch RI #237 multiple times. RI #237 was assessed with redness and bruising to the right wrist. The FRI report did not contain any information about the location, number, or intensity of the punches with which RI #247 was hit. RI #237 was admitted to the facility on [DATE], with diagnoses to include Cerebrovascular Disease, Vascular Dementia with Severe Agitation and History of Falling. RI #237's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/08/2023 documented a Brief Interview for Mental Status (BIMS) score of six of 15, which indicated severely impaired cognition. RI #239 was admitted to the facility on [DATE] with diagnoses to include History of Traumatic Brain Injury, Disorders of Brain-Encephalomalacia, Depression, and History of Transient Ischemic Attack. The facility investigative file was reviewed and a report titled Opening Statement documented that on 05/22/2023 RI #239 pulled RI #237 out of the recliner and began hitting at RI #237, but there were not any details about the location, number, or intensity of the punches with which RI #247 was hit. Witness statements in the investigative files were reviewed as follows: A handwritten witness statement dated 05/22/2023, signed by Registered Nurse (RN) #5 documented RN #5 was called to help after a resident had been pulled from a recliner and punched multiple times by another resident, until four members of staff separated the residents. RN #5 did not witness the abuse but in her statement she documented part of her conversation with RI #237 after the incident took place as follows: . Upon speaking (with) patient that was allegedly hit, patient states. 'I was pulled out my chair and attacked. I want the police.' . The facility's investigative file contained an undated handwritten statement signed by CNA #6 that documented: (RI #239) was in the day area and I saw (him/her) drag (RI #237) out of the recliner and start punching (RI #237) repeatedly. The Nurse, CNAs and I immediately went over and removed (RI #239) away from (RI #237) . The statement did not contain the location, number, or intensity of the punches with which RI #247 was hit. On 10/25/2024 at 10:37 AM CNA #6 said, she did see RI #239 punch RI #237 repeatedly, but she could not remember the location, number, or intensity of the punches with which RI #247 was hit because it was long ago and happened so fast. CNA #6 also said, it did not really take four staff members to pull RI #239 off of RI #237, instead, two assisted RI #239 and two assisted RI #237. The facility's investigative file contained an undated handwritten statement signed by CNA #7 that documented: (RI #237) . was in the day area, and I seen (RI #239) pulled (RI #237) out of the recliner and start punching (him/her) repeatedly. It took all of us to pull (RI #239) off of (RI #237) and remove (him/her) from the room. We took (RI #239) to (his/her) room where a CNA had to sit with (him/her). The statement did not contain the location, number, or intensity of the punches with which RI #247 was hit. On 10/25/2024 at 10:59 AM CNA #7 said, she did see RI #239 punch RI #237 repeatedly, but she could (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not remember the location, number, or intensity of the punches with which RI #237 was hit because it was long ago and happened so fast. CNA #6 also said, it did not really take four staff members to pull RI #239 off of RI #237, instead they responded instantly to separate them. The facility's investigative file contained an undated handwritten statement signed by CNA #8 that documented: I witnessed (RI #237) was sitting in the day room in the recliner when (RI #239) pulled (him/her) out the recliner and proceeded to punch (him/her) multiple times me and other staff pulled (him/her) off and redirected patient . (RI #239) stated (RI #237) was annoying and I quote The Shit out of him. The statement did not contain the location, number, or intensity of the punches with which RI #237 was hit. CNA #8 was unavailable for interview during the survey. The facility's investigative file contained an undated handwritten statement signed by CNA #9 that documented: I witnessed (RI #239) pull (RI #237) out of (his/her) chair and proceeded to punch (him/her) multiple times. It took 4 (four) CNAs to pull (RI #239) off of (RI #237). The statement did not contain the location, number, or intensity of the punches with which RI #247 was hit. CNA #9 was unavailable for interview during the survey. RI #237's nursing progress note dated 05/22/2023 electronically signed by RN #4 documented: . Pt (patient) had been in day room in recliner for most of this shift. Pt yelling out but when asked what (he/she) needs (he/she) states (he/she) doesn't know or that (he/she) needs to urinate, . Another patient rolled over to (RI #237) . My CNAS (Certified Nursing Assistant) reported to me that the patient pulled (RI #237) from recliner when I came around the corner I seen the patient punching (RI #237). Pt was stopped and separated . assessed for injuries. Redness noted to (R/right) wrist and Ear., but the note did not contain the location, number, or intensity of the punches with which RI #237 was hit. On 10/23/2024 at 10:45 AM RN #4 was asked about the incident on 05/22/2023. RN #4 said, she did see RI #239 punching with fists but did not see actual contact as RI #237 was on the floor with RI #239 leaning over RI #237. RN #4 said she heard RI #237 say, RI #239 had hit him/her. The facility's investigative file also contained a form titled Incident Investigation Summary, dated 05/25/2023 signed by the Administrator (ADM) that documented: . Incident Summary: (RI #237 and RI #239) . were up in dayroom on 5/22/23. (RI #239) was observed pulling on (RI #237) and (RI #237) fell to floor (and RI #239) was punching (RI #237). Conclusion Summary: Physical abuse was substantiated ., but the form did not contain any documentation about the location, number, or intensity of the punches with which RI #237 was hit, nor did it explain how this could have been prevented or why it took four staff members to pull RI #239 off of RI #237, as explained by staff in their witness statements. The form also did not explain why local law enforcement agencies were not notified of the abuse even after RI #237 told staff he/she had been attacked and wanted the police. The Abuse Coordinator (AC) was interviewed on 10/26/2024 at 10:33 AM. The AC was asked where in the abuse investigation of RI #237 was the severity of the punches, the number of punches, and the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	location of the punches with which RI #237 was hit. The AC answered, there was not a statement in the investigation that indicated those details. The AC said, she did not know to ask those questions during an investigation. The AC said, those details would have been important to an investigation to indicate if the police should have been notified, they would have known exactly where the resident was hit and would have known who actually saw the contact made between the two residents. The Administrator (ADM) was interviewed on 10/26/2024 at 2:48 PM and was asked where in the abuse investigation of RI #237 was the severity of the punches, the number of punches, and the location of the punches with which RI #237 was hit. The ADM stated, in the investigation there was no indication of the severity, number, or location of punches to RI #237. The ADM said, to decide of what needs to be done for the resident, look what was leading up to the incident, what was observed and what may have been contributing factors to have a thorough investigation. The ADM said, she did not have an answer for why those details were not in the investigation and she did not think they were looking at the severity of the punches during the investigation. The ADM said, those details would be important to an investigation to determine the potential for any injury to the resident.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record reviews, review of the facility policy titled BEHAVIORAL HEALTH SERVICES, the facility failed to provide immediate and necessary behavioral interventions and supervision to prevent Resident Identifier (RI) #290, a resident exhibiting physically aggressive behaviors, from physically abusing RI #288. On 08/15/2023 RI #290 displayed physically aggressive behaviors toward the facility staff, ramming them with his/her walker and swinging at them with a dispenser for hand sanitizer. RI #290 was then allowed to walk into a day room area with other residents and staff who were preparing for lunch. RI #290 hit RI #288 in the face and chest. This affected RI #288 one of five residents reviewed for behaviors. Findings include: Cross-reference F 600. Review of a facility policy titled BEHAVIORAL HEALTH SERVICES, revised date of 2/2019, revealed the following: . The center must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care . Assessment of mental health needs of a patient is the responsibility of the interdisciplinary care plan team, including the physician or physician/extender . When additional professional evaluation and /or development of a treatment plan is recommended, the attending physician or physician extender may order a mental health consult. The observations and recommendations of mental health professionals are included in the patient's overall care plan . Persons identified as being in need of acute inpatient psychiatric care are . referred to appropriate treatment facilities. The center will ensure they have sufficient and competent staff to provide behavioral health services . On 08/15/2023 the State Agency received an Online Incident Report from the facility alleging physical abuse when RI #290 struck RI #288 on the left side of the face and upper stomach. RI #288 admitted to facility on 03/28/2023 with diagnosis Epilepsy, Down Syndrome, and Unspecified Dementia with Psychotic Disturbance. RI #290 was admitted to the facility on [DATE] with diagnosis Parkinson's Disease and Dementia, Behavioral Disturbance and Mood Disorder. The facility investigative file contained a report titled Opening Statement which documented: . At approximately 11:30am . (RI #290) . came out of (his/her) room . became difficult to redirect and (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	proceeded to nurses station picked up the hand sanitizer and was trying to swing at partners (employees) and then wanted (his/her) phone. was given (his/her) phone . At approximately 12:30pm . (RI #290) . walked over to the day area where lunch was being served. (RI #290) walked over and struck (RI #288) on the cheek and then in the abdomen area. Staff was able to intervene and assist (RI #290) back to (his/her) room until the MD (physician) could be notified and was given orders to send (him/her) to the ER (emergency department) for evaluation. (RI #288) was assessed for injury and no injuries were noted other than a red area to (his/her) face . A Witness Statement Form dated 08/15/2023 for RI #288, the victim, documented an incident type of physical and RI #288's statement as follows: . (RI #288) stated (he/she) hit me. (He/she) knew better . (RI #288) was crying. Review of a facility . Body Audit Form . dated 08/15/2023 at 12:40 PM documented . Slight Redness to (L/left) Cheek . with a line drawn on the left side of the face on the figure on the form. On 10/23/2024 at 4:20 PM CNA #11 who witnessed the incident said, was RI #290 displayed aggressive behavior by using an electronic hand sanitizer dispenser as a weapon against the staff when RI #290 was mad for some reason and began to swing the dispenser at her and a nurse. CNA #11 said, it took several staff to take the dispenser away from RI #290. CNA #11 said, then RI #290 appeared to calm down and went over to the dayroom where RI #288 was. CNA #11 said, about 30 minutes later they were singing in the watch area and RI #288 came up an started talking loudly (RI #288 is deaf) and RI #290 stood up and punched RI #288 in RI #288's face and chest. CNA #11 said, this was physical abuse and it would make someone in that situation feel terrified, upset, and angry. On 10/23/2024 at 3:53 PM an interview was conducted with CNA #12, and he stated while on the unit assisting with activities RI #288 came up to RI #290 and tried to give RI #290 a hug and RI #290 hit RI #288 in the face and upper chest. During an interview on 10/24/2024 at 3:55 PM with Director of Nursing (DON), she stated she was called to the unit by nursing staff who reported RI #290 had hit RI #288 in the left side of the face and chest. The DON stated RI #288 was crying and said RI #290 had hit him/her. The DON said, she asked RI #290 what happened and he/she just shook his/her head and mumbled. The physician was notified, and RI #290 was sent to the hospital for evaluation and was admitted to the hospital. The DON stated she was not aware of the behaviors RI #290 displayed prior to this incident. The DON was asked what the facility could have done to prevent this from happening since RI #290 had displayed behaviors just prior to this incident and she stated they could have called the MD for medication to calm him/her or to get him/her to the hospital sooner or called the family to come sit with resident. She further stated the staff should have kept RI #290 away from other resident when he/she started having behaviors and should have notified the physician when behavior pattern began.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of Resident Identifier (RI) #237's medical record, review of a facility policy titled NEUROLOGICAL CHECKS, and an Online Incident Report (FRI), the facility failed to ensure Registered Nurse (RN) #4 documented assessment details in RI #237's medical record after a resident-on-resident incident on 05/22/2023. This had the potential to affect RI #237, one of 26 sampled residents and was cited as a result of the investigation of complaint/report number AL00044297. Findings include: On 05/22/2023 the State Agency received an Online Incident Report (FRI) from the facility alleging physical abuse when staff witnessed RI #237 being pulled to the floor and punched by another resident. RI #237 was admitted to the facility on [DATE], with diagnoses to include Cerebrovascular Disease, Vascular Dementia with Severe Agitation and History of Falling. Review of RI #237's medical record revealed vital signs were not documented as part of the assessment of RI #237 on 05/22/2023 after the incident. On 10/25/2024 at 10:59 AM Certified Nursing Assistant (CNA) #7, who was present during the incident on 05/22/2023, was asked about RI #237 being assessed on the morning of 05/22/2023. CNA #7 said, she and RN #4 assessed RI #237 and she took vital signs for RI #237, and she gave the vital signs to RN #4, but she did not know if they had been documented or not. On 10/25/2024 at 12:08 PM RN #4 said, on the morning of 05/22/2023, upon assessment RI #237 denied pain, CNA #7 measured his/her vitals while she, RN #4, performed visual assessment and performed neurological checks to document on the neurological check sheet. RN #4 said, she had RI #237 squeeze her hands, checked pupils, and asked RI #237 his/her name. RN #4 said, CNA #7 completed the vital signs and wrote it on a piece of paper. RN #4 said, she documented her assessment and RI #237's vital signs on the neurological check sheet form. RN #4 said, she was responsible for charting the vital signs in the computer. RN #4 said, she did not chart the vital signs in the computer but she did record them on the neurological check sheet. RN #4 said, the neurological check sheet was a paper form that was scanned into medical records. RN #4 said, the facility had not been able to locate the neurological check sheet that was completed that morning. On 10/25/2024 at 2:50 PM the Director of Nursing (DON) was asked about the neurological check sheet that was completed for RI #237 on 05/22/2023. The DON said, she was not able to locate the neurological check sheet. The DON said, when those sheets were completed by the nurses they went into a box on the units that went to Health Information Management and they were to be scanned into the resident's chart. The DON said, the vital signs and neurological checks were not recorded in the electronic medical chart for RI #237 but they should have been charted to be able to catch changes in the residents condition.