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	185290	A. BUILDING _____ B. WING _____	06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY00033670, KY00033787, KY00033849, KY00033860, KY00033864, KY00033858, KY00033743, KY00034054, and a COVID-19 Focused Infection Control Survey was initiated on 06/21/2021 and concluded on 06/28/2021. KY00033670, KY00033787, KY00033849, KY00033860, KY00033864, KY00033858, and KY00034054 were unsubstantiated without deficiencies cited. However, KY00033743 was substantiated with deficiencies cited. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and had implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 77.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/23/2021

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to protect two (2) of twelve (12) sampled residents, Residents #6 and #7, from physical abuse. On 04/11/2021, Residents #6 and #7 were involved in a resident-to-resident physical altercation. Resident #6 removed the leg rest from his/her wheelchair and banged it against Resident #7's room door. Resident #7 responded by opening the door and pushing Resident #6 over in his/her wheelchair, causing the resident to hit his/her head. Resident #6 bit Resident #7 on the hand causing an injury that required medical treatment.

The findings include:

Review of the facility's policy titled, "OPS300 Abuse Prevention," revised 07/01/2018, revealed the facility would prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. Under the subtitle, "Federal Definitions," abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, injury, or mental anguish. More specifically, the policy listed hitting, slapping, pinching, kicking, et cetera, as well as controlling behavior through corporal punishment as

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examples of physical abuse.

Review of the facility's investigation of the incident, dated 04/15/2021, and signed by the facility's Center Executive Director (CED), revealed, on 04/11/2021, Resident #6 knocked on Resident #7's door, and when Resident #7 opened the door, Resident #6 took the leg rest from his/her wheelchair and started swinging it at Resident #7. According to the report, in an effort to protect himself/herself from being hit, Resident #7 grabbed Resident #6, and while doing so, Resident #6 bit the palm of Resident #7's right hand. Resident #7 then pushed Resident #6 over in his/her wheelchair, causing him/her to fall. Per their investigation, staff members separated the residents, and the nurse assessed both residents and treated their minor injuries. The investigation stated the facility conducted interviews with staff, interviewed residents with a Brief Interview for Mental Status (BIMS) cognitive score of eight (8) to fifteen (15), and performed skin assessments on residents who were unable to answer the interview questions. The investigation revealed the facility did not identify any additional concerns with resident interviews, staff interviews, or skin assessments.

Review of Resident #6's clinical record revealed the facility admitted the resident, on 03/28/2017, with diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, Adjustment Disorder with Anxiety, Delusional Disorders, Conduct Disorder, Unspecified Cataract, Unspecified Open Wound of the Right Lower Leg, and Cirrhosis of the Liver.

Review of Resident #6's Quarterly Minimum Data Set (MDS) Assessment, dated 05/04/2021,

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revealed the resident scored a six (6) out of a possible fifteen (15), on the Brief Interview for Mental Status (BIMS) assessment, indicating severe cognitive impairment, and the resident was not interviewable.

Review of Resident #7's clinical record revealed the facility admitted the resident, on 12/27/2019, with diagnoses of Schizoaffective Disorder/Bipolar Type, Conversion Disorder with Seizures or Convulsions, Cognitive Communication Deficit, Gastrostomy Status, and Dysphagia Unspecified.

Review of Resident #7's Quarterly MDS Assessment, dated 04/05/2021, revealed the resident scored a twelve (12) out of a possible 15, on the BIMS assessment, indicating the resident was moderately cognitively impaired but was interviewable.

Review of an Incident Report in Resident #6's clinical record, dated 04/11/2021 at 5:15 PM, further revealed the nurse's assessment of Resident #6. He/she had an abrasion on his/her forehead, and the resident had hit the back of his/her head when he/she fell. The nursing staff notified the Physician, initiated neurological checks and placed the resident on one-to-one (1:1) observation.

Review of the Incident Report in Resident #7's clinical record, dated 04/11/2021 at 5:15 PM, further revealed the nurse's assessment of Resident #7 after the altercation, which stated Resident #7 had an open area on the palm of his/her right hand. Staff notified the resident's Physician, and she ordered a treatment for Resident #7's wound. Per the report, when staff

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asked Resident #7 if he/she needed to notify the police, he/she said no.

Continued review of Resident #7's clinical record revealed, on 04/11/2021 at 6:51 PM, revealed Licensed Practical Nurse (LPN) #1 contacted the resident's Physician, and she ordered an antibiotic, Keflex five hundred (500) milligrams (mg), to be administered two (2) times per day via the resident's gastrostomy tube (g-tube, a tube permanently placed into the stomach to give nutritional products, fluids, and medications) over five (5) days, for bite marks. Review of Resident #7's Medication Administration Record (MAR) for April 2021, revealed the resident received the antibiotic, as ordered.

Interview with LPN #1, on 06/23/2021 at 12:30 PM, revealed Resident #6 acted out in the afternoon most every day. She stated on 04/11/2021, she was standing at the medication cart on the West Hallway, and Resident #6 was agitated and cursing at her in Spanish. She said Resident #6 took off the leg rest from his/her wheelchair and started waving it at her. LPN #1 said she asked the resident to go to his/her room. She stated instead of complying with her request, Resident #6 moved himself/herself near the treatment cart that was by Resident #7's door. She said Resident #7 was at his/her doorway, and she told him/her to go in his/her room and shut the door. LPN #1 stated another resident was also in the hallway, but State Registered Nurse Aide (SRNA) #3 took that resident back to his/her room. LPN #1 said she was trying to clear the hallway because Resident #6 was so agitated, and he/she continued to curse and act upset. She stated she walked away for a moment to find another nurse to assist her with

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getting Resident #6 back to his/her room. However, she said before she could get help, Resident #6 began banging on Resident #7's door with the wheelchair leg rest, and things escalated from there. LPN #1 stated Resident #7 opened his/her door, and he/she pushed Resident #6 so that his/her wheelchair tipped backward, causing Resident #6 to fall. She said Resident #6 spoke mostly Spanish, so it was difficult to ask him/her what happened. LPN #1 stated she assessed Residents #6 and #7 for injury. She said Resident #7 had a bite on his/her hand, and it was bleeding. LPN #1 said she notified the medical provider, and she ordered antibiotics and a tetanus shot. LPN #1 stated Resident #6 had superficial scratches to his/her forehead. LPN #1 stated there had been other occasions when Resident #6 cursed and pulled off the wheelchair leg rest, raising it as if he/she might use it as a weapon. She said as far as she knew, Resident #6 had not previously hit staff or residents with the leg rest.

Interview with SRNA #3, on 06/25/2021 at 11:15 AM, revealed on the day of the incident, Resident #6, was having an attitude with LPN #1. She said Resident #6 spoke mostly Spanish and directed his/her anger toward the nurse. She said LPN #1 asked Resident #6 to go to his/her room, and she also told Resident #7 to shut the door to his/her room. SRNA #3 stated just as she saw Resident #6 hit Resident #7's door with the leg rest, she ran to Resident #7's door. She said Resident #6 had the leg rest in his/her hand acting as if he/she was going to hit Resident #7. SRNA #3 said Resident #7 went at Resident #6, putting his/her arm around Resident #6's neck and would not let go. She said Resident #6 sustained scratches to his/her forehead, and Resident #6 bit Resident

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#7's hand. SRNA #3 stated Resident #7's hand started bleeding. She said, during the altercation, Resident #6's wheelchair turned over, and he/she fell. Per the interview, SRNA #3 stated, while attempting to help Resident #6, the resident acted as if he/she wanted to continue fighting with Resident #7. SRNA #3 said Resident #6 could easily remove the right-side wheelchair leg rest, and she had seen him/her remove it many times. She reported the resident had previously removed, waved, and pointed the leg rest at staff when he/she became angry. SRNA #3 said Resident #6 would show that type of behavior when staff did not immediately meet his/her requests. In addition, SRNA #3 stated this was the first time she had actually seen Resident #6 try to hit a resident. SRNA #3 stated she had heard that Residents #6 and #7 did not get along, but she could not remember who told her that.

Interview with SRNA #4, on 06/26/2021 at 4:45 PM, revealed she previously had seen Resident #6 take the leg rest off his/her wheelchair. She said the resident would exhibit that behavior when he/she was agitated about something or upset with someone. For example, she said if staff asked Resident #6 to put on his/her facemask when in the hallway, he/she would get angry, remove the leg rest, and raise it into the air. She stated she had seen Resident #6 swing the leg rest at staff if they tried to take the leg rest away from him/her. In addition, SRNA #4 said she had seen Resident #6 swing at anyone that got in his/her way. SRNA #4 said she was on maternity leave for a couple of months, so she thought the last time she saw Resident #6 swing the leg rest at others was probably mid to late January 2021.

Interview with SRNA #5, on 06/27/2021 at 3:30

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PM, revealed both Residents #6 and #7 had a history of exhibiting aggressive behaviors. SRNA #5 said she had seen Resident #6 remove the wheelchair leg rest and act angrily, especially when he/she did not immediately get what he/she wanted, and she had witnessed Resident #6 try to hit an agency-employed nurse. SRNA #5 said Resident #6 wanted a Tums (used for indigestion) tablet, and when the nurse could not get it for him/her immediately, the resident tried to hit the nurse with the leg rest. She stated that occurred about two (2) months ago, but she could not recall the nurse's name. SRNA #5 said she had seen Resident #6 try to hit a resident with the leg rest, but to her knowledge, he/she was unable to do so. She stated Resident #6 was strong, and he/she could easily remove the wheelchair leg rest. SRNA #5 stated the staff tried to redirect Resident #6 by giving him/her a snack or something to drink.

Interview with LPN #6, on 06/23/2021 at 4:30 PM, revealed she heard that Residents #6 and #7 were involved in a physical altercation. She stated she had not personally seen Resident #6 try to strike anyone with his/her wheelchair leg rest, but she had heard the resident curse at staff and residents.

Interview with LPN #4, on 06/23/2021 at 4:00 PM, revealed he heard about the incident between Residents #6 and #7. He stated he had not personally seen Resident #6 strike anyone with the leg rest. However, he stated about forty-five (45) minutes ago, Resident #6 became very upset and started yelling at the housekeeper who was in his/her room trying to clean and empty the trash. LPN #4 said Resident #6 hoarded things. He stated the resident had come from an

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extremely poor background and had even been homeless prior to his/her admission to the facility. He stated Resident #6 spoke mostly Spanish and could be loud. LPN #4 said Resident #7 seemed cantankerous all the time, and it did not take much to tick off the resident. LPN #4 said Resident #7 would get upset and curse over small things and would yell out statements such as, "Hey-Hey, shut the God Damned Door!" LPN #4 said it seemed Resident #7 wanted to stay to himself/herself and did not want to be bothered by anyone.

Observation, on 06/21/2021 at 3:30 PM, revealed Resident #6 was in his/her room. The resident was sitting in his/her wheelchair.

Additional observation, on 06/23/2021 at 11:44 AM, of Resident #6, revealed he/she was sitting in his/her wheelchair in the hallway, near the medication cart by the nurse's station. The resident was dressed in street clothes and was wearing a ball cap. LPN #4 was at the medication cart talking with the resident, and the resident did show signs of agitation.

Observation, on 06/22/2021 at 4:05 PM, of Resident #7 revealed he/she resided in Bed A, nearest to the door. The resident was dressed and sitting on the side of his/her bed. In an interview, Resident #7 stated when Resident #6 banged on his/her door, he/she opened the door, and Resident #6 acted like he/she was going to hit him/her (Resident #7). Resident #7 said he/she went after Resident #6. Resident #7 said Resident #6 was "a stupid Mother Fucker." Resident #7 also said, "That S.O.B. don't want no more of my ass, because I will hit him/her." Resident #7 also stated, "He/she don't want to

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mess with me because I will put him/her in the hospital." Resident #7 said since the incident, Resident #6 had tried to talk to him/her in the common area where the television was, but Resident #7 said he/she did not say much to Resident #6 because he/she did not want to go to jail over him/her.

Interview with the Social Services Director (SSD), on 06/24/2021 at 3:10 PM, revealed Resident #7 told her he/she did not want to live at the long term care facility and had previously expressed his/her anger about the situation. The SSD said Resident #7 was at the facility because he/she could not take an oral diet, and had a gastrostomy tube (g-tube) to ensure adequate nutritional intake. The SSD said she had not seen Resident #7 exhibit physical aggression. She stated, at times, the resident mumbled things but then moved on. She said she thought Resident #7 just wanted everyone to let him/her alone. The SSD stated she was not at the facility the day the incident occurred, but staff told her about it. She said she had never seen Resident #6 remove the wheelchair leg rest and raise it when he/she was angry.

Interview with LPN #10, on 06/28/2021 at 9:12 AM, revealed she learned about the physical altercation between Residents #6 and #7, on 04/11/2021, when the off-going day shift nurse gave her the dayshift report. She said the nurse said to keep the residents separated from each other. She said Resident #6 was on one-to-one (1:1) observation when she reported to work. LPN #10 stated Resident #6 spoke mainly Spanish; however, she was not aware of any communication board or other devices used to communicate with the resident. She said, if

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Resident #6 could at least give the staff hints about what could be bothering him/her, that would be helpful.

Interview with the Center Nurse Executive (CNE), on 06/24/2021 at 4:10 PM, revealed the incident between Residents #6 and #7 occurred the first week she was at the facility, and she was not involved in a review of the incident. The CNE said she thought the SSD had reviewed the report of the residents' fight. She said both residents sustained injuries during the physical altercation, but neither resident wanted to go to the hospital for evaluation and treatment. She said the psychiatric care providers saw both residents after the incident, and Resident #6's provider ordered Tegretol (a medication used to stabilize mood) to address Resident #6's impulsive behaviors. She said Resident #7 had a diagnosis of Schizoaffective Disorder, and she was aware Resident #7 was still upset about the incident. The CNE stated the facility would not want residents to engage in physically aggressive behaviors because the goal was to protect residents and staff from all forms of physical abuse and/or injury. She stated she had not personally seen Resident #6 remove the leg rest from his/her wheelchair.

Review of the Psychiatric Periodic Evaluation, dated 04/19/2021, in Resident #6's clinical record, revealed the purpose of the visit was for evaluation of the resident's physically aggressive and impulsive behaviors, his/her anxiety and depression, and the nursing staff's report of the resident's recent involvement in a resident-to-resident altercation. The report revealed the provider assessed the resident as having poor insight and judgement and ordered

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F 600	Continued From page 11 Tegretol two hundred (200) mg twice daily for management of his/her impulse control disorder. The psychiatric provider visited the resident again, on 05/21/2021, and recommended the staff set clear boundaries for the resident. Review of the Psychiatric Periodic Evaluation, dated 04/19/2021, in Resident #7's clinical record, revealed the resident was seen due to his/her diagnosis of Schizophrenia and his/her involvement in a recent resident-to-resident altercation. The provider documented that Resident #7 said he/she had never gotten along with Resident #6, so he/she tried to stay away from him/her. The provider also wrote that the resident stated he/she had recovered from the altercation and was not upset about it anymore. Interview with the Medical Director, on 06/28/2021 at 10:38 AM, revealed she thought physical abuse was committed by both residents during the altercation on 04/11/2021. The Medical Director said the facility routinely trained staff on how to recognize and prevent abuse. She stated staff reacted quickly to diffuse the situation, but all staff should be aware of the history between Residents #6 and #7 and continue to monitor and hopefully prevent any future arguments or fights between the two of them.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		

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F 656	Continued From page 12 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to develop the comprehensive care plan for one (1) of twelve (12) sampled residents, Resident #7, to address behaviors exhibited by the resident after he/she was involved in a physical altercation with Resident #6 on 04/11/2021. Resident #7 pushed Resident #6 backward in his/her wheelchair causing the resident to fall, and interview with Resident #7, on 06/22/2021, revealed he/she was still upset about the incident and stated Resident #6 better not mess with him/her because he/she would hit Resident #6, if he/she bothered him/her (Resident #7) again.

The findings include:

Review of the facility's policy for care planning titled, "Social Services (SS) 101 Person-Centered Care Plan," revised 01/15/2021, revealed Social Services staff, as members of the Interdisciplinary Team, would participate in developing a comprehensive individualized care

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plan for each resident. The purpose of the care plan was to structure and guide therapeutic interventions to meet resident needs and achieve expected outcomes. Additionally, care plans should be reviewed, evaluated, and updated as required.

Review of the facility's investigation of the incident between Residents #6 and #7, dated 04/15/2021 and signed by the facility's Center Executive Director (CED), revealed on 04/11/2021, Resident #6 banged on Resident #7's door with the leg rest he/she removed from his/her wheelchair. When Resident #7 opened the door, Resident #6 started swinging the leg rest at Resident #7. According to the report, in an effort to protect himself/herself from being hit, Resident #7 grabbed Resident #6, and while doing so, Resident #6 bit the palm of Resident #7's right hand. Resident #7 then pushed Resident #6 over in his/her wheelchair, causing him/her to fall. Per the investigation, staff members separated the residents, and the nurse assessed both residents and obtained a Physician's order to treat Resident #7's injury.

Review of Resident #6's clinical record revealed the facility admitted the resident, on 03/28/2017 with diagnoses of Major Depressive Disorder, Recurrent Moderate, Generalized Anxiety Disorder, Adjustment Disorder with Anxiety, Delusional Disorders, Conduct Disorder, Unspecified Cataract, and Unspecified Open Wound of the Right Lower Leg.

Review of Resident #6's Quarterly Minimum Data Set (MDS) Assessment, dated 05/04/2021, revealed the resident scored a six (6) out of a possible fifteen (15), on the Brief Interview for

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Mental Status (BIMS) assessment, indicating severe cognitive impairment, and the resident was not interviewable.

Review of Resident #6's comprehensive care plan, with a "Last Care Plan Review" completed date of 08/24/2020, revealed Resident #6 became aggressive at times. The care plan revealed Resident #6 demonstrated aggressive behaviors toward staff, swinging his/her wheelchair leg rest toward staff members. An intervention within Resident #6's care plan directed staff to postpone care/activity, when the resident was combative or aggressive, and to allow the resident time to regain his/her composure. The care plan also revealed psychiatric services followed the resident, and the nursing staff was to administer psychoactive medications, as ordered.

Review of Resident #7's clinical record, revealed the facility admitted the resident, on 12/27/2019, with diagnoses of Schizoaffective Disorder/Bipolar Type, Conversion Disorder with Seizures or Convulsions, Cognitive Communication Deficit, Gastrostomy Status (gastrostomy tube (g-tube, a tube permanently placed into the stomach to give nutritional products, fluids, and medications)), and Dysphagia Unspecified.

Review of Resident #7's Quarterly MDS Assessment, dated 04/05/2021, revealed the resident scored a twelve (12) out of a possible fifteen (15) on the BIMS assessment, indicating the resident was moderately cognitively impaired, but was interviewable.

Observation and interview, on 06/22/2021 at 4:05

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PM of Resident #7, revealed he/she resided in Bed A, nearest to the door. The resident was dressed and sitting on the side of his/her bed. Resident #7 stated, when Resident #6 banged on his/her door, he/she opened the door and Resident #6 acted as if he/she was going to hit him/her (Resident #7). Resident #7 said he/she went after Resident #6. Resident #7 stated Resident #6 was "a stupid Mother Fucker." Resident #7 also stated, "That S.O.B. don't want no more of my ass, because I will hit him/her." In addition, Resident #7 stated, "He/she don't want to mess with me because I will put him/her in the hospital." Resident #7 said since the incident, Resident #6 had tried to talk to him/her in the common area where the television was, but Resident #7 said he/she did not say much to Resident #6 because he/she did not want to go to jail over him/her.

Review of Resident #7's comprehensive care plan, with a "Last Care Plan Review" completed date of 01/19/2021, revealed the resident had a care plan for use of psychotropic medications, and a care plan component for the resident's impairment and decline in cognitive function or impaired thought processes. The goal, until the next care plan review, was to optimize the resident's functional ability through modifications and alterations within his/her environment. However, Resident #7's care plan did not show evidence the facility had evaluated and developed his/her care plan (on or after 04/11/2021) to include a focus area with interventions to address his/her observed physically and verbally aggressive behaviors or the potential for aggression toward another resident.

Interview with LPN #1, on 06/23/2021 at 12:30

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PM, revealed on 04/11/2021, she was standing at the medication cart on the West Hallway, and Resident #6 was agitated and cursing at her in Spanish. She said Resident #6 took off the leg rest from his/her wheelchair and started waving it at her. LPN #1 said she asked the resident to go to his/her room. She stated instead of complying with her request, Resident #6 moved himself/herself near the treatment cart that was by Resident #7's door. She said Resident #7 was at his/her doorway, and she told him/her to go in his/her room and shut the door. LPN #1 said she was trying to clear the hallway because Resident #6 was so agitated, and he/she continued to curse and act upset. She stated she walked away for a moment to find another nurse to assist her with getting Resident #6 back to his/her room. However, she said before she could get help, Resident #6 began banging on Resident #7's door with the wheelchair leg rest, and things escalated from there. LPN #1 stated Resident #7 opened his/her door, and he/she pushed Resident #6 so that his/her wheelchair tipped backward, causing Resident #6 to fall. LPN #1 stated she assessed Residents #6 and #7 for injury. She said Resident #7 had a bite on his/her hand, and it was bleeding. LPN #1 said she notified the medical provider, and she ordered antibiotics and a tetanus shot. LPN #1 stated Resident #6 had superficial scratches to his/her forehead.

Interview with SRNA #3, on 06/25/2021 at 11:15 AM, revealed on 04/11/2021, she saw Resident #6 hit Resident #7's door with the wheelchair leg rest, and she ran to Resident #7's door. She said Resident #6 had the leg rest in his/her hand acting as if he/she was going to hit Resident #7. SRNA #3 said Resident #7 went at Resident #6

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putting his/her arm around Resident #6's neck and would not let go. She said Resident #6 sustained scratches to his/her forehead, and Resident #6 bit Resident #7's hand. SRNA #3 said Resident #7's hand started bleeding. She said she had heard that Residents #6 and #7 did not get along, but she could not remember who told her that.

Interview with LPN #4, on 06/23/2021 at 4:00 PM, revealed Resident #7 seemed cantankerous all the time, and it did not take much to tick off the resident. LPN #4 said Resident #7 would get upset and curse over small things, and would yell out statements such as, "Hey-Hey, shut the God Damned Door!" LPN #4 said it seemed Resident #7 wanted to stay to himself/herself and did not want to be bothered by anyone.

Interview with the Social Services Director (SSD), on 06/24/2021 at 3:10 PM, revealed she was not on duty on the day of the altercation between Residents #6 and #7. She said she received a report about the incident, when she returned to work on the following Monday, and completed psychosocial assessments on both of the residents. The SSD said she saw Resident #7 every day, and the resident told her he/she was angry about being at the facility. She said the resident had a gastrostomy tube to ensure adequate nutritional intake, and she thought that was the main reason the resident lived at the facility. She said Resident #7's parents were elderly and could not take care of him/her. The SSD stated she had not personally seen Resident #7 exhibit aggressive or combative behaviors, but at times, she said the resident would mumble comments, but then go on his/her way. The SSD stated it seemed he/she wanted others to let

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him/her alone.

Continued interview with the SSD, on 06/24/2021 at 3:10 PM, revealed when she discussed the incident with the Center Executive Director (CED) and the Interim Center Nurse Executive (CNE), she told them to make sure the nursing staff was aware of the incident and to develop the care plans to include the incident and a list interventions to guide staff in how to address aggression exhibited by either resident. The SSD said the direct care staff should not allow Residents #6 and #7 to cohort in activities in order to avoid any confrontational behaviors. She said the Activities Staff should try to communicate with Residents #6 and #7 and find out what activities interested them. The SSD said staff should have developed Resident #7's care plan after the incident so that all care givers would be aware of his/her display of aggressive behavior on 04/11/2021. She said licensed nurses could have updated Resident #7's care plan immediately after the incident, but she thought that ensuring the resident's care plan was modified to reflect the behaviors he/she exhibited during the resident-to-resident physical altercation ultimately fell on her. The SSD said she was not aware that staff had not modified Resident #7's care plan on or after 04/11/2021. The SSD said she was going to develop his/her care plan today, 06/24/2021 to include Resident #7's aggressive behavior.

Additional interview with LPN #1, on 06/23/2021 at 12:45 PM, revealed she did not update or revise Resident #7's care plan after his/her physical altercation with Resident #6 because she had only recently learned she could update/revise resident care plans. LPN #1 said the care plan

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should be a communication tool for all caregivers, and it should offer acceptable interventions for addressing a resident's behaviors and/or meeting other care needs. She stated she should have updated Resident #7's care plan after the physical altercation on 04/11/2021.

Interview with the CNE, on 06/24/2021 at 4:10 PM, revealed the incident between Residents #6 and #7 occurred the first week she was at the facility, and she was not involved in the review of the incident. The CNE said she thought the SSD reviewed the report of the residents' fight. She said both residents sustained injuries during the physical altercation, but neither resident wanted to go to the hospital for evaluation and treatment. She said the psychiatric (psych) care providers saw both residents after the incident. She said Resident #7 had a diagnosis of Schizoaffective Disorder, and she was aware Resident #7 was still upset about his/her fight with Resident #6. The CNE stated the facility would not want residents to engage in physically aggressive behaviors because the goal was to protect residents and staff from all forms of physical abuse and/or injury.

Interview with the CED, on 06/28/2021 at 2:06 PM, revealed the psych care provider did not think Resident #7's care plan needed any development or modification after the incident because he/she reacted in defense when Resident #6's banged on his/her door with the wheelchair leg rest. The CED stated the contracted psychiatric services providers continued to periodically visit Residents #6 and #7.

Interview with the Medical Director, on

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F 656	Continued From page 21 06/28/2021 at 10:38 AM, revealed she was aware that Resident #6 could demonstrate aggressive behaviors toward staff, and his/her behaviors had been previously identified and addressed in his/her care plan. She stated the facility should have developed a care plan to address Resident #7's anger and acts of physical aggression toward Resident #6, on 04/11/2021, because direct care staff members should understand how to minimize Resident #7's anger, and hopefully prevent Resident #7 from committing any additional acts of physical aggression.	F 656		