Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100346	A. BUILDING _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPARKS NURSING CENTER	500 EAST WHITMER STREET CENTRAL CITY, KY 42330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(P 000)	Initial Comments Based upon implementation of the acceptable Plan of Care (PoC), the facility was deemed to be in compliance on 08/06/2024.	(P 000)		

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

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P 000	Initial Comments A Complaint Survey investigating KY00042892, KY00042854, KY00042492, KY00041998, KY00041833, KY00042062, KY00042148, KY00042605, KY00041648, KY00042883, KY00040446, KY00040555, KY00041458, KY00041882, KY00041901, KY00041997, and KY00042274 was initiated on 07/08/2024 and concluded on 07/15/2024. Complaints KY00042854, KY00042605, KY00041648, and KY00042883 were substantiated with deficiencies cited. No regulatory violations were identified with KY00042892, KY00042492, KY00041998, KY00041833, KY00042062, KY00042148, KY00040446, KY00040555, KY00041458, KY00041882, KY00041901, KY00041997, and KY00042274.	P 000	RECEIVED AUG - 9 2024 CHFS Office of Inspector General Division of Health Care - WB Received by	
P 075	902 KAR 20:036 3(6)(d) Section 3. Administration and Operation (6) Transfer and discharge. (d) The administrator shall initiate a transfer through the resident's physician or appropriate agencies if the resident's condition is not within the scope of services of the PCH or SPCH. This requirement is not met as evidenced by:	P 075	P075 07/11/2024 Administrator sent 30 day discharge letter to son/guardian. Signed for by guardian on 07/18/2024. See Attachment Page 1. 08/05/2024 Administrator educated staff on Activities of Daily Living relating to Personal Care. Discussed level of care and reporting changes in residents ability to do ADL's. See Attachments Page 2 - 5.	

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P 075	Continued From page 1	P 075		

Based on interview, record review, and facility policy review, it was determined the facility failed to provide transition of a resident to a higher level of care for one of 22 sampled Residents, R4.

Resident #4 was admitted to the facility on 10/01/2020 with a diagnoses of Alzheimer's Disease; however, the facility failed to transfer the resident to the level of care required. Therefore, R4 was repeatedly attacked and assaulted by other residents in the facility due to her wandering behaviors and going into residents' rooms.

The findings include:

Review of the facility's policy entitled, "Abuse and Neglect Policy and Procedure" undated, revealed it should be the policy of the facility to ensure each resident was free of any type of abuse, neglect, or misappropriation of resident property while a resident at the facility. Continued policy review revealed each resident had the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. Further review revealed any instance or alleged instance of abuse was to be investigated, have interventions to identify the event, protect all parties involved, report the allegation to the proper parties and agencies, and prevent further occurrences.

1. Review of the investigation file documentation revealed on 01/04/2024, an incident report involving R4 related to an incident with no apparent injury. Per review, of the investigation documentation a staff member was headed down the D Hall and R3 told R4 to stay away from him. Continued review revealed the staff member reported hearing some noise and went in R3's room and observed R4 lying on the floor by the

P075
08/05/2024 Administrator educated staff on Understanding Wandering Residents and How to Address It. See attachment pages 6-11.

P075
08/005/2024 Administrator educated staff on Sparks Nursing Facility Abuse and Policy and Procedure. See attachment pages 12-16.

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P 075	Continued From page 2	P 075		

trashcan. Further review revealed R3 claimed he did not "lay" hands on R4 and never would do that. Additional review revealed R3 said R4 had been in his room and was turning around to go back out into the hall and tripped over his trashcan. Review further revealed R3 stated he loved her (R4) and could never hurt her.

1(a). Record review revealed the facility admitted R3 on 06/25/2019, with diagnoses that included depression, intellectual disability, and hypertension.

Review of R3's care plan dated 12/10/2023, revealed the resident was at high risk for behaviors related to his diagnosis of agitation, with a goal that he would be without periods of agitation and combative behaviors. Continued review revealed the nursing interventions included: providing reality orientation as needed, provide a quiet, stimuli free environment; give medications (meds) as ordered by Physician, and redirect his attention from agitating situations.

Review of the nursing progress note dated 01/04/2024 at 10:31 PM for R3, revealed he hit and shoved a wandering resident. Continued review revealed the aides removed the other resident (R4) who had no injuries.

Observation of R4 on 07/10/2024 at 12:15 PM, revealed the resident was sitting in the dining hall and rocking in a chair while she was eating her meal. Continued observation revealed R4 did not interact or speak with other residents in the dining hall.

In interview with R3 on 07/11/2024 at 3:30 PM, the resident stated, when asked about the altercation with R4 on 01/04/2024, he stated

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P 075	Continued From page 3	P 075		

"she" wandered into his room and hit him. He stated she had not "bothered" him again since that time.

1(b). Review of the medical record for R4 revealed the facility admitted the resident on 10/01/2020, with diagnoses that included Alzheimer's Disease, Anxiety, Hypertension.

Review of R4's care plan dated 10/09/2022, revealed the resident was high risk for altered mental status due to the diagnosis of Alzheimer's (Disease), with a goal for the resident to maintain current mental status as much as allowed by the disease process. Continued review revealed the nursing interventions included: reality orientation as needed, redirecting R4 as needed for distracting attention away from agitating situation, give meds as ordered by Physician, encourage the resident to visit with peers and attend activities. Further review revealed no documentation noting care plan interventions aimed at protecting R4 or related to the resident's wandering precautions.

Review of the nursing progress note dated 01/04/2024 at 10:32 PM for R4 documented by Nurse Aide (NA) 2, revealed the resident had been wandering in another (resident's) room and the resident who lived in that room shoved her (R4) and she fell down. Further review revealed R4 had slight bruising on her cheek, with no other apparent injuries, no pain and her "vitals" (vital signs) were normal.

In interview with Nurse Aide (NA) 2 on 07/11/2024 at 11:15 AM, revealed she did not recall the specifics of what happened on 01/04/2024. She stated her written nursing progress notes were accurate and she stood by what she had written

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P 075	Continued From page 4	P 075		

in a resident's chart NA 2 stated she did not recall having conversations about what took place with R4 and R3 as they were both poor historians. The NA said she would "take a look" at (residents') care plans when she was going through paperwork; however, the Medical Records Department wrote out the care plans.

2(a). Record review revealed the facility admitted R5 on 03/02/2009, with diagnoses that included: epileptic seizures, mild retardation, and aggressive behavioral problems per his chart cumulative diagnosis sheet.

Review of R5's care plan dated 09/02/2021, revealed the resident was a high risk for agitation related to behavior problems with a goal for R5 to be without periods of agitation and combative behavior. Continued review revealed the nursing interventions included: providing reality orientation as needed; providing a quiet, stimuli free environment; give meds as ordered by the Physician MD; and report any uncontrollable behavior to Physician.

Review of the nursing progress note dated 05/25/2024 at 9:15 PM for R4, revealed the resident had been hit in the face and head by another resident (R5), who also pulled R4's hair. Continued review revealed no documented staff member's signature for the nursing progress note

Review of the nursing progress note dated 06/29/2024 at 5:10 PM completed by NA 4, revealed R4 had been in a male resident's (R5's) room wandering. Continued review of the note revealed the male resident (R5) got upset and pushed R4 against the door and started choking her. Further review revealed R4 fell to the floor

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hitting her head on it which caused unconsciousness.

Review of the nursing progress note dated 06/29/2024 at 5:10 PM documented by NA 2, revealed R5 had a wandering resident (R4) in his room and he "got upset" and pushed the female wandering resident (R4) into the door and started choking her. Continued review of the note revealed R4 then fell hitting her head which caused her to go unconscious. Review of the nursing progress note dated 06/29/2024 at 5:17 PM, revealed the "med tech" (medical technician) called Emergency Medical Services (EMS) for a female resident (R4) who had a knot on her head. Review of the nursing progress note completed by NA 2 dated 06/29/2024 at 9:45 PM, revealed the resident (R4) returned via EMS with a (diagnosis of a) thoracic spine fracture.

In continued interview on 07/11/2024 at 11:15 AM with NA 2, she stated she had been on break during the incident on 06/29/2024 and law enforcement officers were arresting R5 during the time she came back from break. She further stated law enforcement had called dispatch to send EMS to transfer R4 to the hospital.

In interview with NA 3 on 07/11/2024 at 2:20 PM, she stated on the night of the incident on 06/29/2024, she went into the room of the "aggressor," (R5) and he had his legs wrapped around the body of R4 and had knocked her out. NA 3 said she yelled for help and had to pull R5 off of R4 who had been "completely knocked out." She stated "we" called for an ambulance to take R4 to the hospital. The NA said she did not know "anything" about care plans and stated the (facility's) leadership would not allow her to look at residents' medical records. She further stated

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she thought R 4 needed to go to a higher level of care at that time.

In interview with NA 4 on 07/11/2024 at 11:00 AM, "I was in the med room getting ready to do 7:00 PM med pass" on 06/29/2024 and another aide saw a resident grab R4 by the throat. The NA stated the other aide saw R4 fall to the floor and the resident had "passed out" for about two to three minutes. NA 4 stated, "I checked her pulse, and it was shallow, but she woke up and said her hip was hurting" and EMS was called because R4's pulse was shallow and the back of her head was hurting. Per the NA, R4 had a large knot on the back of her head, and EMS and local Police Department officers came and assisted as well until EMS took over. NA 4 stated R4 was a wanderer and wandered in other residents' rooms "all the time." The NA said R5 had been the aggressor in the incident, and the resident did not like the fact that R4 was in his room, so he attacked her. NA 4 further stated, "When I asked" R5 why he did it, he said "honey I just don't like her."

During an interview on 07/10/2024 at 2:06 PM, with the police officer he stated R5 had a history of doing the doing those types of things, and had previously been warned that he would be arrested if he attacked anyone else.

In interview with Facility Administrator 1 on 07/11/2024 at 11:38 AM, regarding the incident on 01/04/24 12:15 PM, she stated both residents were poor historians, and it was hard to tell exactly what had taken place. She said "we" conducted staff in-service education about how to talk with a resident and how to redirect a resident when they were confused. The Administrator stated "our staff" might not know anything specific

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P 075	Continued From page 7 about residents' care plans and how to use them. She stated staff should look at care plans when they do the charting (on residents). Facility Administrator 1 said, on 01/04/2024 R4 was "checked out" and found not to have any injuries. In continued interview on 07/11/2024 at 11:38 AM, the Facility Administrator stated the incidents with R5 and R4 on 05/25/2024 and 06/29/2024 were "very territorial." She stated R4 wandered into the "wrong place" and R5 did not like her and went after her. The Administrator stated "we" also have talked about providing extra supervision because R4's roaming and wandering were getting worse and she needed to be placed in a memory care facility. She said "we" have talked to R4's son about transferring her and he (the son) was trying to find somewhere for her to be placed. Facility Administrator 1 stated he (the son) started working on finding a place for her (R4) to go about one month ago. She stated that she as Administrator had not personally been doing anything to find new placement for R4. The Administrator stated on 08/01/2024 a 30-day letter would be written for R4 so that they (R4's family) have some time to get her to a new location. She further stated if she (R4) was not monitored carefully or her care plan was not followed, R4 was in danger of getting hurt in the facility.	P 075		
P 105	902 KAR 20:036 3(8)(c) Section 3. Administration and Operation (8) Personnel. (c) A PCH or SPCH shall obtain a criminal record check on each applicant for initial employment in accordance with KRS 216.789 and 216.793.	P 105	P105 07/31/2024 Administrator educated office staff about each background check that is required before new employees can start. See attachment pages 17-18.	

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P 105	Continued From page 8	P 105	P105 07/31/2024 Administrator implemented a new check off list for all new employee files. See attachment page 19.	

This requirement is not met as evidenced by:
Based on interview, and record review it was determined the facility failed to provide necessary and adequate criminal record checks for one of 24 sampled employees, Employee 8.

Review of Employee 8's personnel record revealed his employment start date was 03/08/2024; however, the facility failed to complete his criminal record check until 03/11/2024.

The findings include:

Review of the facility's personnel file for Employee 8 revealed his start date as 03/08/2024; however, the facility failed to conduct Employee 8's criminal record check until 03/11/2024, three days after his start date. Continued review of the file revealed Employee 8 had been charged with four drug related charges for methamphetamine abuse approximately one month prior to his start date at the facility.

Review of R16's medical record revealed the facility admitted the resident on 02/15/2024, with diagnoses that included schizophrenia, depression, and anxiety.

Review of R16's care plan dated 02/15/2024, revealed the facility developed a problem for potential for periods of disorganized thought processes due to diagnosis of anxiety for the

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resident. Per review, the goal was for R16 to be free from anxiety attacks. Further review revealed the nursing interventions included: maintaining a calm, non-threatening manner while working with R16; provide reassurance and comfort measures; give medication as ordered by Physician; provide a quiet area with minimal stimuli; and notify the Physician of any uncontrolled behaviors.

Review of the facility's internal incident report documentation revealed on 05/29/2024 at approximately 5:30 PM, Employee 8 pushed R16 while on the front porch of the facility. Continued review revealed R16 was her own guardian and the resident experienced no injury as a result of the incident. The facility completed the State Survey Agency's (SSA) Long-Term Care Facility Self-Reported Incident form on 05/30/2024, which stated R16 had been in an incident which involved Employee 8, who had been terminated for acting out against a facility resident.

In interview with R16 on 07/12/2024 at 4:00 PM, she stated she Employee 8 had pushed her, however, since both Employee 7 and 8 were terminated, she had not had any more problems.

Review of the facility internal investigation file documentation revealed it contained a written statement from the Facility Administrator dated 05/30/2024. Per review of the written statement, the Facility Administrator asked R16 what happened (in regards to the incident) and the resident said she had been arguing with other residents and the staff calmed her down. Continued review revealed the Administrator told R16 she was talking specifically about the issue with Employee 8 pushing her and the resident stated "I tried to talk to" Employee 7 about

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"calming down and she got mad at me, and I pushed her out of the way." Review revealed Employee 8 then pushed R16 and the resident stumbled against the ashtray on the porch and then Employee 8 began to cuss at her. Further review revealed Employee 8 and Employee 7 were both told to just leave the area, but Employee 8 continued to cuss and yell. Review also revealed both employees finally left and Administration and the facility owner were notified and Employee 8 was terminated for his actions against R16, and Employee 7 was suspended Additionally, review further revealed witness statements which corroborated the incident.

In interview with Employee 13 on 07/12/2024 at 3:45 PM, she stated she had been the nurse aide present during the altercation involving Resident 16 and Employees 7 and 8. She stated Employees 7 and 8 were both sent home by charge nurse after the incident. Employee 13 said she stayed with R16 until she calmed down and felt safe to go back inside the facility from the porch. She stated R16 had not appeared injured, there were no bruises or broken skin. Employee 13 stated R16 really had not had any other outbursts or problems with staff or residents since the incident with Employees 7 and 8.

In interview with Facility Administrator 1 on 07/12/2024 at 3:30 PM, he stated the charge nurse at the facility sent Employee 8 home immediately following the incident and contacted the police. He stated Employee 8 had eventually been served a bench warrant and taken into custody for an unrelated issue after the police department was contacted about the incident. The Facility Administrator stated the caretaker at the facility went to R16's room and stayed there with her (R16) until she was able to calm down

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P 105	Continued From page 11 after the incident. When the SSA questioned the Facility Administrator about Employee 8's background check she did not dispute the fact that the facility completed the background check after the employee's start of employment. See above.	P 105		
P 185	902 KAR 20:036 4(1)(a)1-4 Section 4. Provision of Services (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to assure that the resident's health care needs are met, 2. Supervision of self-administration of medications, 3. Storage and control of medications, and 4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility.	P 185	P185 07/23/2024 Administrator had a meeting with third shift charge person Shannon Sowders. Shannon was in-serviced over the proper way to monitor and run her shift. All topics discussed in the meeting are on page 20 of the attachments. She also received a write-up at this meeting. See attached page 20. P185 08/02/2024 Administrator in-serviced staff about our newly implemented Elopement Profile. The profile will be completed during admission of all new residents. An elopement profile has also been filled out and added to all current resident's charts. See attachment pages 21-25.	

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This requirement is not met as evidenced by:
Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to provide supervision and monitoring of residents to ensure the Resident's (R) health care needs were met for two of 22 sampled residents (R1 and R4).

On 06/26/2024 after 11:00 PM, R1 used the facility's door code to let herself out and eloped from facility. R1 was found by a concerned citizen down by the park around the corner from facility. The concerned citizen called the Police Department at 12:36 AM, and a police officer responded. When the police officer asked R1 what she was doing, R1 could not remember how to return to facility.

The findings include:

Review of the facility policy titled, "Elopement Risk" undated, Policy revealed the policy of the facility was to identify risks for elopement and prevent elopement Per policy review, upon admission, a resident was to be classified as an elopement risk based on information from physician's notes presented to the facility as well as information from family or guardian who were admitting the resident. Continued review revealed if a resident was found to be a risk, a wander guard was to be placed on the resident's ankle which was to be checked every Friday by the nurse or administrator. Further review revealed if a resident was there for a while and did not appear to have any elopement risk behaviors, the administrator would discuss removing the wander guard with their guardian and the physician. Review revealed any time after admission, if a resident without a wander

P185
08/02/2024 Administrator educated staff about the new resident sign in and out sheet located at the nurses station as well as the office. Administrator educated residents about the sign in and out sheet on 07/22/2024, which is the day we started using the new sheet. See attached pages 26-29.

P185
08/02/2024 Administrator completed educating all staff about elopement. What is elopement? How to prevent? What to do? This was also added to the new employee in-service list. See attachment pages 30-33.

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guard began to show concerning elopement risk behaviors, the facility contacted the doctor as well as the guardian to alert them a wander guard was needed. Per review of the policy, a wander guard was then to be placed on the resident after the order was received from the physician. Additionally, review revealed staff were to be informed about door alarms and elopement risk residents upon hire and the importance of monitoring those residents more closely was to be stressed to staff upon hire as well.

Review of the facility policy titled, "Resident Rights" undated, revealed the facility would inform each resident of all services available and of his/her rights as a resident. Further review revealed it was important any person be provided certain rights to ensure dignity, self-esteem, privacy and individuality.

Review of the facility policy titled, "Abuse/Neglect Policy and Procedure" undated, revealed it should be the policy of the facility to ensure that each resident was free of any type of abuse, or neglect while a resident of the facility. Continued review revealed any instance or alleged instance of the abuse of neglect was to have interventions to identify the event, investigate allegations, protect all parties involved, report to the proper parties and agencies, and prevent further occurrences. Further review revealed the facility was to make any effort to prevent abuse or neglect from occurring by monitoring the incidents, trends and signs that a possible harmful situation could occur.

1. Record review revealed the facility admitted R1 on 04/03/2023, with diagnoses to include: Dementia, unspecified severity, Chronic Obstructive Asthma, Sinus Bradycardia. Further

P185
08/02/2024 Administrator educated maintenance staff about the new weekly elopement check list to check all exits to assure all equipment is working properly. See attachment pages 34-36.

P185
08/02/2024 Administrator educated all staff about the new Wander Assessment Form. It will be completed upon admission by medical records staff of all new residents and every six months after, unless it is seen to be needed sooner. See attachment pages 37-41.

P185
08/02/2024 Administrator educated staff about the new Door Code Policy. The door code was changed on 07/11/2024. It has been changed several times since.

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P 185	Continued From page 14 record review revealed no documentation noting R1 was considered an elopement risk on admission. Review of the Facility Investigation dated 06/26/2024, revealed on that date "central dispatch" called the facility to alert staff that a female resident had been located at a park around the corner from the facility. Per review, a citizen driving by noticed R 1 at the park, stopped to check on her, called the police, and gave the resident a ride back to the facility. Continued review of the Investigation revealed R1 had been in her room when third shift staff did their rounds and bed checks at around 11:00 PM. Review also revealed R1 had not attempted to leave the facility prior to the incident and was not aware of the door codes to leave the facility. Further review revealed the facility updated R1's elopement risk and placed a wander guard on her left ankle after the incident. Review further revealed R1 had no injuries and told staff she went on an adventure. In addition, review revealed R1 was transported to the Emergency Department (ED) for evaluation due to mental status change and her guardian was notified. Review of the City Fire Department Call For Service documentation dated 06/26/2024 at 12:36 AM, revealed a citizen called to report an elderly person in a nightgown was at the local park trying to find her way to town. Review of the hospital ED Summary dated 06/26/2024, revealed there were no acute findings and the patient was discharged back to the facility. Continued review revealed per discussion with nursing staff patient only had been found wandering with no complaints. Further review revealed the clinical impression	P 185	P185 cont. Door code will be changed the first business day of each month unless residents become familiar with code, and at that time, it will be changed immediately. The code is for staff only now. See attached pages 42-44.	

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was noted as: Dementia without behavioral disturbance, psychotic or mood disturbance, or anxiety.

Observations of R1 revealed on: 07/08/2024 at 3:30 PM, R1 was sitting on the side of bed in room; 07/08/2024 at 4:30 PM, R1 was in the dining room waiting on dinner, 07/09/2024 at 5:00 PM, R1 was in the dining room eating dinner; and 07/09/2024 at 5:30 PM, R1 was at nurse's station.

In an interview on 07/08/2024 at 2:17 PM, R1 stated she had been in facility since November 2023, but it was hard to remember the date because of the Alzheimer's. The resident stated (on 06/26/2024) she was asleep in her room and wanted to go get some fresh air and had not been out of facility in a long time. R1 stated she went out the front door and knew the numbers two, three, four star would get her out (the door). She stated it was dark and a little hot, not raining and the sky had been clear. The resident stated she started walking down to the park because she had been down there with staff supervision and other resident two days ago when it was daylight. She stated when she got to the park, she became confused and could not remember how to get back to the facility. R1 stated a lady came by in a car and asked her what she was doing, and she told the lady she was getting some fresh air and could not remember how to get back to the facility. She stated the lady called the police and took her back to the facility, after she told her where she lived. R1 further stated after returning to the facility she went back to bed and could not recall what time of the night it was when she got back. In addition, R1 stated the facility called her guardian and her guardian had been upset with her.

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Telephonic (Phone) attempts were made to contact R1's guardian on 07/08/2024 at 2:17 PM; on 07/09/2024 at 2:22 PM; and on 07/10/2024 at 9:15 AM, with messages left; however, no return call received.

In an interview on 07/08/2024 at 3:10 PM, Non-Certified Medication Technician (NCMT) 2 stated R1 had been in bed at 11:00 PM during rounds. The NCMT said she had been up front cleaning all night and had not seen the resident go out the door. She stated several residents sat outside late at night and one of them might have let R1 out. NCMT 2 stated the facility's phone rang and it was dispatch and they asked if the facility knew where R1 was, and she told them to hang on. She stated after checking R1' s bed she observed the resident was not there, so she checked elsewhere in the facility and could not locate R1. NCMT 2 stated she returned to the phone to tell dispatch that information and they told her they had R1. She further stated she checked R1 for any injuries when the resident returned and R1 told her she went out for a little adventure. In addition, NCMT 2 stated she had no idea how long R1 had been out of facility, and had not received education on elopement before or after the incident.

In an interview on 07/09/2024 at 7:00 AM, NCMT 1 stated she had been late to work the night of the incident (on 06/26/2024) and when she got there the police were on the phone. NCMT 1 stated she checked R1's room and the resident had not been in there. She stated police said they had R1 and were bringing the resident back to facility; however, the police never came inside building, an aide went outside and assisted R1 back into the facility. NCMT 1 stated R1 said she had taken a midnight stroll, and met a real nice

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police officer and lady. She stated R1 was put on every 15-minute checks and the resident had gone back to bed and slept the rest of the night. NCMT 1 stated she had never received any education on anything while working at the facility where she had been employed for six years. The NCMT stated the door code (to go outside) had always been the same, and had never changed. She further stated she did not know how long R1 had been out of facility or how she got out of facility, she thought maybe another resident had let her out.

Phone contact was attempted with the "concerned citizen;" however, there had been no working telephone number.

In interview with the police officer on 07/10/2024 at 2:06 PM, he stated a call had came into dispatch (on 06/26/2024) about a resident walking off from the facility and when he arrived "on scene," R1 had already been sitting in the (concerned) citizen's car. The police officer stated he was in his personal vehicle, a large four wheel drive truck, so he let the citizen transfer R1 back to facility. He stated when he asked R1 where she had been going the resident seemed confused and told him she did not know and had gotten lost. The police officer stated R1 told him she could not remember how to get back to the facility. He stated when they got to the facility a young man met him and R1 in front of the facility and he assisted the resident back into facility. The police officer further stated he thought the time had been somewhere between 11:30 PM to 11:40 PM that night.

In an interview on 07/11/2024 at 5:45 PM, the Administrator stated she had been unaware R1 exited the facility without staff's knowledge on

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06/26/2024 until the next day. She stated the door codes had not been changed and the code remained the same as no one in the facility knew how to change the door codes and most of the residents did have the code to the doors. When the State Survey Agency (SSA) Surveyor asked the Administrator why residents were allowed to have the door codes, she the residents had the codes so they could go out and smoke, walk around the facility grounds or walk to the store. She stated the facility had never had any problems with elopement and R1 had never been any problem before the incident. The Administrator further stated she had not provided any recent elopement education to staff and did not feel R1's elopement was a problem. She stated residents left the facility all the time and if she and staff thought one of the residents might be an elopement risk, they put a wander guard on their ankle.

2(a) Review of the facility's investigation file revealed on 01/04/2024, revealed a staff member was headed down D Hall when R3 told him he told R4 to stay away from him. He said he heard some noise and went in R3's room and R4 had been lying on the floor by the trashcan. Per review, R3 claimed he did not lay hands on R4 and never would do that because he loved her and could never hurt her. Continued review revealed R3 reported R4 had been in his room and was turning around to go back out into the hall and tripped over his (R3's) trashcan.

Record review revealed the facility admitted R4 on 10/01/2020, with diagnoses which included anxiety, Alzheimer's disease, and hypertension.

Review of the care plan for R4 dated 10/09/2022, revealed the facility care planned the resident for

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high risk for altered mental status due to the diagnosis of Alzheimer's, with goals for R4 to maintain current mental status as much as by allowed disease process. Further review revealed the interventions included providing reality orientation as needed; redirecting the resident as needed; distracting the resident's attention away from agitating situations; giving medications as ordered; and encouraging the resident to visit with peers and attend activities.

Review of the progress note for R4 dated 01/04/2024 at 10:32 PM, revealed the resident had wandered into another resident's room and the resident residing in that room shoved R4 and she fell (to the floor). Continued review revealed R4 had slight bruising on her cheek, no apparent injuries and no pain.

Observation of R4 on 07/10/2024 at 12:15 PM, revealed the resident rocking in a chair in the dining hall while eating her meal. Per observation, R4 did not speak or interact with other residents in the dining hall.

2(b). Record review revealed the facility admitted R3 on 06/25/2019, with diagnoses that included hypertension, depression, and intellectual disability.

Review of the care plan for R3 dated 12/10/2023, revealed the facility care planned the resident for high risk for behaviors related to the diagnosis of agitation, with goals for the resident to be without periods of agitation and combative behaviors. Further review revealed the interventions included providing a quiet, stimuli free environment and reality orientation as needed; giving medication as ordered by the Physician; and redirecting the resident's attention from agitating situations.

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Review of the 01/04/2024 at 10:31 PM, nursing progress note for R3 revealed the resident hit and shoved a resident who wandered (into his room). Continued review revealed the aides removed the wandering resident and R4 had no injuries and his vital signs were normal.

During interview with R3 on 07/11/2024 at 3:30 PM, the resident stated, when asked about what happened on 01/402024, he stated "she" (R4) wandered into his room and hit him. He stated "she" had not bothered him anymore since that time.

During interview on 07/11/2024 at 11:15 AM, with NA 2 she stated that she did not recall the specifics of the incident in question (01/04/2024 incident involving R4). The NA stated her written nursing progress notes were accurate and she stood by what was written in the chart. She stated both R4 and R3 were poor historians and she did not recall having conversations with them about what took place. In interview, NA 2 stated the medical records department wrote out residents' care plans which she took a look at when going through paperwork.

During interview on 07/11/2024 at 11:38 AM, with the Facility Administrator, about the incident on 01/04/2024, she stated both residents were poor historians, and it had been hard to tell exactly what took place. She stated on 01/04/2024, R4 had been checked out and found to have no injuries.

2(c). Record review revealed the facility admitted R5 on 03/02/2009, with diagnoses which included mental retardation, epileptic seizures, and aggressive behavioral problems.

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Review of R5's care plan dated 09/02/2021, revealed the facility care planned the resident as a high risk for agitation related to a diagnosis of behavior problems, with goals for R5 to be without periods of agitation and combative behavior. Per review, the interventions included providing reality orientation as needed; providing a quiet, stimuli free environment; giving medication as ordered; and reporting any uncontrollable behavior to the Physician.

Continued review of R4's record revealed a progress note dated 05/25/2024 at 9:15 PM for the resident revealed R4 had been hit in the face and head by another resident (R5) and her hair was pulled by that resident. Further review revealed the document had not been signed by the staff member who wrote it, but the document was retained for the record.

During continued interview on 07/11/2024 at 11:38 AM, the Facility Administrator stated R4 had wandered into R5's room and R5 did not like R4 and was very territorial.

Review of R4's progress note dated 06/29/2024 at 5:10 PM, completed by Nurse Aide (NA) 4, revealed R4 had wandered and been found in a male resident's room (R5's room). Continued review revealed the male resident (R5) got upset and pushed R4 against the door and started choking her. Review further revealed R4 fell and hit her head against the floor, making her unconscious.

Review of R5's progress note, written by NA 2 on 06/29/2024 5:10 PM, revealed R5 had a resident wander into his room and R5 got upset and pushed the female resident (R4) into the door and

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started choking her. Per review, the female resident (R4) fell and hit her head causing her to go unconscious. Review of the progress note for 06/29/2024 at 5:17 PM, revealed the med (medication) tech (technician) called emergency medical service (EMS)for a female resident with a knot on her head.

Further review of R4's progress note, completed by NA 2, dated 06/29/2024 at 9:45 PM, revealed the resident returned to the facility via EMS with a thoracic spine fracture.

During interview on 07/11/2024 at 11:00 AM, with NA 4 she stated she had been in the med (medication) room preparing to do 7:00 PM med pass on 06/29/2024. The NA stated another aide saw a resident grab R4 by the throat, and saw R4 fall to the floor and pass out for about two to three minutes. NA 4 stated "I checked her pulse, and it was shallow, but she woke up and said her hip was hurting." The NA said EMS was called because R4's pulse was shallow and the back of her head, which had a large knot on it, was hurting. NA 4 stated police officers came and assisted until EMS arrived and took over. In interview the NA stated R4 was a wanderer, and wandered into the rooms of other residents all the time. NA 4 said R5 had been the aggressor in the incident and he did not like the fact that R4 was in his room, so he attacked her. The NA further stated "When I asked" R5 why he did it, he said "honey I just don't like her."

In continued interview with NA 4 on 07/11/2024 at 11:00 AM, she stated R4 was a wanderer, and wandered into other residents' rooms all the time. NA 4 said R5 had not liked the fact that R4 was in his room so he attacked her. She stated R5 had those explosive behaviors from time to time. She

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stated staff walked R4 and tried to "change her attention" and take her mind off wandering, so she did not wander in the wrong room. The NA said due to the dementia, R4 wandered and was not able to talk in a way that was sensible when interacting with others

In additional interview on 07/11/2024 at 11:15 AM, with NA 2 she stated "I was on break" during the incident on 06/29/2024. She stated the police were arresting R5 during the time when she came back off break, and dispatch had been called for EMS for R4. NA 2 stated, regarding R4, "she wanders into patient rooms, may pick up things, and when we catch her going in the room, we will redirect her." She stated staff took R4 instead to a main room where she could hang out. The NA said R4 did not read books, but would sit and look at books. Per NA 2' s' interview regarding R4's care plan, staff redirected R4, and kept "her in touch with reality as much as possible."

During interview on 07/11/2024 at 2:20 PM, with NA 3 she stated on the night of 06/29/2024 (when the incident involving R4 occurred) she had gone into the room of the aggressor (R5), and the resident had his legs wrapped around the body of R4 and he had knocked her out. She stated she yelled for help and had to pull the resident (R5) off of R4, who was completely knocked out. Per NA 3's interview "we" called for an ambulance to take R4 to the hospital. The NA further stated she thought R4 needed to go to a higher level of care at that time.

During the interview on 07/11/2024 at 11:38 AM, the Facility Administrator stated R5 was very territorial and for the incidents with R5 and R4 on 05/25/2024 and 06/29/2024. R4 had wandered into the wrong place and as R5 did not like her