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	255207	A. BUILDING _____ B. WING _____	C 01/09/2025

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PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification Survey with three (3) Complaint Investigations (CI MS #26993, CI MS #26961, and CI MS #26842), at the facility from 1/06/25 through 1/09/25. The SA investigated CI MS #26993 for abuse and neglect and CI MS #26842 for quality of care and dignity and there were no citations related to those CIs. The SA investigated CI MS #26961 related to resident on resident abuse, dignity, safety and infection control and cited F600, F607, and F689. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F584, F600, F607, F641, F689, F812, and F880. The facility had a census of 95 and was licensed for 100 beds.	F 000		
F 600 SS=E	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		2/13/25

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

Electronically Signed | 02/02/2025

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F 600	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to protect residents' right to be free from physical abuse when Resident #62 received scratches to his neck and face in an altercation with Resident #48 and Resident #41 received a hematoma to her head during an altercation with Resident #78 for four (4) of 20 sampled residents. Findings included: A review of the facility's "Abuse, Neglect, Exploitation, and Misappropriation Prevention Program," updated October 2022, revealed, "Residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms." Resident #48 and Resident #62 Altercation Record review of the facility's investigation dated 11/2/24 revealed Resident #62 and Resident #48 were involved in an altercation in the dining room. Resident #62, who was assisting with handing out clothing protectors, was punched by Resident #48 when he attempted to place a clothing protector on him. In response, Resident #62 hit Resident #48 back, and both residents fell to the floor. A dietary aide witnessed the incident, reported it to Registered Nurse (RN) #4 and both residents were separated. Resident #62 sustained scratches to his face and neck, while Resident #48 had no noted injuries. The physician, Director	F 600	The facility failed to protect residents □ right to be free from physical abuse for resident # 62, #48, #78 and #41. Residents #62 and #48 were interviewed by the Social Service Director concerning the incident that occurred on 11/2/24 on 01/10/25. No adverse effects were noted. There have been no further issues between resident # 62 and #48 since 11/2/24. Residents #78 and #41 were interviewed by the Social Service Director concerning the incident on 01/07/25. Both residents have no adverse effects. All residents have the potential to be affected. All staff were educated beginning 01/10/25 and ending 0/31/2025 on abuse, neglect and exploitation policy the Director of Nursing and Nursing Administration staff. The Social Service Director conducted a person-centered in-service on resident #62 for all staff. On 01/07/2025, the dining area which leads to the smoking area was opened to residents to wait for smoke break so they can spread out more. On 01/07/2025, staff were informed that residents, when grouping together before smoke break or during mealtimes, must be supervised in the main dining room. The dining room will only be open for activities, mealtimes and when waiting to smoke. The administrator met with the smokers on 01/13/25 and explained that the area to wait for smoke break will not be opened	

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F 600	Continued From page 2 of Nursing (DON), and Administrator were notified. Interventions included instructing staff to prevent Resident #62 from distributing clothing protectors in the dining room and referring Resident #48 to the in-house psychiatric Nurse Practitioner. During an observation on 1/6/2025 at 10:50 AM, Resident #48 was noted sitting in his wheelchair in his room. Resident #48, who has expressive aphasia, communicated with head nods. During an interview on 01/06/2025 at 11:00 AM, Registered Nurse (RN) #3 explained that Resident #48 can talk but may not want to communicate because he cannot speak clearly. RN #3 reported she did not recall many details about the night Resident #48 and Resident #62 were involved in an altercation in the dining room. She noted both residents have a history of other altercations, which usually occurred due to Resident #62 wandering into rooms. RN #3 added that Resident #48 had hit Resident #62 previously when Resident #62 wandered into his room. During an observation and interview on 01/08/2025 at 09:30 AM, Resident #48 was observed sitting in his wheelchair in his room. When asked if he could answer yes or no questions, the resident nodded yes. When asked if he remembered the altercation in the dining room with Resident #62, the resident nodded yes. When asked if he and Resident #62 had previous issues, he nodded yes. When asked if he was upset about the clothing protector, he nodded no. When asked if he became upset when he saw it was Resident #62, he nodded yes. When asked if he landed on the floor during the incident, he	F 600	until 20 minutes prior to scheduled smoke time. Residents were asked to please not come down an hour before smoke breaks. Resident #62 will be monitored to ensure he does not hand out clothing protectors starting 01/10/25 and ending 03/01/2025. The Quality Assurance Performance Improvement (QAPI) Team met on 01/10/25 and discussed policies and procedures on abuse, neglect, and exploitation with no revisions needed at this time. All residents will be supervised while in the main dining area while gathering for smoke breaks, mealtimes, and activities. The Life Connections Department will use a daily monitoring tool beginning 01/13/25 ending 03/01/25 to ensure the main dining area is being supervised during smoke breaks, mealtimes, and activities. Any adverse findings will be reported to the Administrator or Director of Nursing. All findings will be reported to the QAPI Team monthly beginning 02/13/25 and ending 03/31/25 for review and recommendations.	

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nodded yes. When asked if he was hurt, he nodded no. When asked if he had punched Resident #62 before, he nodded yes. When asked if this occurred when Resident #62 came into his room, he nodded yes. When asked if he had any further altercations with Resident #62 since the dining room incident, he nodded no. When asked if everything was better now, he nodded yes and smiled.

During an interview on 01/08/2025 at 12:15 PM, Dietary Aide #4 confirmed she provided a witness statement for the incident between Resident #48 and Resident #62. She stated the incident occurred around 5:20 PM as the dining room trays are typically distributed starting at 5:25 PM. She was at the kitchen window and saw Resident #62 walking around placing clothing protectors on other residents. Resident #48 was seated at the back table. When Resident #62 attempted to place a clothing protector on Resident #48, Resident #48 punched Resident #62, who punched him back, leading to a tussle. Dietary Aide #4 stated she told other kitchen staff the residents were fighting and then saw Resident #48 fall from his wheelchair to the floor. She immediately sought help from a nurse and Certified Nursing Assistant (CNA). She stated that residents were temporarily prohibited from being in the dining room without staff for about a week after the incident, but that policy was not maintained because residents would often gather unsupervised in the hallways instead.

During a phone interview on 01/08/2025 at 05:40 PM, RN #5 stated she did not witness the incident between Resident #48 and Resident #62. She explained that Dietary Aide #4 informed her about the altercation. While walking down the hall, she

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encountered RN #4, who was with Resident #62. RN #4 informed her that Resident #62 had been fighting with another resident. RN #5 then escorted Resident #62 to his room and completed a body audit. She observed scratches on Resident #62's neck and face, noting that the scratches were superficial and required only first aid. RN #5 stated she completed the incident report for Resident #62, while RN #3 completed the incident report for Resident #48. She also confirmed she notified the Administrator and Director of Nursing (DON) about the incident.

During a interview on 01/09/2025 at 03:50 PM, the Administrator stated that on the night of the incident, she was notified, and the Registered Nurses (RNs) completed the incident reports. She used the incident reports and statements from RN #4 and Dietary Aide #4 to complete her final report. She explained that she does not know if any other residents were present in the dining room at the time of the incident, except for Resident #26, whose interview was included in one of the incident reports. She acknowledged there were no staff in the dining room at the time of the altercation, as they were busy assisting other residents to the dining room. She confirmed interventions implemented included informing Resident #62 that he could no longer distribute clothing protectors and instructing staff not to allow him to pass out the clothing protectors.

A record review of progress notes dated 6/3/2024 at 5:45 PM revealed that Resident #48 and Resident #62 had a prior altercation. The progress notes stated, "This writer was walking the hallway and noticed a wheelchair flipped up in the room. Upon entering the room, the resident was noted sitting in his wheelchair, and another

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male resident was on the floor underneath Resident #48's wheelchair. Both residents were exchanging punches and holding each other's shirts." When asked how the altercation occurred, Resident #48 stated, "He came in my room, and I asked him to get out and he wouldn't and got smart with me." When asked, "Who struck who first?" Resident #48 admitted to striking the other resident first. Both residents were separated by this writer and two other staff members and assessed for injuries. Upon assessment, Resident #48 was noted to have two small scratches on his left cheek. The areas were cleaned and left open to air. The family, physician, Director of Nursing (DON), and Administrator were notified of the incident.

A record review of the "Admission Record" revealed the facility admitted Resident #48 on 05/07/20 with the diagnoses including Hemiplegia And Hemiparesis Following Cerebral Infarction.

A record review of the Quarterly MDS with an ARD of 10/09/24 revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.

A record review of Resident's "Physical Aggression Initiated" report dated 11/02/24 prepared by RN #3 revealed " ... I did not witness event. I was told by resident 48 and resident #62, that Resident #62 put on the clothing protector. Resident #62 put it on Resident #48 took it off then resident #48 hit Resident #62 in the gut, Resident #62 returned hit to Resident #48 in the torso ... Nursing supervisor notified by RN #5. Residents were separated ... no injuries observed at time of incident ... No statements found ..."

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A record review of the "Admission Record" revealed the facility admitted Resident #62 on 01/26/22 with the diagnoses including Unspecified Dementia.

A record review of the Quarterly MDS with an ARD of 12/11/24 revealed Resident #62 had a BIMS score of 7 which indicated he was severely cognitively impaired.

A record review of Resident's "Physical Aggression Initiated" report dated 11/02/24 prepared by RN #3 revealed " ... I did not witness event. I was told by resident #48 and Resident #26, that Resident #62 put bib on Resident #48 took it off then Resident #48 hit Resident #62 in the gut, Resident #62 returned hit to Resident #48 torso ... Nursing supervisor notified by RN #5, residents were separated ... no injuries observed at time of incident ... No statements found ..."

Resident #41 and Resident #78 Altercation

On 1/7/2025 at 5:15 PM, during an observation, several residents were standing in the hallway near the main dining room without staff supervision. Residents were overheard using profanity, and Resident #78 was observed hitting Resident #41 with her walker, knocking her to the floor. Staff intervened and separated the residents.

A record review of the facility's incident reports dated 1/7/2025 revealed Resident #41 sustained a hematoma to the back of her head and was sent to the emergency room for evaluation. Resident #78 denied hitting Resident #41 with her

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F 600	Continued From page 7 walker and reported no injuries. A record review of the "Admission Record" revealed the facility admitted Resident #41 on 3/21/2023 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of the Quarterly Minimum Data Set (MDS) with an assessment Reference Date (ARD) of 11/20/2024 revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of three (3), indicating severe cognitive impairment. A record review of the "Admission Record" revealed the facility admitted Resident #78 on 3/22/2023 with diagnoses including Dementia. A record review of the Quarterly MDS with an ARD of 10/24/2024 revealed Resident #78 had a BIMS score of seven (7), indicating severe cognitive impairment.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		2/13/25

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F 607	Continued From page 8 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review the facility failed to implement their policy related to abuse, as evidenced by not reporting an allegation of abuse by Resident #54 in a timely manner and allowing an accused staff member to work during the investigation process and not completing a thorough investigation regarding an altercation between Resident#48 and Resident #62 for three (3) of 20 sampled residents. Findings include: A record review of the facility's policy "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation" with reviewed date 10/2022 revealed, " ... All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current	F 607	The facility failed to implement policies and procedures related to residents #54, #62 and #48. The Director of Nursing interviewed resident #54 on 01/07/25 to follow up on the allegation of abuse. Residents #62 and #48 were interviewed by the Social Service Director on 01/10/25 concerning the incident on 11/2/24. Both residents reported no adverse effects. The Administrator and Director of Nursing were educated by the Regional Director of Operations on 1/10/25 on facility policies and procedures of reporting abuse allegations in a timely manner and allowing an accused staff member to work during an investigation. 01/10/25, the administrator was also educated on the use of a check off tool to ensure all information is gathered at time of investigation.	

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F 607	Continued From page 9 regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported ... Reporting Allegations to the Administrator and Authorities ... 3. "Immediately" is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury ... Investigating Allegations 1. All allegations are thoroughly investigated. The administrator initiates investigations ... 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. 7. The individual conducting the investigation as a minimum: c. observed the alleged victim, including his or her interaction with staff and other residents; ... e. interviews any witnesses to the incident; ... h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; ... j. interviews other residents to whom the accused employee provides care or services, k. reviews all events leading up to the alleged incident, and l. documents the investigation completely and thoroughly. 8. The following guidelines are used when conducting interviews: ... d. Witness statements are obtained in writing, signed, and dated. The witness may write his/her statement, or the investigator may obtain a statement ... Follow -Up Report 1. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report. 2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegations were verified ... Corrective Actions ... 3. Any allegations of abuse are filed in the accused employee's personnel record along	F 607	All residents have the potential to be affected. All staff were educated beginning 01/10/25 and ending 01/31/25 on abuse, neglect, and exploitation policy by the Director of Nursing and Nursing Administration staff. The Social Service Director conducted a person-centered in-service on resident #62 for all staff. The Quality Assurance Performance Improvement (QAPI) team met on 01/10/25 and discussed policies and procedures on abuse, neglect and exploitation and reporting abuse, neglect and exploitation with no revisions needed at this time. Any allegations of abuse will be reported within 2 hours of receiving the report. Any accused of abuse will not be allowed to work during an investigation. Regional Director of Operations, Director of Nursing and Administrator will use a weekly monitoring tool to ensure all allegations of abuse are reported in a timely manner and to ensure the abuse, neglect, and exploitation policy is followed by not allowing an employee to work while being investigated and that all statements of all witnesses are collected during the investigation starting 01/10/2025 and ending 03/01/2025. All findings will be reported to the QAPI Team monthly beginning 02/13/25 and ending 03/31/25 for review and recommendations.	

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with any statement by the employee disputing the allegation, if the employee chooses to make one ..."

Resident #48 and Resident #62 Altercation

Record review of the facility's investigation dated 11/2/24 revealed Resident #62 and Resident #48 were involved in an altercation in the dining room. Resident #62, who was assisting with handing out clothing protectors, was punched by Resident #48 when he attempted to place a clothing protector on him. In response, Resident #62 hit Resident #48 back, and both residents fell to the floor. A dietary aide witnessed the incident, reported it to the nurse's station, and both residents were separated. Resident #62 sustained scratches to his face and neck, while Resident #48 had no noted injuries. The physician, Director of Nursing (DON), and Administrator were notified. Interventions included instructing staff to prevent Resident #62 from distributing clothing protectors in the dining room and referring Resident #48 to the in-house psychiatric Nurse Practitioner.

On 01/07/25 at 02:00 PM, during an interview with the Administrator when she presented the final report of the Facility Reported Incident (FRI), she explained that is the final report that she submitted to the Attorney General Office (AGO) and to the State Agency (SA). She confirmed the report consisted of her final typed report and the two (2) statements obtained regarding the incident. She confirmed there were no other statements or interviews obtained from any other witnesses, to include who separated the residents and any other residents who may have witnessed the altercation. She confirmed body audits and incident reports were completed for both

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residents via the residents' nurses. She confirmed no other staff or residents were interviewed regarding the altercation except the ones mentioned in the report, that included Resident #26, Dietary Aide #4, and RN #4. She stated that she felt she completed the investigation.

A record review of the "Admission Record" revealed Resident #48 was admitted by the facility on 05/07/20 with the diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/09/24 revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.

A record review of the "Admission Record" revealed Resident #62 was admitted by the facility 1/26/22 with diagnoses including Unspecified Dementia.

A record review of the Quarterly MDS with an ARD of 12/11/24 revealed Resident #62 had a BIMS score of 7 which indicated severely cognitively impaired.

Resident #54 Allegation of Abuse

On 01/06/25 at 02:20 PM, during an interview with Resident #54, she reported on Friday around 2 PM she had a Certified Nurse Aide (CNA) tell her that she wasn't going to put her back to bed and she would have to wait on the next shift to put her back to bed. She went to the nurse's station and complained about wanting to go to

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bed. The CNA did come back and put her to bed but while doing so the CNA whirled her around fast and made her cry. She stated she had not reported this to the Director of Nursing (DON) or the Administrator yet. She was so upset on Friday she could not tell anyone. The resident's roommate (unsampled resident #1) reported she heard the CNA on Friday tell Resident #54 she had to wait for the next shift.

On 01/06/25 at 02:53 PM, during an interview in Resident #54's room with the DON and Administrator, she explained to both the incident that occurred on Friday in which the CNA told her that she was not going to put her back to bed and she would have to wait on next shift and about her quickly turning her around in her wheelchair. Both the DON and Administrator confirmed that they did not know anything about the issue and assured the resident to report any concerns to them right away. The DON and Administrator reported they will start their investigation regarding Resident #54's complaint.

On 01/07/25 at 02:05 PM, during an interview with the Administrator, she stated she did not report the allegation to anyone because she did not feel it was abuse or neglect due to the CNA did put resident to bed before she left work on Friday and there were no problems. She reported she was not aware of the requirements to report any allegations of abuse if it was just allegations. She thought it had to be reported if the abuse was substantiated, and the abuse was not substantiated at this time, but the investigation continues.

On 01/07/25 at 03:00 PM, during an interview with the DON, she confirmed she obtained the

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statements from both CNAs and the CNAs denied the allegations. She reported since Resident #54 was put to bed on Friday and changed, there was no need to suspend the CNA from working. A review of the facility's policy Abuse-Investigation was reviewed with the DON, she confirmed the policy indicates that allegations of abuse should be reported within two hours of an allegation involving abuse and that any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. The DON reported she is still doing more interviews and investigations regarding the allegations and the final report is not completed.

On 01/08/25 at 10:30 AM, during an interview with CNA #4, she denied any abuse toward the resident, but confirmed she has been working this current week since 1/6/2025 at the facility on day shift.

On 01/09/25 at 04:00 PM, during an interview with the Administrator and the DON, they both confirmed the investigation regarding Resident #54 is almost complete and the facility has five (5) days to send the final report. A review of the facility's policy with the Administrator and the DON, they both confirmed the facility policy explained any witnesses of the allegations should be interviewed and/or a statement given. The policy revealed the accused worker should be suspended while the investigation continues and should not have any resident care. Both confirmed the CNA continued to work and the allegation of abuse was not reported within two (2) hours. The Administrator reported she thought since the CNAs denied the allegations, there was no need to suspend or to report within two (2)

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F 607	Continued From page 14 hours because there was no abuse. A record review of the facility's assignment logs for days 01/03/25, 01/06/25, 01/07/25, and 01/08/25 confirmed CNA #4 worked and had resident assignments. A record review of the "Admission Record" revealed Resident #54 was admitted by the facility on 8/03/24 with current diagnoses including Cerebral Palsy. A record review of the Quarterly MDS with an ARD of 11/13/24 revealed Resident #54 had a BIMS score of 14, which indicted she was cognitively intact.	F 607		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and the facility policy review the facility failed to provide adequate supervision to prevent resident-on-resident altercations between Resident #62 and Resident #48 and between Resident #41 and Resident #78 for four (4) of 22 sampled residents. Findings included:	F 689	The facility failed to protect residents #62, #48, #78 and #41 from accidents and hazards. Residents #62 and #48 were interviewed by the Social Service Director concerning the incident that occurred on 11/2/24 on 01/10/25. No adverse effects were noted. There have been no further issues between resident # 62 and #48 since 11/2/24.	2/13/25

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F 689	Continued From page 15 Resident #48 and Resident #62 Record review of the facility's investigation dated 11/2/24 revealed Resident #62 and Resident #48 were involved in an altercation in the dining room. Resident #62, who was assisting with handing out clothing protectors, was punched by Resident #48 when he attempted to place a clothing protector on him. In response, Resident #62 hit Resident #48 back, and both residents fell to the floor. A dietary aide witnessed the incident, reported it to Registered Nurse (RN) #4 and both residents were separated. Resident #62 sustained scratches to his face and neck, while Resident #48 had no noted injuries. The physician, Director of Nursing (DON), and Administrator were notified. Interventions included instructing staff to prevent Resident #62 from distributing clothing protectors in the dining room and referring Resident #48 to the in-house psychiatric Nurse Practitioner. On 01/06/2025 at 11:51 AM, during an observation in the dining room, Resident #26 was placing clothing protectors on other residents without staff present. On 01/07/2025 at 02:20 PM, during an interview, Resident #26 confirmed he witnessed the altercation between Residents #62 and #48. He stated that no staff were present in the dining room at the time and that it was common for the dining room to be unsupervised. On 01/08/2025 at 12:15 PM, during an interview, Dietary Aide #4 stated she observed the altercation between Residents #62 and #48 on 11/2/24 from the kitchen window and sought help	F 689	All residents have the potential to be affected. All staff were educated beginning 01/10/25 and ending 0/31/2025 on abuse, neglect and exploitation and accidents and incidents-investigating and reporting policies the Director of Nursing and Nursing Administration staff. The Social Service Director conducted a person-centered in-service on resident # 62 for all staff. The dining area which leads to the smoking area was opened to residents to wait for smoke break so they can spread out more. Staff were informed that residents, when grouping together before smoke break or during mealtimes, must be supervised in the main dining room. On 01/10/25, the dining room will only be open for activities, mealtimes and when waiting to smoke. The administrator met with the smokers on 01/13/25 and explained that the area to wait for smoke break will not be opened until 20 minutes prior to scheduled smoke time. Residents were asked to please not come down an hour before smoke breaks. Residents #78 and #41 were interviewed by the Social Service Director concerning the incident on 01/07/25. Both residents have no adverse effects. The administrator met with Resident Council on 01/28/25 concerning supervision in the main dining area for mealtimes, activities, and waiting for smoke break. Residents were told the main dining room will be closed except for mealtimes, activities, and 20 minutes prior to smoke break.	

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F 689	Continued From page 16 from a nurse and Certified Nursing Assistant (CNA). She confirmed there were no staff in the dining room at the time. Dietary Aide #4 added that after the incident, residents were temporarily prohibited from being in the dining room without staff, but this restriction was not maintained. A record review of the "Admission Record" revealed Resident #62 was admitted by the facility on 01/26/2022 with diagnoses including Unspecified Dementia and Psychotic Disorder. A record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/11/2024 revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of seven (7), indicating severe cognitive impairment. A record review of the "Admission Record" revealed Resident #48 was admitted by the facility on 05/07/2020 with diagnoses including Hemiplegia and Aphasia. A record review of the MDS with an ARD of 10/09/2024 revealed a BIMS score of 15, indicating the resident was cognitively intact. Resident #41 and Resident #78 On 01/07/2025 at 03:00 PM, during an observation there was an altercation between Resident #78 and Resident #41 near the exit door for smoking, which is near the dining room. No staff were present at the time of the incident. Record review of the facility's, "Incident Report", dated 01/07/25 revealed Resident #41 was walking in the hallway next to the kitchen when another resident called this resident a (expletive)	F 689	The Quality Assurance Performance Improvement (QAPI) team met on 01/10/25 and discussed policies and procedures on abuse, neglect and exploitation and accidents and incidents □investigating and reporting with no revisions needed at this time. All incidents and accidents will be monitored 5 times a week in our morning clinical meetings starting 01/13/2025 and ending 02/28/25 to ensure proper investigating and reporting and to ensure interventions are in place. All findings will be reported to the QAPI team of all accidents and incidents starting 02/13/25 and ending 03/31/25.	

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this resident then called the other resident a (expletive) and then proceeded to slap the other resident in the face. Both residents began pushing each other when the Resident #78 pushed Resident #41 with her wheelchair, knocking Resident #41 to the floor where she hit the back of her head. The staff immediately intervened and assessed the resident for injury. Resident #41 noted to have quarter sized hematoma to the back of her head. Charge nurse took Resident #41's vital signs, and the Medical Director and family was notified the resident was sent to the local emergency room for an evaluation.

A record review of Resident #41's "Admission Record" revealed the resident was admitted on 03/21/2023 with diagnoses including Chronic Obstructive Pulmonary Disease and Major Depressive Disorder.

A record review of Resident #41's MDS dated 11/20/2024 revealed a BIMS score of (3), indicating severe cognitive impairment.

A record review of Resident #78's "Admission Record" revealed the resident was admitted on 03/22/2023 with a diagnosis of Unspecified Dementia.

A record review of Resident #78's MDS dated 10/20/2024 revealed a BIMS score of seven (7), indicating severe cognitive impairment.