STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING ______ B. WING ______	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CHAMBERLAIN CARE CENTER	**300 S BYRON BLVD CHAMBERLAIN, SD 57325**

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F 000	INITIAL COMMENTS A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/7/25 through 1/9/25. Areas surveyed included quality of care/treatment, nursing services to include abuse/neglect, resident safety, administration, and staff training. Sanford Chamberlain Care Center was found not in compliance with the following requirements: F600. IMMEDIATE JEOPARDY NOTICE Notice of immediate jeopardy was given verbally and in writing on 1/8/25 at 4:57 p.m. to licensed social worker (LSW) A, executive assistant D, and director of finance M for F600: *The provider failed to have an immediate plan of action in place and implemented following an incident that occurred on 1/2/25. *When resident 1 had become physically aggressive with staff and had struck resident 2 in the face during that occurrence. *His behaviors are impulsive, unpredictable, and have the potential to cause harm to both the residents and staff. *Through interviews, document review, and video review, it was identified that there was no plan or education presented to the staff on how to address their ongoing concerns about how to assist the resident during those episodes to ensure the safety of the residents and staff had occurred. *A plan for the removal of the immediacy was requested at that time. The immediate jeopardy was removed on 1/9/25 at 4:43 p.m. after the survey team verified the provider had implemented their removal plan	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Erica Peterson
TITLE: Administrator/CEO
(X6) DATE: 1/30/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 through document review and staff interviews. The current resident census was 44.	F 000		
F 600 SS=J	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; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) 1/2/25 facility-reported incident (FRI), observation, interview, record review, and policy review, the provider failed to: *Ensure there was a plan of action implemented following an incident where one of one sampled resident (1) had become physically aggressive with staff and had struck another resident (2) in the face during the interaction. *Ensure one of one sampled resident (1) who had cognitive impairment was free from psychological and physical abuse by three of three certified nursing assistants (CNA) (G, K, and L) during an episode of the resident having had increased agitation and aggression.	F 600	1. Corrective action to residents affected: On 1/8/2025 1309 a message was sent to the resident's psychiatric provider with updates on behaviors. Verbal orders were received by a nurse on 1-9-2025 from psych provider. Stated to discontinue hydroxyzine and to use PRN Seroquel. He is also scheduled with the psychiatric provider for a revisit on 1-13-25. PRN pain medication Tylenol has been scheduled instead of PRN and labs CBC and CMP were ordered by PCP. 2. Identify other potential Residents affected: All residents could be impacted if the follow measures are not taken: 1. Ensuring staff are properly trained in abuse neglect reporting 2. Ensuring staff are properly trained and competent with dementia care skills 3. Ensure that staff are educated and appropriately using 1:1 resident monitoring 3. Measures put into place or systemic changes made to ensure that will not recur: On 1/27/25, Abuse and Neglect, LTC & Swing bed Chamberlain policy reviewed by Administrator, DON, LSW & IDT. Policy also sent to Medical Director on 1/27/25 to review. All licensed and unlicensed staff to be educated on their roles and responsibilities to maintain residents' basic rights to be free of abuse from staff, other residents, or visitors. Education also completed with unlicensed and licensed staff on requirements of mandatory reporting. Education by DON or designee started on 1/27/25 and will be completed by 2/8/25. Education on how to find care plans was sent to all staff via email, put on each kiosk, and by the nurse's station computers on 1/9/25 by DON or designee. One to one education by DON or designee with each staff on how to find care plans will be completed by 2/8/25 to include sign off on education received. Care plan updates will be added to the 7-day sheet which is communicated in the report to nurses and CNAs. Standard Operating Procedure (SOP) developed by DON on 1/9/25 for One to One monitoring. The SOP specifically states that staff doing 1:1 observation are only to be doing 1:1 duties with that resident. Daily schedule needs sheet now reflects a specific 1:1 shift for residents with that	2/8/25

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*Ensure extended education and training on how to take care of residents with dementia and psychosocial behaviors for all staff had occurred to help them assist one of one sampled resident (1) during episodes of increased agitation and aggression.
*Ensure all direct care-givers had knowledge of how to access and review updated care plan changes for the residents.
Findings include:

1. IMMEDIATE JEOPARDY NOTICE
Notice of immediate jeopardy was given verbally and in writing on 1/8/25 at 4:57 p.m. to licensed social worker (LSW) A, executive assistant D, and director of finance M for F600:
*The provider failed to have an immediate plan of action in place and implemented following an incident that occurred on 1/2/25. *When resident 1 had become physically aggressive with staff and had struck resident 2 in the face during that occurrence.
*His behaviors are impulsive, unpredictable, and have the potential to cause harm to both the residents and staff.
*Through interviews, document review, and video review, it was identified that there was no plan or education presented to the staff on how to address their ongoing concerns about how to assist the resident during those episodes to ensure the safety of the residents and staff had occurred.
*A plan for the removal of the immediacy was requested at that time.

IMMEDIATE JEOPARDY REMOVAL PLAN
On 1/9/25 at 4:43 p.m. the provider gave the following acceptable immediate jeopardy removal plan:

F 600 (Plan of Correction)

need. One to one education about the resident on 1:1 SOP by DON or designee with each staff was started on 1/13/2025. All staff will be educated by 2/8/2025 or at the start of their next scheduled shift. Residents whole care plan was reviewed to ensure appropriate for resident and if any updates needed to be established. Care plan was updated with ways to approach resident from the front instead of the side or from behind do to diagnosis of dementia. Care plan review and update completed 1/9/25. Resident is care planned one to one. One to one is provided as definition of one to one is 1 person assigned to resident that focuses on 1 person's needs, abilities, strengths, and interests during staff to resident one to one situation while awake. Ensure ALL direct care staff have the resources necessary to provide individualized resident care to include access to care plans and necessary staffing when 1-1 care is assigned.

1/8/25 starting at 0645pm in person dementia training on Lewy Body Dementia "What Everyone Needs to Know" was given to staff from day shift and for the overnight. Teepa Snow Dementia certified trainer does the training with supporting videos and role playing. Training resumed in the morning at 630-830, 12-2, 3:30-5:30 and continued with all staff educated in their next scheduled shift. Staff will sign in on designated sign in sheet to indicate completion. Additional mandatory in-person dementia training with the Ombudsman began 1/28/25, will be offered again on 2/13/25 and 3/19/25 with additional dates as the Ombudsman returns, this training is tracked via sign in and all staff will complete the Ombudsman training by 5/31/25, to allow for prn staff to receive the training.

4. Monitor process for the system change including frequency and person responsible: DON or designee will review all SafetyZone reports to ensure mandatory reporting requirements are followed weekly x 4 weeks, then 5/month x 6 months. Results will be reported to the monthly QAPI meeting x 6 months or until the committee deems necessary. Cameras will be monitored especially on nights and weekends. Random 1-hour snips will be viewed and monitored ensuring proper mandatory reporting 5x/week for 1 month then 3x/week for 6 months by DOO or designee. Results will be reported to

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F 600	Continued From page 3 *"On 1/8/2025 1309 [1:09 p.m.] a message was sent to residents' psychiatric provider with updates on behaviors. Verbal orders were received by a nurse 1-9-2025 from Psych Provider stated to discontinue Hydroxyzine [allergy and anxiety medication] and to use the PRN [as needed] Seroquel [antipsychotic]. He is also scheduled with the Psychiatric provider for a revisit on 1/13/25. PRN pain medication Tylenol has been scheduled instead of PRN, and Labs CBC, and CMP are ordered by PCP. *"1/8/2025 starting at 0645 pm [6:45 p.m.] In person Dementia training Lewy Body Dementia "What Everyone Needs to Know" was given to staff from day shift and for the overnight. [Name] Administrative Assistant who is Teepa Snow Dementia certified. Training will resume in the morning at 0630-830 [6:30 a.m. - 8:00 a.m.], 12-2 [12:00 noon - 2:00 p.m.], and 3:30-5:30 [3:30 p.m. - 5:30 p.m.] and will continue until all staff are educated before their next scheduled shift. Monitoring of efficacy will be done by scenario role playing drills of all staff by picking random 5 people per week for 1 month and 5 random people a month for 6 months will be documented. *"1/9/2025 education on how to find care plans was sent to all staff via email and put on each kiosk, and by the nurse's station computers. Will do one to one education with each staff and they will sign they have received the education. Care plan updates will be added to the 7-day sheet which is communicated in the report to nurses and CNA. MDS [Minimum Data Set] or designee will monitor care plan documentation to the seven-day sheet for updates only from the care plans that were updated weekly for 3 months. *"1-8-2025 Residents whole care plan was reviewed to ensure appropriate for resident and if any updates needed to be established. Care plan	F 600	the monthly QAPI meeting x 6 months or until committee deems necessary. MDS or designee will monitor care plan documentation to the seven-day sheet for updates only from the care plans that were updated weekly x 3 months then monthly x 6 months. Results will be reported to the monthly QAPI meeting x 6 months or until committee deems necessary. DON or designee will audit appropriate One to One provided and engaging resident in their care plan daily x 4 weeks, then weekly x 3 months. Results will be reported to the monthly QAPI meeting x 6 months or until committee deems necessary. Training on mandatory in person Lewy Body training "What Everyone Needs to Know." has been completed by all staff that have worked a shift. Mandatory in person Ombudsman training is ongoing. Monitoring of efficacy will be done by the DON or designee with scenario role playing drills of all staff by picking a random 5 people per week for 1 month and 5 random people a month for 6 months. Results will be reported to the monthly QAPI meeting x 6 months or until the committee deems necessary	

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was updated with ways to approach resident from the front instead of the side or from behind do [due] to diagnosis of dementia. Resident is care planned one to one. One to one is provided as definition of one to one is 1 person assigned to resident that focuses on 1 person needs, abilities, strengths, and interests during staff to resident one to one situation while awake."
*"Cameras will be monitored especially on nights and weekends random 1-hour snips will be viewed 5 times per week for 1 month 3 times a week for 6 months and will be reviewed at that time for further discussion.
*"To ensure the safety of all the residents who are likely to suffer or have suffered serious adverse outcomes we are doing current medication review for the resident. We have been in contact with his Psychiatric provider in person. Education for staff including training on dementia before working next shift and setting up quarterly training through the state's ombudsman program."

The immediate jeopardy was removed on 1/9/25 at 4:43 p.m. after the survey team verified the provider had implemented their removal plan through document review and staff interviews. After the removal of the immediate jeopardy, the scope and severity of the citation level was an H. Current census was 44.

2. Review of the provider's 1/2/25 submitted SD DOH FRI regarding resident 1's interaction with resident 2 revealed:
*His Brief Interview for Mental Status (BIMS) assessment score was zero which indicated he was severely cognitively impaired.
*"[Resident 1's name] was laying on the floor next to the window, CNA attempted to assist resident off the floor, [the resident] attempted to go after

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another CNA chasing her, swung his arms as he was running and hit another resident in the face [and] made contact with her right cheek."
*Investigation Conclusion:
-"Investigation started. Separated the resident and staff tried to get [resident 1's name] out of dining room. LSW [licensed social worker] came in and assisted to get his [him] calmed down and then got him ready for bed. Staff stated [resident 1's name] got upset and threw up his arms and hit [resident 2's name]."
-"Called and updated [resident 1's name] PCP [primary care provider] and will update his psych [psychiatry] provider tomorrow. Plans going forward will continue to monitor [resident 1's name] and will wait and see if his providers make any changes."
-"The facility has reached out to HSC [Human Service Center] and [behavioral health provider's name] through November and December and have been told his [he] [resident 1] doesn't need an inpatient stay."
*No documentation that indicated how the staff should have monitored and assisted resident 1:
-To ensure the safety of the other residents and staff during episodes of increased agitation .
-Until they received further direction from his providers.
-To help decrease his agitation and aggressive behaviors.
-No documentation that indicated if resident 2 had been assessed for injury after being struck in the face by resident 1.

3. Observation on 1/7/25 at 12:50 p.m. of resident 2 in the dining room revealed:
*She had been sitting at the dining room table visiting with another resident.
*She was pleasantly confused and answered

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F 600	Continued From page 6 simple questions. *They had just finished lunch and the dirty dishes remained on the table. *She repeatedly made gestures towards the dirty dishes and had commented several times that we needed to pick them up. *No visible injury had been observed to her face. Observation on 1/7/25 at 1:10 p.m. of resident 1 in his room revealed: *He was attempting to get out of his bed. *His legs were hanging over the edge of the mattress and he was waving his left arm while yelling "hey, hey." *LSW A went into his room and assisted him with getting out of bed. 4. Interview on 1/7/25 at 1:15 p.m. with CNA N revealed: *All of her dementia and abuse training had been online. *She was not aware of any additional dementia training outside of those online course. Interview on 1/7/25 at 1:20 p.m. with resident 5 in her revealed: *Her room was located across the hall from resident 1's room. *She would have left her room once a day to exercise per her preference. *She had: -Changed the time of day that she exercised to avoid resident 1. -Not felt safe from resident 1 and could hear interactions he had with staff and other residents. *She stated: -"He goes into other people's rooms." -"He tried to come into my room once but an aide stopped him."	F 600	MDS or	

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-"We can't lock our doors to keep him out."
-"I've never seen it, but I know he hits the aides because I hear everything that's going on out there."
-"About four days ago they gave him a bath and he was fighting, yelling, and screaming the entire time."
-"He has a bad mouth and says the "F" word all the time and I find it very offensive."
-"I don't want to be around him either."

Interview on 1/7/25 at 1:50 p.m. and again on 1/8/25 at 11:00 a.m. with CNA E revealed:
*She was a traveling CNA and had been working at the facility for approximately two months.
*Her dementia and abuse training had been through the mandatory online courses.
-She had completed those upon hire at the facility.
-There had not been additional training on dementia care outside of those online courses.
*She had worked with resident 1 frequently and he had required a lot of staff to take care of him when he was agitated.
*She stated:
-"Nothing will trigger him and he will just start throwing stuff, like chairs, anything in front of him."
-"He pushes and hits at the staff."
-"He'll start fighting with you when you try to take care of him. Sometimes it takes three of us to work with him."
-"He's hit other residents too."
-"It's happens almost daily."
-"He only likes the office staff."
-"The office staff take him to their office sometimes when he is awake."
-"When they're not here we just have to deal with it."

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F 600	Continued From page 8 -"Yeah, it's scary because I don't want to get hit." -"I just get the nurse or someone who knows him when he acts like that." *He had required one to one (one staff assigned to one resident) monitoring when he was awake. *The CNAs were assigned to him and when he was awake someone had to stop helping on the floor and stay with him. -No additional staff were scheduled to work with him. *She stated: -"When there are just two CNAs, one of us stops helping on the floor and work just with him." -"If the other CNA needs help with a transfer the med [medication] aide had to help or the nurse if she could." -"The med aide was supposed to stop what she was doing and help." *She confirmed that unit where resident 1 resides had nine residents who required two staff to assist with a transfer. *There had been times when resident 1 was calm and she would have left him to assist with other residents. *She stated: "Usually I was not far [away] and was in the area where he was." *She confirmed: -His behaviors had been unpredictable, quick, and aggressive. -Those behaviors had placed the other residents at risk for being struck by him when staff were not sitting with him. *She stated "When he's awake, he's the priority over the others." *She had been working on 1/2/25 when he had an aggressive outburst with the staff and struck resident 2. -He was awake and had required a one to one to follow him around.	F 600		

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F 600	Continued From page 9 -The incident happened in the dining room and he had been sitting on the floor. -After the staff tried to help get him up off the floor he turned around and started running after CNA K. She had been assigned to be his one to one. -His arms were waving around and he had punched resident 2 in the cheek. She had been sitting at the dining room table. -The hit had left a red mark on resident 2's cheek. -The police had been called and came to the facility. *Resident 2: -Was confused and had forgotten the incident shortly after it had occurred. -Her husband had recently passed away and she would wander around the two wings looking for him. *Since that incident: -There had been no additional training and education on how to take care of resident 1 or those residents with dementia and behaviors. -There had been an all-staff meeting in December but she had not attended it. To her knowledge those meetings were not mandatory. -The one to one monitoring had been in place prior to the 1/2/25 incident. *She: -Knew where the care plans were located in the electronic system but would not have checked it. -Was not aware if the care plan information was located in the electronic kiosk system where the CNAs charted on the residents. -Had relied upon the nurses and other staff to inform her of care changes for the residents. -Had not been instructed on what the policy and process for one to one monitoring was. -Had relied upon the other staff to tell her. Interview on 1/7/25 at 2:26 p.m. with CNA H	F 600		

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F 600	Continued From page 10 revealed: *She was a traveling CNA and was on her fourth contract with the facility. *She had been involved in two incidents with resident 1 where he had hit her. *Regarding the first incident: -She had her hands full of laundry, he came up from behind her, and without warning started hitting her in the head. -She had required medical treatment, had two knots on her head, and missed two days of work. -The travel staffing agency would not allow her to work with him after that incident. *Regarding the second incident she: -Had been on vacation for two weeks and was not informed he had moved to another wing. -Happened to be outside of the room where he had moved to, he came out of his room, and started to punch her in the face. -Had no interaction with him that shift prior to him coming out of his room and hitting her. -Stated: "I had no idea he was even down that wing. I was told to take a breather." *His behaviors had been impulsive, unpredictable, and quick. *He had attacked other residents during his episodes of increased agitation. *She stated: -"I heard he hit [resident 2's name] in the face, I think it was last week." -"Such a sweet lady, but very confused." -"She wanders down here [from the other wing] looking for her husband." -"The only dementia training we've had is the required course online." -"He's a one to one now. Someone has to be with him when he's awake." *There had not been any recent training on abuse, dementia care, or how to take care of	F 600	MDS or designee	

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F 600	Continued From page 11 residents with aggressive behaviors. Interview on 1/7/25 at 3:15 p.m. with CNA N revealed: *Regarding resident 1: -When he was calm he was a "peach." -He could chit-chat with you but he could not have a full conversation. -He was unpredictable and the staff could not tell what triggered his aggressive behaviors. -When he would become aggressive with residents and staff she would have called LSW A to help work with him. -She had been scared of him at times depending on the situation. -He would not have targeted anyone during one of his episodes unless someone was in his way at that time. -He was to have one to one monitoring while awake. -There was no extra staff scheduled to monitor him and the staff had been pulled from the floor to perform one to one monitoring of resident 1. *She stated: -"That leaves us one person short on the floor to help with transfers and answer lights." -"He is very unpredictable and quick, there is no plan for his outbursts." -"He hurt [resident 2's name] last week." -"He hit her on the cheek and it left a mark across it." *A dementia training had been offered a couple of months ago. -The training had been offered from 11:00 a.m. to 3:00 p.m. and was not mandatory. -Anyone working during that time, students, and the night shift staff would not have been able to participate in that training. -She was unsure if it had been recorded.	F 600	MDS	

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F 600 Continued From page 12 F 600

*She was not aware of a plan on how to take care of residents like resident 1.
*She was not aware of any mandatory or updated training and education after above incident between residents 1 and 2.

Interview on 1/7/25 at 3:45 p.m. with CNA G revealed:
*He had been a college student and only worked during holiday leave.
*He was required to catch-up on additional trainings and education prior to working.
*Regarding resident 1:
-He had worked frequently with the resident and was aware of his episodes of increased agitation and aggression.
-The resident was to have one to one monitoring by staff when awake.
-He was sporadic in allowing assistance with personal cares and toileting.
-At times it would take two or three CNAs to assist him.
-He had a history of biting, kicking, screaming, spitting, and hitting at staff when they had tried to calm him down or assist him with cares.
-He had increased behaviors almost daily. Those behaviors occurred mostly during the evening hours when the office staff had left for the day.
-No one was aware of what triggered his behaviors. Those behaviors were sporadic and hard to control.
-There had not been extra staff scheduled to take care of him when he was awake.
-A CNA would have been pulled off the floor to work with him during those times.
-That would have left them short staffed on the floor to assist other residents with transfers, cares, and to answer their call lights.
-LSW A would have been called to assist with

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watching him during the daytime hours.
-When he was awake he became a priority over the other residents.
*CNA G had been working on 1/2/25 when resident 1 had become upset and aggressive towards others.
-The resident had sat down on the floor and he attempted to help him get up.
-He had been told by the nurses to pick him up and not leave him on the floor.
-After staff had assisted resident 1 in getting up, he had taken off after resident 2 and hit her in the face.
-He ran to the refrigerator at the nurse's station and threw some yogurt on the floor.
-Staff had attempted to get him to sit down in his Broda chair [specialized positioning wheelchair].
*After the incident CNA G had been told he was not following resident 1's care plan and had been reprimanded.
-He was not aware that one of the resident's interventions was to let him lay on the floor when he had put himself there.
*He was not aware of where the care plans were or how to locate them.
*He stated:
-"I think they are in a book down the hallway."
-"I don't know, I just do what the nurses tell us to do."
*He had not received any extra training on residents with dementia and how to take care of them.
-The training he had completed was on the provider's online training site and had been required to be completed on a yearly basis.
*He was not aware of any updated training or plan on how to take care of resident 1.
*He was not aware of additional training on one to one monitoring or a policy for that.

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Interview on 1/8/25 at 8:30 a.m. with the interim Minimum Data Set (MDS) coordinator J revealed:
*She had been hired:
*She started a 13-week contract on 11/4/24 as the interim MDS coordinator until the full-time MDS coordinator returned.
*She had been working on 1/2/25 when resident 1 had become upset, aggressive, and hard to calm down.
-The incident happened just after dinner and during the nurse's shift report.
-He had sat down on the floor and the staff assisted him up off of the floor.
-He had bumped into another resident on his way out of the dining area.
-He went into the kitchen area and was assisted into a Broda chair.
-The police were called per the direction of the on-call staff.
-Being in the Broda chair calmed him down and he was calmer by the time the police arrived.
-He had not hit resident 2 but rather brushed up against her. She did not have a red mark on her face, it appeared to be an age spot.
-Resident 2 had been uninjured and did not remember the incident shortly after it occurred.
-There had been a video recording of the incident and she had watched it.
-After resident 1 was assisted off the floor he had "taken off" with his arms flying and brushed up against resident 2.
*She had provided verbal education to the staff at that time on resident 1's care plan interventions.
-He should have been left to lay on the floor per his wishes.
*She stated:
-"We talk about him all the time and we tell the staff what they should do."

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F 600	Continued From page 15 -"He is a priority, we talk about him daily." -"Those staff should tell the other staff." *There was no documentation that indicated she had provided that verbal education. *There was a clipboard at the nurse's station that contained updated resident care plan information. -Sometimes those updates were given verbally to the direct care staff. -She agreed if it had not been documented there was nothing to support that education had been provided. -She would have expected those staff to inform the other staff of any care plan changes/updates. *She stated: "Everyone knows to use it [regarding the clipboard at the nurse's station] they use it every day." *Resident 1 was on a one to one monitoring plan and staff were assigned to take care of him on the daily sheet at the nurse's station. -The staff had been pulled off the floor to work with the resident when he was awake. -The nurse and med aide had been expected to assist with transferring and answering other residents' call lights during that time. -During the daytime hours, resident 1 spent a lot of his time with the office staff to help assist with the one to one monitoring. -Those office staff had not been there on weekends or after daytime hours to have assisted with resident 1. *She was not aware of any additional training, education, or updates regarding resident 1's episode on 1/2/25. *She stated: -"There is extra hands-on training for dementia care in the works." -"In the meantime we are trying to keep him a one to one." -"No, the one to one is not a new change for him."	F 600		

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F 600	Continued From page 16 *She agreed the staff should have had hands-on dementia care training sooner. Interview on 1/8/25 at 9:56 a.m. with licensed practical nurse (LPN) F revealed: *She had been working the evening of 1/2/25 when resident 1 had an outburst. -He had been agitated prior to her leaving the area for the nurse's change of shift report. -She had walked with him until he had calmed down prior to that meeting. -A CNA came and got her out of the report room to help with resident 1. -Resident 1 had sat on the floor and the staff had attempted to assist him with standing. -He became upset and ran after CNA K and in the process had hit resident 2 in the face. -He was uncontrollable and was in the kitchen area going through the refrigerator. -The staff helped him to sit down in his Broda chair. -Most of the time the Broda chair was a comfort for him. -She called the on-call administrator and was instructed to call the police. -She checked resident 2's right cheek and it had a large reddened area and measured it. It was not raised or hurtful to the resident. *The CNA assigned as resident 1's one to one that evening was fearful of him and had been involved in other episodes of his agitated and uncontrolled aggressive behaviors. *Resident 1: -Had frequent, almost daily outbursts of uncontrollable and aggressive behaviors. -During those episodes he had been hard to calm down and would start hitting, scratching, biting, and kicking at staff. -There had been times when LPN F had walked	F 600		

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F 600	Continued From page 17 with him during those episodes and he hit and scratched at her. -She had received bruises from his hitting. -She had not filled out an incident report on all of those resident-to-staff occurrences because she thought nothing would have changed with his plan. -His behaviors were unpredictable because they were sporadic, quick, and it was hard for staff to tell what would have triggered an onset of increased aggression. -Most of the staff had been scared of him because of his aggressive behaviors. -During the daytime hours through the week days he spent most of the time in LSW A's office. She thought the LSW had a good relationship with the resident. *He had been placed on one to one monitoring after the last complaint survey on 10/31/24. -The direct caregivers working the floor had all been assigned to do that task. -Whoever was available would take over the one to one task with him when he was awake. *No extra staff had been scheduled to provide his one to one monitoring only the already scheduled staff. -At times this would have left them short staffed on the floor to assist the other residents with transfers, cares, and answering resident call lights. -The nurses and med aides had been expected to assist him or the other residents during those times. *She had been told he was a priority when he was awake. *She helped the staff on the floor and with his one to one as much as she could. -She had other tasks that she was responsible for and had to finish herself.	F 600		

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F 600	Continued From page 18 *She confirmed: -Nine out of the twenty-two residents that lived on the same wing as resident 1 had required two staff for assistance with transfers. -Those nine residents had to wait at times for assistance when resident 1 was awake and required one on one. *There had been no changes since the last episode with resident 1 on 1/2/25. -There had been no changes to the staffing to accommodate the needs of resident 1. -Resident 1's plan of care had not been updated or shared with staff if it had been updated. -No mandatory education was provided on how to work with him or residents who had dementia and increased behaviors. *She had completed dementia and abuse training that year. -That training was mandatory and part of the yearly required online trainings. *The staff had not been educated on what the provider's one to one monitoring policy requirements were. -She was not sure if they had a policy or process in place on how to take care of resident 1. *She was not part of the care planning process and was not aware of how that process worked. *She did not know how to access the care plans to check for any changes. *She had not been informed of any resident care plan updates or changes. *She stated: -"I would think I should be updated on any care plan changes so we know how to take care of the residents." -"I'm in charge of the residents and staff and new myself so I would think I should know these things." -"I don't think there is a good plan in place to take	F 600	MS	

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care of [resident 1's name] and if there is I'm not aware of it."
*The all-staff meetings had not been mandatory.
-There was one in December and dementia care was scheduled to be discussed.
-She had not attended it because it was not mandatory, she had not worked that day, and had other obligations.
-It was optional for the staff to attend the dementia training and all staff meetings.

Interview on 1/8/25 at 11:54 a.m. with LSW A revealed:
*She had assisted the staff with one to one monitoring of resident 1 during the week and during the daytime hours.
*A staff had not been assigned one to one monitoring for resident 1 until December.
-The office staff had been providing the one to one monitoring since the last complaint survey on 10/31/24 to support that plan of correction.
*To her knowledge there had been extra staff to provide the one to one, but she was not responsible for the scheduling.
*Since the incident on 1/2/25 they had been in touch with the Ombudsman to try and set-up additional dementia care training for the staff.
-To her knowledge there had not been any other changes or updates to resident 1's care plan to help the staff with taking care of him.
*She stated:
-"He is just fine with me and I'm not scared of him."
-"I talk to the staff all the time on different things they can do to help keep him calmer."
-"He has problems with his peripheral vision and I'm not sure if that's a part of his care plan."
-"But the care plan doesn't explain the one to one expectations either."

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F 600	Continued From page 20 -"The expectation is that staff keep him, other residents, and staff safe." *She agreed: -The peripheral vision difficulties should have been a part of his care plan so the staff would have known how to approach him better. -One to one monitoring expectations should have been a part of his care plan so the staff would have known how to take care of him. *They had mis-interpreted the CMS guidance for gradual dose reductions and his antipsychotic medication had been discontinued a few months ago. -Since then his behaviors had increased and the Seroquel had been restarted. He was not quite to the dose he had been on before it was discontinued. *She had no response when asked if the staff had been properly educated on: -How to take care of resident 1 or residents with dementia and aggressive behaviors. -What the one to one monitoring expectations for resident 1 had been. Interview on 1/8/25 at 12:42 p.m. with CNA K revealed: *She had been working there for approximately 6 months. *She had been working the evening of 1/2/25 during the episode with resident 1. *The expectation was for her to be with him at all times while he was awake. -That had included walking with him, giving him things to do, and assisting him with his care needs. *She had been walking with him when he laid down on floor in the dining room. *She and CNA G had not been aware that when he sat or laid down on the floor he was to have	F 600	MDS or designee	

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F 600	Continued From page 21 been left there. *CNA G assisted resident 1 up off the floor and he ran after her. *In the process of running after her, he had hit resident 2 in the face. *Resident 1 ran into the kitchen area and rummaged through the refrigerator. *They had tried to help him sit down in the Broda chair but he kept trying to get out. *She stated: -"I was afraid of getting hit." -"Honestly, I'm scared of him and so are some others." -"Leadership knows we are, they just ignore it." *She confirmed: -Resident 1 had required one to one monitoring when he was awake. -She had not received extra training on what the one to one person should have done when working with him. -There had not been extra staff scheduled to assist or monitor him when he was awake. -Whoever was available would have provided the one to one monitoring. -That staff person still had other residents to take care of and tasks. -The needs of the other residents had to wait until a staff person was available to assist them. -She had been instructed that the one to one resident had taken priority over the other residents. -She thought resident 1 had been neglected because of his increased behaviors. There had been times he had sat in his bowel movement because they had been to scared to change him. *She stated. "Sometimes it takes up to three of us to change him or work with him so that no one gets hurt or kicked." *She had:	F 600		

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-Not felt that she had the proper training to help take care of resident 1 and other residents with similar behaviors.
-Not been aware of any updates or changes to his plan of care since the incident on 1/2/25 to ensure the safety of others and himself.
-Had not been kept informed of when the resident's care plans had updated or changed."
*She stated. "One time a resident's diet changed to puree [food blended to a smooth consistency] and the only reason I knew that was because it was on the sheet they checked to see what the resident's wanted."
*She had not completed any dementia care training and to her knowledge the online course was not mandatory.
*She stated:
-"I've been told there is an upcoming training."
-"But they also said it won't be for a while now because all the students were going back to school"

Interview on 1/8/25 at 1:43 p.m. with director of nursing (DON) B revealed:
*The online dementia training that should have been completed by 11/29/24 per their plan of correction from the 10/31/24 survey was for their ancillary staff only.
-Such as, dietary, maintenance, and housekeeping.
*The online dementia training was mandatory for the other staff every year and they should have completed it.
-It was the expectation that the staff had completed that training.
*The extra training that had been offered to all the staff was optional, it was just for extra support for them, and not mandatory.
-It had been optional for the staff to complete any

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F 600	Continued From page 23 extra trainings. *At this time, the only training that would have been completed for her staff would have been the yearly online mandatory training. *The in-person training for dementia care was still in process at that time. -They had reached out to other providers for guidance and they had nothing to offer. -She had been working with the Ombudsman program to setup in-person training for the staff on taking care of residents with dementia care and challenging behaviors. -Review of the email communication between the DON B and Ombudsman had been initiated on 1/6/25 and had not been intentionally delayed. *She would not have been able to ensure what her staff comprehended regarding the process for the one to one monitoring of resident 1. *She stated: -"The expectation is there is someone with him when he is awake for his safety." -"If he is awake there should be staff with him a few steps away, nearby him." -"Someone should keep eyes on him at all times." -"He's in the offices with us to for his safety." -"Extra staff? Well the best that we can, depends on census." -"If staff are busy and there's only one CNA on the floor then they can ask the med aide for help." -"They can call each other for help." *The staff working that day had been verbally educated after the 1/2/25 incident that involved residents 1 and 2. -She had not been in the facility when that education had occurred and could not comment on what that education had involved. -Education was in real-time and had not been documented to support that it had occurred or what the staff had been educated on.	F 600		

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F 600	Continued From page 24 -They continued to work on setting up staff education with the Ombudsman. -Some staff had been disciplined after they had watched the video from the 1/2/25 incident. *Each staff person had gone through training on how to access the care plans. *She stated: -"They can always ask, help is available [regarding care plan access]." -"I just wonder if there is a lack of interest or buy-in." -"Staff are still expected to work with him [resident 1] even if they are scared of him." -"We can't just drop him off somewhere and say good-luck to you." -"We don't have options, he was dropped off here too and nobody will take him." *She had not been aware that resident 1 had peripheral vision issues or that it had not been care planned. *On 1/7/25 they had developed a Standard Operating Procedure for one to one monitoring. -The staff had not been educated on that procedure document. 5. Observation on 1/8/25 at 12:30 p.m. of the video recording of the 1/2/25 incident involving resident 1 revealed: *The timeframe for the occurrence was from 6:34 p.m. through 6:40 p.m. *At 6:34 p.m. he was located at the back of the dining room by the double doors. *He had placed himself on the floor and laid down underneath a small table. *CNA K (who had been assigned to monitor to him one on one) was located across the dining room and approximately 30 feet away from him. *The residents had just finished supper and a large group of residents were still in the dining	F 600		

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F 600	Continued From page 25 room. *CNA G: -Had come from one of the hallways and went to the dining room to check on the resident. -Situated himself behind the resident and appeared to be talking to him. -At times sat on the table as if to wait and see what the resident was going to do. *CNA K went by the resident and was facing him from the front. *The resident was on the floor in the sitting position with his back to CNA G. *CNA G walked up behind the resident and placed his arms underneath the residents arms and armpits. -He then lifted the resident up off the floor on his own. *That action startled the resident and he started to run with his arms waving widely all around. *CNA K ran in front of the resident as if to get away from him. *The resident's balance was unsteady and he staggered around while trying to get out of the dining room area. *In the process of trying to get out of that area it appeared as if he fell towards resident 2. -Resident 2 had been sitting in a dining room chair during the encounter. *Resident 1: -Had not appeared to target the resident or punch her but accidentally fell into her. -Continued to run in a frightened state with his arms flying about. -Ran into the kitchen area behind the nurse's station and opened the refrigerator door. -Rummaged through the refrigerator and a container fell out and onto the floor. *While resident 1 was at the refrigerator: -CNA G came around to the left side of the	F 600		

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resident and CNAs K and L came up from behind him with the Broda chair.
-The actions of the staff had barricaded him in that small area.
-The staff pushed the Broda chair up to him several times trying to get him to sit down.
-That process had trapped him up by the refrigerator, appeared to have startled him, and he tried to again get away from the staff.
-That action was repeated a number of times by the staff and appeared to have caused the resident to fall to the floor three or four times.
-Each time the resident fell to the floor he had to get himself up. None of the staff present had attempted to help him get up after he fell.
-CNA G was observed taking his cell phone out of his pants pocket when the resident tried to get away from them and repeatedly fell to the floor. He recorded the resident as he was falling to the floor, trying to get himself up, and trying to escape from the boundaries of how the three staff members had positioned themselves.
*CNAs G, K, and L and CMA O had been laughing the entire time the resident starting running through the dining room area to the refrigerator, while he was falling to the floor, and trying to escape from the boundaries of the staff.
-The staff had cornered resident 1 by the refrigerator with the Broda chair and CNA G on his left side. He could not escape the entrapment that the staff had created and they appeared to be antagonizing him.
*At 6:40 p.m.:
-Resident 1 was observed sitting down in the Broda chair.
-The nurse's had come to assist.
*At no time was the staff observed in that recording to have attempted to calm him down or assist him from falling to the floor and ensuring

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F 600	Continued From page 27 he had not hurt himself. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted on 7/25/23. *His diagnoses included: dementia without behavioral disturbances, psychotic disturbance, mood disturbance, and anxiety; Alzheimer's Disease, Parkinson's disease, pain in right shoulder, and conduct disorder. *His Brief Interview for Mental Status (BIMS) assessment score which indicated his was severely cognitively impaired. *He was dependent upon the staff: -For daily decision making. -To develop a plan of care for him that allowed him to be safe from himself, other residents, and staff. -To assist him with all activities of daily living to include personal hygiene, toileting, bathing, bed mobility, and transfers. -To ensure his environment was less stimulating and calming. -To have been educated on how to care for him and other residents who had dementia and/or increased agitation and aggressive behaviors. 6. Review of resident 1's comprehensive care plan revealed: *Problem: "One to one while awake for behavioral issues." -Goal: "To keep [resident's name], staff and other residents safe." -Approach: --"Resident will have 2 staff to assist with cares when given due to aggressive behaviors." --"[Resident's name] will have a co [another person] with him while awake." *No documentation supported what approaches	F 600		

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F 600	Continued From page 28 had worked well for the resident to attempt to ensure he remained calm, safe, and how to assist him when he was agitated. *No documentation supported his peripheral vision decline and the importance to approach him from the front so he could see them. Review of resident 2's EMR revealed: *She was admitted on 4/11/23. *Her diagnoses included: Alzheimer's disease with the late onset-with behavioral disturbance, dementia, psychotic disturbance, mood disturbance, and anxiety. *Her BIMS assessment score was a four which indicated she was severely cognitively impaired. *On 1/2/25 she had been hit on the right cheek by resident 2 while sitting at the dining room table. -"[Resident 2's name] was sitting in the dining room table, another resident [resident 1's initials] was being aggressive, he did hit [resident 2's name] in the face on her right cheek leaving a 5.5 cm [centimeter] x 2.5 cm mark on it." -There was no documentation that supported her mental health had remained unchanged and not affected from being hit in the face. Review of the nursing staff's daily assignment sheet from 12/1/24 through 1/8/25 revealed: *No documentation that supported: -An extra staff had been scheduled to meet the one to one monitoring needs of resident 1 while he was awake. -A one to one monitoring task for resident 1 had not been implemented prior to 12/18/24. That had been 47 days after their plan of correction completion date of 10/31/24. *All the staff assigned to monitor resident 1 had been also assigned to work the floor, had other residents assigned to them, and tasks.	F 600		

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Review of the nursing staff's undated resident information sheet revealed:
*The sheet had been located at the nurse's station on a clipboard along with the daily assignment sheet.
*All the residents' names and room numbers had been on the sheet for the Mueller wing where resident 1 resided.
*The document had supported if the residents had:
-An exercise program or not.
-How much assistance the residents required for transfers and personal cares.
*The staff were to sign the sheet after they had completed the residents' cares.
*No documentation on that sheet supported:
-How to take care of resident 1 while he was awake, how to keep him calm, and what to do during his episodes of increased aggression.
-How to take care of the other residents who had unique needs or behavioral concerns.

Review of the provider's undated and unsigned Standard Operating Procedure for One to One monitoring revealed:
*"Purpose: To provide a safe quiet environment for individuals who are experiencing too much stimulus."
*"Procedure:
-1. When an individual is becoming aggressive, upset, or unstable for mood, staff will recognize that this individual needs to be deescalated and removed from the overstimulating situation/trigger.
-2. Resident will remain safe and will be care planned to have one to one observation."
*No documentation that supported processes or interventions to implement when a resident

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became aggressive, upset, or unstable.

7. Review of the provider's revised 1/7/25 CNA job description revealed:
*"Provides resident-centered nursing care and daily living assistance to assigned resident under the supervision of a registered nurse (RN).
*"Knowledge of and delivers age-appropriate care related to the physical and psychological needs of the resident a per care plan."
*"Provides assistance with basic health care needs including. physical and psychological needs of the resident per care plan."

Review of the provider's revised 1/7/25 Registered Nurse job description revealed:
*"The Registered Nurse (RN) is responsible for utilizing the nursing process (assessment, diagnosis, outcomes/planning, implementation and evaluation) to provide individualized nursing care to residents."
*"Collaborates with resident and family, other inter-disciplinary colleagues, including providers, to plan, implement and evaluate care."
*"Cares for residents in all phases of preventative care, health maintenance, diagnosis, and treatment."
*"Provides adequate assistance and support to delegates to ensure safe, reliable administration of resident care and resolution of care and service concerns."

Review of the provider's revised 1/9/25 Director of Nursing job description revealed:
*"Administers the nursing program in a long term care facility to maintain standards of resident care."
*"Facilitates the optimization of the geriatric care process to improve the quality and efficiency of

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F 600	Continued From page 31 service." *"Responsible for the overall quality of care provided by the organization's nursing personnel." *"Monitors the operations of the nursing staff and ensures compliance with regulations on organizational and governmental standards and practices." *"Has overall responsibility for the day-to-day operations of the long term care facility." *"Monitors operations of nursing staff and ensures compliance with regulations on organizational and governmental standards and practices." Review of the provider's revised 1/7/25 Social Worker job description revealed: *"Provides supportive services/counseling on healthcare and home care programs and services." *"Serves as a member of the interdisciplinary team in providing assistance with social, emotional and economical concerns of patients/clients/residents and families/caregivers, thus enabling them to achieve or maintain an optimal level of functioning by coordinating and planning program." *"Responds to suspected abuse, neglect or violence in accordance with the National Association of Social Work Code of Ethics policies and procedure alongside the appropriate state laws." *"Develops appropriate plan of care for patients/clients/residents and families/caregivers ...." Review of the provider's revised 1/9/25 Administrator/Chief Executive Office job description revealed: *"Direct the overall administration of medical	F 600		

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facilities, long term care, clinics, and/or hospital."
*"Develop strategic plans, including facility assessment, that enhance the patient care experience while keeping staff accountable for set departmental goals."
*"Accomplish and maintain patient care, safety and education,......."

Review of the provider's revised 2023 Resident Information Packet revealed:
*Page 9: "The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. [Provider's name] will protect and promote the rights of each resident ...."
*Page 16: "Residents have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion. Residents are protected from abuse by anyone including facility staff, other residents. .... "
*Page 16 Quality of Life:
-"Residents have a right to be cared for in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life, dignity and respect in full recognition of his/her individuality.
-The staff of the facility will show an appreciation for and make every attempt to promote each resident's self-worth
-Staff will speak respectfully, listen carefully, and address residents in the way he/she wishes."
*Page 16 Staff Treatment of Residents:
-"The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect or abuse of residents.
-"Staff are trained and not allowed to use verbal, mental, sexual, or physical abuse, including corporal punishment or involuntary seclusion."

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*Page 17: "The facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."

Review of the provider's revised 12/2/24 Advance Care Planning policy revealed:
*The administration had been asked to provide the surveyors with a copy of their care plan policy.
-They had provided the surveyors with this policy that directed the staff on how to work with the resident and family on how to make future healthcare decisions.
*The policy had not supported:
-A process for the staff to follow on developing a document that supported the resident's health conditions, the level of support they required, how the support should have been given, and what the goals of the care should have been.
-Who was involved with the care plan development and implementation.
-How to develop a care plan for the staff to follow to ensure the daily needs of the resident's had been implemented.
-How to develop a robust care plan for the staff to follow to ensure the resident's received quality of care and quality of life.

Review of the provider's revised 7/10/24 Abuse and Neglect policy revealed:
*"Patients and residents have the right to be free from verbal, sexual, physical, mental abuse, neglect. ......"
*"Patients and residents must not be subjected to any kind of abuse by anyone, including, but not limited to facility staff, other patients or residents. ...."