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BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER	**2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203**

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00415035. This visit resulted in a Partially Extended Survey- Substandard Quality of Care-Immediate Jeopardy. Complaint IN00415035 - Federal/State deficiencies related to the allegations are cited at F600. Unrelated deficiency is cited. Survey dates: August 21, 22, 23, 24, 2023 Facility number: 000063 Provider number: 155138 AIM number: 100266210 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type Medicaid: 56 Other: 12 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 28, 2023.	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,	F 600		

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

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F 600	Continued From page 1 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 interview and record review, the facility failed to protect the resident's right to be free from physical abuse from a staff member related to a staff member pushing a resident to the floor after a verbal altercation, for 1 of 4 residents reviewed for abuse. A facility staff member failed to react and respond to a resident's behavior appropriately and professionally, resulting in the staff member purposefully pushing the resident to the ground. (Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 7/27/23 at approximately 8:00 p.m., when the facility failed to protect the resident's right to be free from physical abuse. The Administrator, Director of Nursing, the Regional Director of Clinical Operations, Area Vice President, and Vice President were notified of the Immediate Jeopardy, on 8/22/23 at 2:15 p.m. The Immediate Jeopardy was removed on 8/24/23 at 11:30 a.m., and the deficient practice corrected on 8/9/23, prior to the start of the survey and was therefore Past Noncompliance. Finding includes:	F 600	Past noncompliance: no plan of correction required.	

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During an interview on 8/21/23 at 8:26 a.m., the Unit Manager indicated there was an abuse allegation made by Resident B against LPN 1 (Licensed Practical Nurse). The allegation was that LPN 1 pushed Resident B down.

During an interview on 8/21/23 at 8:33 a.m., Resident B indicated a staff member was trying to come into her room and pushed her down to the floor. Resident B fell and hurt her left hip, but she didn't have to go to the hospital. Resident B couldn't remember the staff member's name.

During an interview on 8/21/23 at 8:52 a.m., the Administrator indicated on 8/8/23, she was informed of an allegation that LPN 1 pushed Resident B. The Administrator immediately suspended LPN 1 and began an investigation. CNA 2 (Certified Nursing Aide) and CNA 3 heard LPN 1 tell LPN 2 that she pushed Resident B. CNA 1 was in Resident B's room with LPN 1 while they were looking for cigarettes. CNA 1 turned her head away from LPN 1 and Resident B. CNA 1 reported she saw Resident B fall face forward onto the bed. The Administrator terminated LPN 1 on 8/11/23, when the investigation was completed and the allegation was substantiated.

During an interview on 8/21/23 at 9:17 a.m., CNA 2 indicated Resident B went into another resident's room and took a can of soda and some cigarettes while CNA 2 and CNA 3 were providing care to another resident. CNA 2 notified LPN 1. LPN 1 said she was going to get those "f****** cigarettes". LPN 1 asked CNA 1 to go with her to Resident B's room. CNA 2 and CNA 3 heard LPN 1 tell LPN 2 that Resident B grabbed her shirt while LPN 1 was trying to search Resident B's

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room. LPN 1 said she wasn't going to let that "big b*****" do that to her, so LPN 1 pushed that "b***** across the f****** floor" and Resident B can pick herself up. Resident B told CNA 2 that LPN 1 pushed her hard and hurt her back. LPN 1 continued to work as Resident B's nurse for the rest of CNA 2's shift. CNA 2 did not report to the Administrator until the next day (7/28/23).

During an interview on 8/21/23 at 9:38 a.m., CNA 1 indicated LPN 1 asked CNA 1 to go with her to Resident B's room. LPN 1 was going to look for cigarettes. When LPN 1 started looking in Resident B's closet, Resident B grabbed LPN 1's shirt. At that time, CNA 1 turned around to look behind Resident B's bed and when CNA 1 turned back around, Resident B was falling onto the bed. Resident B landed with her knees on the floor and face first onto bed. CNA 1 was going to help Resident B, but LPN 1 told CNA 1 to leave Resident B on the floor. Resident B was still on the floor when LPN 1 and CNA 1 walked out of the room and closed the door. Approximately 10 minutes later, CNA 1 heard LPN 1 say that "b****" was probably still getting herself up off the floor. CNA 1 did not report this to a manager until the next day (7/28/23).

During an interview on 8/22/23 at 8:16 a.m., CNA 3 indicated she had to write a statement. CNA 2 and CNA 3 wrote the statement together. CNA 3 did not see LPN 1 push Resident B. CNA 2 and CNA 3 finished providing care to another resident. When they were walking out of that resident's room, LPN 1 said Resident B had a hold of her, but LPN 1 got those "f****** cigarettes". Then LPN 1 said Resident B was probably still getting herself off the ground. Resident B's door was closed so CNA 3 indicated she opened the door

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and saw Resident B getting up off the floor. Resident B's knees were on the floor and her arms were on the bed. CNA 3 didn't help Resident B get up because she was getting up on her own. At that time, Resident B said LPN 1 pushed her. Then CNA 2 and CNA 3 went outside with some residents and LPN 1 was outside bragging about pushing Resident B down. LPN 1 said that "b****" grabbed a hold of her, so LPN 1 pushed her down and said "don't f****** touch me b****". CNA 3 indicated she didn't report this to the Administrator because LPN 1 was telling LPN 2. CNA 2 and CNA 3 thought the nurse would report it. They should have been reported the incident immediately. Resident B said LPN 1 pushed her so hard she almost broke her back.

During an interview on 8/22/23 at 8:30 a.m., LPN 2 indicated on 7/27/23, LPN 1 told LPN 2 that she had been "jacked up" by Resident B. Resident B pulled LPN 1 up by her shirt. Then LPN 1 grabbed LPN 2's shirt collar to show LPN 2 how Resident B grabbed her shirt.

The clinical record for Resident B was reviewed on 8/21/23 at 12:51 p.m. The diagnoses included, but were not limited to, anxiety, depression, and schizophrenia.

An Admission MDS (Minimum Data Set) assessment, dated 6/2/23, indicated Resident B was moderately cognitively impaired and was having hallucination and delusions.

A witness statement, dated 7/28/23, indicated Resident B took soda and cigarettes from another resident. LPN 1 searched Resident B and then started looking in Resident B's closet. Resident B started hitting LPN 1 and CNA 1 started

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searching behind Resident B's bed. Resident B told LPN 1 the cigarettes belonged to her. Then CNA 1 saw Resident B fall face first into the bed. Resident B said LPN 1 hit her. Then CNA 1 and LPN 1 walked out of the room. LPN 1 closed the door. After that, CNA 1 heard LPN 1 tell another nurse what happened.

A witness statement, dated 7/28/23, indicated CNA 2 heard LPN 1 say she was going to get those mother f****** cigarettes. CNA 1 told CNA 2 that Resident B grabbed LPN 1. CNA 1 turned to look for more cigarettes and then Resident B was "flying across the room" and face down on the bed. A few minutes later, LPN 1 was outside telling LPN 2. LPN 1 said she wasn't letting that b**** get her, so LPN 1 pushed Resident B's a** across the floor.

During an interview on 8/21/23 at 1:02 p.m., the SSD (Social Service Director) indicated she didn't know very much information about the allegation that LPN 1 pushed Resident B because she didn't work that day. The SSD heard Resident B had another resident's cigarettes and that became a struggle. The SSD also heard that Resident B pushed LPN 1, so LPN 1 pushed Resident B.

On 8/21/23 at 9:04 a.m., the Administrator provided a copy of an undated facility policy, titled Abuse, Neglect, and Exploitation, and indicated this was the current policy used by the facility. A review of the policy indicated the facility will prohibit and prevent abuse.

The past noncompliance Immediate Jeopardy began on 7/27/23. The Immediate Jeopardy was removed and the deficient practice corrected by 8/9/23 after the facility implemented a systemic

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F 600	Continued From page 6 plan that included the following actions: in-services related to procedures for resident abuse, resident behaviors, and ongoing monitoring. This Federal tag relates to Complaint IN00415035. 3.1-27(a)(1)	F 600		
F 740 SS=G	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a behavioral health care plan that included person-centered interventions to reduce or prevent intrusive, physically violent, and verbally aggressive behaviors for 1 of 4 residents reviewed for behavioral health services. This deficient practice resulted in one resident being pulled out of bed and one resident being hit repetitively. (Resident C, Resident D, Resident E) Finding includes: During an interview on 8/21/23 at 10:22 a.m.,	F 740	Past noncompliance: no plan of correction required.	

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LPN 3 (Licensed Practical Nurse) indicated Resident C was aggressive with staff and other residents. If someone looked at him, Resident C would yell or ball his fist. Resident C would get physical with other residents. Resident C was physically aggressive with Resident D.

During an interview on 8/21/23 at 11:27 a.m., Administrator 2 indicated the police were called to the facility approximately 37 times, over a 4 month period, because of Resident C's behaviors. About a month ago, at the beginning of July, Resident C became physically aggressive with Resident D. Two days after he became aggressive with Resident D, Administrator 2 was notified by floor staff that Resident C was going into Resident D's room again and yelling he wanted Resident D dead. Administrator 2 went to Resident C's room and Resident C told Administrator 2 to get the "f*** out of his room. Administrator 2 exited the room and Resident C came out of his room and stomped his feet and then charged at Administrator 2. The police had to "take him down to the ground". Resident C was removed from the facility with police assistance and was taken to a hospital.

During an interview on 8/21/23 at 3:03 p.m., the Regional Nurse indicated there were two separate incidents between Resident C and Resident E. The first incident was when Resident E was sitting in his wheelchair and Resident C walked up to Resident E and punched him. Resident E fell out of his wheelchair. Resident E complained of pain in his ribs and needed x-rays. The second incident was when Resident C and Resident E were both outside in the smoking area with staff present. Resident E punched Resident C and they got into a fight. Before staff could get

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to them Resident C was on top of Resident E punching him.

During an interview on 8/22/23 at 11:16 a.m., CNA 2 (Certified Nurse Aide) indicated Resident E told her Resident C hit him so hard Resident C fell out of his wheelchair. Resident E told CNA 2 that he was scared to death. Resident E wanted to press charges.

During an interview on 8/22/23 at 3:35 p.m., LPN 1 indicated there were so many incidents of resident to resident abuse in that facility and nothing was ever done. Resident C hit Resident E so hard he fell out of his wheelchair. LPN 1 wasn't on the unit the day Resident C dragged Resident D out of bed and on to the floor, but LPN 1 got in report that Resident D was sent to the hospital the day that happened. LPN 1 was Resident D's nurse the next day and LPN 1 sent Resident C to the hospital again. LPN 1 also got in report that Resident D had not eaten, drank anything, nor smoked a cigarette the entire day. Resident D also complained of pain and didn't want to be touched. LPN 1 knew Resident D had already been sent to the hospital the day he was attacked but Resident D was not acting himself. If Resident D didn't want to do anything else, he would have at least went to smoke a cigarette. There was definitely a change in condition in Resident D. Resident D's brother was not happy when LPN 1 called to notify him that Resident D was being sent to the hospital. Resident D's brother was not aware Resident D was dragged out of bed. It sounded like the facility gave the impression that Resident D was the aggressor. Resident C's room was directly across the hall from Resident D's room.

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During an interview on 8/23/23 at 9:12 a.m., RN 1 (Registered Nurse) indicated she was Resident E's nurse the day the Resident C walked up and punched Resident E. Resident E was sitting in his wheelchair and Resident C walked up and punched him. Resident E fell out of his wheelchair to the floor. Staff were able to intervene after Resident E was on the floor. Resident C continued to be aggressive toward Resident E and was difficult to redirect. Resident E complained of pain in his ribs, so the facility ordered x-rays for him. Resident E does complain of generalized pain but this time he specifically complaint of pain in his ribs. RN 1 was not sure what happened the second time Resident C and Resident E had a physical altercation.

The clinical record for Resident C was reviewed on 8/21/23 at 10:42 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression, bipolar disorder, psychotic disorder, schizophrenia, intermittent explosive disorder, impulsiveness, and intellectual disability.

A Quarterly MDS (Minimum Data Set) assessment, dated 6/26/23, indicated Resident C was cognitively intact. Resident C had hallucinations, verbal behavioral symptoms directed toward others, and wandered.

A progress note, dated 4/19/23 at 4:10 p.m., indicated writer heard loud yelling coming from hallway. Writer went to see what was happening. Resident C observed yelling at Resident E and attempting to hit Resident E. Staff members noted standing between residents keeping them apart. Writer and the Administrator attempted to redirect Resident C, Resident C continued yelling

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that Resident E threatened Resident C's life and family, and Resident C was going to slaughter Resident E. Writer and Administrator continued to redirect Resident C to his room on the other unit. Resident C then sat on his bed and continued to shout that he was going to slaughter Resident E.

A progress note, dated 4/20/23 at 8:06 a.m., indicated writer spoke with Resident C about his violent behavior towards Resident E. Writer educated resident that aggressive behaviors towards others would not be tolerated. Resident C agreed to not be violent towards staff or other residents. Writer also spoke with Resident C about his inappropriate sexual behaviors towards female staff.

A therapy note, dated 4/24/23, indicated assessed Resident C's mental health and recent events. Discussed a recent altercation where he assaulted another resident. Patient reported the incident incorrectly and blamed the other resident, however when challenged by therapist, he admitted to assaulting the other resident. Target Symptoms and current severity on a scale of 0 (no symptoms) to 10 (maximum severity): anxiety 5/10, depression 5/10, withdrawal/isolation 0/10, panic 0/10, hopelessness 0/10, rumination (engaging in a repetitive negative thought process) 6/10, inappropriate behavior 0/10, agitation 6/10, verbal aggression 5/10, physical aggression 6/10, interpersonal problems 6/10, poor self-esteem 0/10, paranoia 0/10, delusions 7/10, auditory hallucinations 0/10, visual hallucinations 0/10, disorganized thinking 7/10, hypomania/mania 0/10, sleep disturbance 4/10, appetite disturbance 0/10, adjustment 2/10, pain exacerbation 0/10, somatization 0/10, tearful

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affect 0/10. Continue current plan created, on 3/29/23.

A therapy note, dated 5/4/23, indicated Resident C reports that when he leaves his room other resident bother him. Resident C reported paranoia that he believes other residents are trying to get rid of him by the bubonic plague, a heart attack, or colon cancer. Target symptoms and current severity on a scale of 0 (no symptoms) to 10 (maximum severity): anxiety 5/10, depression 6/10, withdrawal/isolation 4/10, panic 0/10, hopelessness 0/10, rumination 6/10, inappropriate behaviors 0/10, agitation 3/10, verbal aggression 2/10, physical aggression 2/10, interpersonal problems 6/10, poor self-esteem 0/10, paranoia 6/10, delusions 7/10, auditory hallucinations 0/10, visual hallucinations 0/10, disorganized thinking 7/10, hypomania/mania 0/10, sleep disturbance 4/10, appetite disturbance 0/10, adjustment 4/10, pain exacerbation 0/10, somatization 0/10, tearful affect 0/10. Depression, withdrawal/isolation, paranoia, and adjustment symptoms were more severe compared to the severity scores, on 4/24/23. Continue treatment plan created, on 3/29/23.

A progress note, dated 5/11/23 at 10:53 a.m., indicated during a supervised smoke break, Resident C was approached by Resident E and Resident E made contact to the right side of Resident C's face with a closed fist. Resident C then made contact to Resident E with a closed fist to his head and ribs. Resident C placed on 15-minute checks.

A progress note, dated 5/11/23 at 12:20 p.m., indicated writer met with resident due to verbal

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aggression and homicidal behaviors towards another resident. Resident states that he was going to cut another residents head off and burn it.

A progress note, dated 5/11/23 at 1:29 p.m., indicated writer spoke with Resident C's guardian. Writer informed guardian that due to Resident C's homicidal ideations today. Writer informed guardian that all documents were sent to the hospital and Resident C had been approved for hospitalization.

A psychiatric evaluation, dated 5/12/23, indicated Resident C was admitted via power of attorney guardian for psychosis, schizoaffective disorder, intermittent explosive disorder, intellectual disability, mood affect disorder, anxiety disorder, impulsiveness, agitation, violent behaviors, Parkinson's, Alzheimer's, and dementia. Resident C had been physically aggressive and making homicidal statements towards other individuals. Resident C stated that he was going to cut their heads off and burn their heads. Resident C is in need of rapid emergent mental health stabilization due to the fact that he was a harm and danger to others. Past psychiatric history included, but was not limited to, inpatient hospitalization for mental health from 7/20/22 through 7/29/22, 10/19/22 through 10/28/22, and 2/28/23 through 3/16/23. Resident C failed outpatient treatment and has historical diagnoses of bipolar disorder, Alzheimer's dementia with signs and symptoms of verbal aggression, impulsivity, mania, with suicidal and homicidal ideations.

A history and physical, dated 5/13/23, indicated Resident C presented with acute homicidal

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ideations, verbal aggression, impulsive behaviors, and mania. He had been verbally making homicidal statements toward others stating that he was going to cut their heads off and burn them.

A therapy note, dated 5/25/23, indicated target symptoms and current severity from 0 (no symptoms) to 10 (maximum severity): anxiety 5/10, depression 6/10, withdrawal/isolation 4/10, panic 0/10, hopelessness 0/10, rumination 6/10, inappropriate behaviors 0/10, agitation 3/10, verbal aggression 2/10, physical aggression 2/10, interpersonal problems 6/10, poor self-esteem 0/10, paranoia 6/10, delusions 7/10, auditory hallucinations 0/10, visual hallucinations 0/10, disorganized thinking 7/10, hypomania/mania 0/10, sleep disturbance0/10, appetite disturbance 0/10, adjustment 4/10, pain exacerbation 0/10, somatization 0/10, tearful affect 0/10. Continue treatment plan created, on 3/29/23.

A progress note, dated 6/22/23 at 9:30 a.m., indicated Resident C was actively engaging in auditory hallucinations. Resident C was verbally aggressive towards staff and other residents. Resident C was exhibiting signs of paranoid ideations as he stated, "everyone is out to get me." Resident C continues to have outbursts as he engages in loud self-talk when no one else is around.

A progress note, dated 6/24/23 at 2:19 a.m., indicated Resident C was asking staff and residents for cigarettes. Resident C grew angry when told no and that residents are not allowed to smoke at this time. Resident C began storming around facility yelling "f***" you all and threatened another resident by telling her he was going to kill

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her and called her a "b****". Police were discussing incident with Resident C.

A progress note, dated 6/24/23 at 3:30 p.m., indicated Resident C was screaming at the nurses station for staff to give him cigarettes during non-smoking times. Resident C continues to act verbally aggressive to staff when reminded about scheduled smoking times screaming "f*** you all". Police and emergency medical team were called.

A progress note, dated 6/30/23 at 12:00 p.m., indicated writer met with Resident C due to Resident C being verbally aggressive, homicidal, and suicidal. Resident C threatened to kill the Executive Director and a CNA (Certified Nursing Aide). Resident C indicated why not he had nothing to live for. When asked if he had a plan resident indicated not right now, I will let you know. Writer will follow up.

A progress note, dated 6/30/23 at 3:06 p.m., indicated writer spoke with caseworker regarding Resident C would be receiving a 30-day notice of discharge due to verbal and physical behaviors towards other residents and staff. Writer informed caseworker of the numerous times the police had been called on Resident C due to his threatening, verbally aggressive behaviors.

A progress note, dated 7/2/23 at 10:57 p.m., indicated Resident C began being verbally aggressive and threatening when asked to lower his voice due to another resident using phone at A wing nurses station. Resident C stated he was going "f***" up everybody here and he could go anyplace he wanted to go in this facility. Resident C would kill anyone trying to stop him. Resident C

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kept yelling he was a man, and he would be respected. Resident C finally calmed down and left the unit. Staff unable to redirect Resident C.

A therapy note, dated 7/6/23, indicated processed the discharge paperwork that Resident C was served, on 7/3/23. Resident C became very belligerent when speaking about this situation and had to be redirected to lower his voice several times, which he was receptive to. Resident C does not plan to discharge from the facility willingly within 30 days and believes he was being wrongly asked to leave the premises. Resident C reported frustrations and complaint related to living in a communal environment. Resident C denied any auditory hallucinations and visual hallucinations and paranoia. Indicated target symptoms and current severity from 0 (no symptoms) to 10 (maximum severity): anxiety 6/10, depression 6/10, withdrawal/isolation 4/10, panic 0/10, hopelessness 0/10, rumination 6/10, inappropriate behaviors 6/10, agitation 6/10, verbal aggression 6/10, physical aggression 4/10, interpersonal problems 6/10, poor self-esteem 0/10, paranoia 6/10, delusions 7/10, auditory hallucinations 0/10, visual hallucinations 0/10, disorganized thinking 7/10, hypomania/mania 0/10, sleep disturbance 0/10, appetite disturbance 0/10, adjustment 4/10, pain exacerbation 0/10, somatization 0/10, tearful affect 0/10. Due to ongoing symptomology, therapist will create a new treatment plan at next encounter.

A progress note, dated 7/7/23 at 6:32 a.m., indicated Resident C was walking down the hall when he was witnessed going into Resident D's room. Resident C grabbed Resident D and pulled him out of his bed and onto the floor. Resident D

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was crying, and staff told Resident C to go to his room. Nurse on B-wing called Executive Director and she was unable talk at that time. Nurse phoned other members of management for further instructions. The manager stated they wanted Resident C removed from the building. When the police arrived, they stated they could not arrest Resident C due to his mental state. The police said both Resident C and Resident D needed to go to the hospital. When the ambulance arrived, they assessed Resident D while on the floor and transferred Resident D from the floor to the stretcher. Resident C continued to come out into the hall and was yelling yeah he did it and he would do it again. Phoned the Director of Nursing, guardian, and doctor on call. Police called for another ambulance to come to transport Resident C to hospital. When the ambulance arrived Resident C continued to refuse. At that time management was working on getting someone to come and do one on one observation with Resident C. Resident C was yelling at one of the CNA's stating you're all just a bunch of 'b******* and h***" so why don't you come to my room and "f*** me". This is the language Resident C continued to use and was offensive to everyone. Resident C continued to pace back and forth. Earlier that day, Resident C was outside and stated he was going to "kill a m**********". Nurse sat with Resident C in hopes he would calm down. Resident C presented to be very angry and was shaking with closed fists. After Resident D was taken to hospital Resident C stayed in his room with the exception of one time he came to the nurse's station asking for snacks.

A progress note, dated 7/7/23 at 11:04 a.m., indicated Resident C began aggressively

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threatening staff and being verbally abusive to residents and staff when asked to calm down. Resident C proceeded to curse and stated he didn't give a "f***". Resident C indicated if he had his gun he would blow all of our heads off and cut all of our throats. Resident C proceeded to verbally yell out sexual threats stating to staff that she need to "f*** him" and go to his room and Resident C would pull her pants down if she act like she didn't know how to "f*** him". Resident C proceeded to walk around yelling and was verbally abusive.

A progress note, dated 7/9/23 at 7:12 p.m., indicated staff witnessed Resident C going into Resident D's room. Staff intervened and separated the two. The Administrator went to talk to Resident C about not going into Resident D's room. Resident C proceeded to scream at the Administrator to get out and Resident C was going to "slit her throat" if she didn't leave. Police and emergency medical service called. Police intervened when Resident C charged the Administrator with a closed fist. Police transported Resident C to the hospital. Hospital aware that we are not taking resident back to facility.

The clinical record for Resident D was reviewed on 8/21/23 at 12:23 p.m. The diagnoses included, but were not limited to, hemiplegia following a stroke affecting right dominant side (was not able to move right arm, hand, nor right leg), depression, and bipolar disorder. Resident D was on hospice.

A Quarterly MDS assessment, dated 5/3/23, indicated Resident D was not cognitively intact.

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A progress note, dated 7/8/23 at 8:08 p.m., indicated at this time the nurse from other unit stated to writer Resident C was witnessed going into Resident D's room and pulled Resident D from his bed onto the floor. After Resident C pulled Resident D to floor, Resident C was in hallway yelling he would do it again, Resident C cursed and called Resident D curse names. Management instructed nurse to call the police and have Resident C removed from the building. While comforting Resident C on the floor, this writer phoned police and ambulance. When police arrived, they stated they were not able to remove him from the building due to it being a private matter and there advice was to have both Resident C and Resident D sent to the hospital. Writer explained Resident C and Resident D were in their rooms waiting on ambulance to arrive so Resident D could be transported to the hospital. Writer assessed Resident D while waiting and did not find and injuries. Resident D was on the floor crying and attempts were made to console Resident D. When ambulance arrived, Resident D was then taken to the hospital. At this time resident on floor was crying and staff made attempts to console. Resident C stood in the doorway to his room and continued to yell and scream. Resident C was instructed to stay in room. Door was open and CNAs were in room with Resident C while he continued to curse and yell obscenities from his room. Resident C continued to threaten to strike Resident D again and also to strike staff. Police returned to facility and questioned why only Resident D was sent to the hospital. Writer explained management was attempting to provided one on one observation.

The clinical record for Resident E was reviewed on 8/21/23 at 11:40 a.m. Diagnoses included, but

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were not limited to, dementia, age related cognitive decline, and schizophrenia.

A Quarterly MDS assessment, dated 2/15/23, indicated Resident E was moderately cognitively impaired.

A progress note, dated 4/19/23 at 4:32 p.m., indicated Resident E was sitting on his wheelchair in hallway. Resident C walked up and told Resident E that Resident C was done threatening Resident E and then hit him on his head. Resident E did not say anything to Resident C. Staff separated Resident C and Resident E. 15 minutes checks were implemented.

A care plan, dated 3/24/23 and current through 7/10/23, indicated Resident C had mental health needs that would be adequately met at the skilled nursing facility related to diagnoses of schizoaffective disorder, bipolar disorder, anxiety, depression, and aggressive behaviors. The interventions included, to provide Resident C with opportunity to express mental health needs to staff and skilled nursing staff will provide routine opportunities to identify mental health needs of Resident C.

During an interview on 8/21/23 at 1:02 p.m., the Social Service Director indicated Resident C threatened to kill the staff. The staff were scared of Resident C and would avoid him. On the day the police removed Resident C from the facility, the staff were very scared. Resident C's aggressive behavior had been happening at least twice weekly for a few weeks. Before that Resident C had threatening behavior. The staff should have monitored for verbally aggressive, physically aggressive behaviors, and paranoia.

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F 740	Continued From page 20 Resident C should have had a care plan that identified behaviors and included person-centered interventions to reduce or prevent his behaviors. On 8/21/23 at 4:35 p.m., the Administrator provided a copy of an undated facility policy, titled Behavioral Health Services, and indicated this was the current police used by the facility. A review of the policy indicated the facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident. 3.1-37(a)	F 740		