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	634560	A. BUILDING _____ B. WING _____	6/17/2024

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SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

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F0000 SS=	INITIAL COMMENTS SKLD Bloomfield Hills was surveyed for an Abbreviated survey on 6/17/24. Intakes: MI00144492, MI00144772, MI00144743, MI00144707, MI00144941, MI00144981 Census = 123	F0000		
F0584 SS= E	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of	F0584	F-584 Safe/Clean/Comfortable/Homelike Environment: SS=E Element I: The facility identified the odor on 2West and it was eliminated. The soiled portable vital sign machine was located and the dried substances and other debris were removed and the base was cleaned. The footprints on the 2West were located and the 2West hallway floor was cleaned with the facility floor scrubber. The heating and cooling unit on 2West was located and the food and trash located inside the unit were removed and the dried chunky substances were removed from the panel with the dial and the entire unit was cleaned by the housekeeping staff. Resident 508 was identified and their sticky and unmopped floor was identified and cleaned and mopped by the housekeeping staff. Resident 505 was identified and the floor in their room restroom was cleared of debris as well as all other substances, and then mopped by the housekeeping staff. Resident 505 was identified and their dresser and closet handles were repaired and are in working order. Resident 505's soiled privacy curtain was identified and replaced. Resident 509 was identified and the food particles and crumbs were swept from the floor, and the floor was mopped by the housekeeping staff. Resident 510 was identified and the dirty,	7/8/2024

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

Electronically Signed | 07/03/2024

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	comfortable sound levels. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00144743 and MI00144492 Based on observation, interview, and record review, the facility failed to maintain an environment that was clean, sanitary, and homelike for four (R505, R508, R509, and R510) of five residents reviewed for the environment with the potential to affect all residents who resided on the second floor of the facility. Findings include: A review of complaints submitted to the State Agency revealed allegations that the facility was dirty and unsanitary. On 6/17/24, an unannounced onsite investigation was conducted. On 6/17/24 from 10:19 AM and 10:32 AM, an observation of the second floor was conducted and the following was observed: Upon entrance to the 2 West Unit, a strong odor that smelled like dirty feet was observed. The air smelled stale. A portable vital sign machine was observed in the hallway of the 2 West Unit. The base was rusted and coated with various dried substances and stuck on debris. The hallway of the 2 West Unit appeared unmopped and foot prints were visible on the floor.		sticky trash littered resident room and bathroom floor were swept and mopped by the housekeeping staff and the dried substances were removed from the sink and the sink was cleaned by the housekeeping staff. The uncovered receptacle box in the floor of the East Lounge was located and securely covered by the maintenance assistant. The hole in the south wall of the East Lounge, with wires protruding from it was located and repaired by the maintenance assistant. Element II: The facility identified like residents as residents who reside at the center. The facility performed an initial audit of resident room and privacy curtain cleanliness, vital sign machine cleanliness, odors on the units, as well as the wire receptacles condition to ensure a safe, clean, comfortable, homelike environment is being provided to its residents. Element III: The facility housekeeping director and his staff have been educated on the 5 and 7 step cleaning process for cleaning resident rooms and bathrooms as well as identifying and changing soiled privacy curtains and cleaning of vital sign machines. The maintenance director and his staff were educated on receptacle safety. Element IV: The housekeeping director/designee will complete random weekly vital sign machine, privacy curtain and room cleanliness audits, times 4 weeks to ensure a homelike environment is being provided. The results will be submitted to the administrator who will present to the QAPI committee for review and recommendation. The maintenance director/designee will complete random weekly receptacle audits, time four weeks to ensure a safe, homelike	

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	The heating and cooling unit at the end of the hallway on the 2 West Unit was observed to have large amounts of food and trash inside the vent. The panel where the dial was located was dirty with multiple areas of a dried, chunky substance observed. R508 was observed lying in bed. The floor in R508's room was sticky and unmopped. R508 reported they were cold, but was unable to answer questions about the cleanliness of the room. R505's room was visibly dirty from the hallway. A large area of a dried, shiny substance was observed underneath the trash can and extended out to the middle of the room. A plastic cup with spilled white powder was observed on the ground next to the trash can. Trash (food wrappers, paper, and crumbs) and debris was observed on the floor, scattered throughout the room, including the bathroom. The floors appeared to be unmopped. A large, thick, dried tan substance was observed under the bed. The handles on the dresser and closet were loose and falling off. The privacy curtain was observed with multiple dark brown stains that resembled feces. R509's floor appeared unmopped with a large area of food particles and crumbs scattered around the bed. R510's room located on the 2 East Unit was observed with a dirty, sticky, unmopped floor. The floor was littered with trash, including a bloody bandage, napkins, juice cartons, and debris. Upon interview, R510 appeared pleasant but confused and reported her room was cleaned all the time, despite the observed condition. R510's bathroom was		environment is being provided. The results of those audits will be submitted to the administrator who will present to the QAPI committee for review and recommendation. Element V: The administrator is responsible for achieving and maintaining compliance. The compliance date is 07-08-2024.	

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	observed with a two plastic bags on the ground, one with used, soiled briefs and another with dirty linens. The bathroom floor was littered with trash that included used disposable gloves and paper towel. The floor in front of the toilet was observed with areas of dark brown stains. The sink was observed with dried toothpaste and areas with a dried pinkish-tan substance. On 6/17/24 at 12:36 PM, the 2 West and 2 East units, including R505, R508, R509, and R510's rooms remained in the same condition as mentioned above. On 6/17/24 at 12:42 PM, an interview was conducted with Housekeeper 'B' who was cleaning the 2 West Unit. Housekeeper 'B' explained they were assigned to that unit and they were required to clean each resident's room. They reported they were required to empty the trash, sweep and mop the floor, and clean any high touch surfaces. On 6/17/24 at 12:59 PM, an interview was conducted with Housekeeping Supervisor (HS) 'A'. HS 'A' reported housekeeping services were provided from 7:00 AM until 3:00 PM each day, including on the weekends. HS 'A' explained that housekeeping staff were responsible for cleaning each room in their assigned hallway which included emptying trash cans, sweeping and mopping the floors, wiping down high touch areas, and cleaning the bathroom including the toilets and sinks. When queried about any concerns about how the 2 West and 2 East units were maintained, HS 'A' reported those units were "more messy" and harder to maintain. On 6/17/24 at 1:05 PM, an observation of the			

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	second floor (2 West and 2 East Units) was conducted with HS 'A'. Upon observing R505's room, HS 'A' reported the condition was "unacceptable" and reported there have been issues with certain housekeepers not thoroughly cleaning the residents' rooms. The cup with white powder that was observed on R505's floor in the morning was no longer on the floor, but the floor remained unmopped and dirty. At 1:15 PM, R509's floor remained unmopped and dirty with food particles and crumbs. At that time, R509 was interviewed and reported nobody had been in to clean their room yet. When queried about the cleanliness of the heating and cooling units at the end of the hallway, HS 'A' reported the maintenance staff were responsible to ensure the internal components were clean and maintained and housekeeping was responsible for wiping down the external component of the unit. R510's floor appeared the have been swept and the plastic bags were removed from the bathroom, but the sink and toilet in the bathroom remained dirty. A review of R505's clinical record revealed R505 was admitted into the facility on 5/21/21. A review of a Minimum Data Set (MDS) assessment dated 5/24/24 revealed R505 had severely impaired cognition. A review of R508's clinical record revealed R508 was admitted into the facility on 8/20/20. A review of a MDS assessment dated 5/24/24 revealed R508 had severely impaired cognition. A review of R509's clinical record revealed R509 was admitted into the facility on 12/15/21. A review of a MDS assessment dated 6/6/24 revealed R509 had intact			

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	cognition. A review of R510's clinical record revealed R510 was admitted into the facility on 6/18/21. A review of a MDS assessment dated 6/6/24 revealed R510 had moderately impaired cognition. A review of a facility policy titled, "Physical Environment", dated 3/8/21, revealed, in part, the following: "...Thorough scrubbing/disinfecting shall be done for all environmental surfaces that are being cleaned in-patient care areas...In patient care areas, cleaning of non-carpeted floors and other horizontal surfaces...shall be done daily...All patient floors shall be wet-vacuumed or mopped with a disinfectant-detergent solution...Cubicle curtains shall be changed is visibly soiled...Ensure surface or item is cleaned before disinfected...Presence of organic soil will alter activity of disinfection...Checklist for Daily Cleaning of Patient Rooms...Lavatory surfaces...Waste receptacles...Floors..." On 6/17/24 at 11:58 AM, observation of the 2 East Lounge/Dining Room revealed nine residents sitting in wheelchairs and at various tables in the room. Near the middle of the room, a circular hole was observed cut into the carpet approximately 2.5 inches in diameter. On closer examination, the hole appeared to be a receptacle box where an old outlet had been in the floor. The depth of the receptacle box was approximately 3.5 inches. Wires and cables were observed down in the box. On the South wall of the Lounge/Dining Room, a cable protruding			

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	from a hole in the wall had multiple wires sticking out of it. On 6/17/24 at 12:20 PM, Certified Nursing Assistant (CNA) "J" was interviewed and asked about the hole in the carpet in the 2 East Lounge/Dining Room. CNA "J" explained the hole had been there for a while. When asked to define "a while", CNA "J" explained it had been approximately one month. CNA "J" was asked about the cable with exposed wires sticking out of the wall. CNA "J" explained she had not noticed those wires before. On 6/17/24 at 12:35 PM, the Maintenance Director was interviewed and asked about the hole cut into the carpet with exposed receptacle box. The Maintenance Director explained they would not know about the hole unless staff told them about the problem. When informed staff had said the hole had been there for one month, the Maintenance Director had no answer. Another maintenance worker was observed placing a metal plate on top of the receptacle box and screwing down to the floor with screws that were approximately 1.25 to 1.5 inches long. When asked about the cable with exposed wires sticking out of the wall, the Maintenance Director explained it was an old telephone cord. On 6/17/24 at approximately 3:10 PM, the Administrator was interviewed and asked about the receptacle box hole in the 2 East			

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	Lounge/Dining Room. The Administrator explained he had been told someone must have kicked the plate off the box. When asked how could the plate be kicked off if it was screwed to the floor, the Administrator had no answer. The Administrator was asked why the hole had been open for a month. The Administrator had no explanation.			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F0609	F609 Reporting of Allegations Resident #510 & 502 resident to resident incident was submitted to the appropriate state agency on 5/27/24. The incident was thoroughly investigated, and 5-day investigation submitted to the appropriate state agency on 6/3/24. Residents # 501 and 502 no longer reside in the facility. All residents have the potential to be affected. The DON reviewed all risk management reports in PCC for the past 60 days to ensure there were not incident/accidents that were not reported per abuse policy/reporting guidance. On 6/17/24 the policy for abuse and reporting guidelines was reviewed with the facility administrator, as well as the process for Corporate Risk Management and reporting of abuse allegations to the RNC and RDO when such allegations occur per company policy It is the intent of the facility to ensure all allegations of abuse/neglect, including but not limited to resident-to-resident interactions are reported timely. The facility will ensure all	7/8/2024

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	This citation pertains to Intake Number(s): MI00144772. Based on interview and record review, the facility failed to report an allegation of resident to resident abuse to the State Agency within the required time frame for two (R501 and R502) of four residents reviewed for abuse. Findings include: A review of a complaint submitted to the State Agency revealed "...On 05/27/2024 around 4 AM, (R501) was assaulted by (R502)...(R502) attacked (R501) twice by going into (R501's) room and punching her in the face. Night shift was present and did nothing to stop the assault. (R502) continued to enter the room of (R501) two more times. Day shift staff (Registered Nurse - RN 'H')...called the local police regarding the matter around 10:30 AM...It is unknown why staff did not report the allegations or intervened to prevent further harm to (R501)..." On 6/17/24, an unannounced onsite investigation was conducted. A review of R501's clinical record revealed R501 was admitted into the facility on 5/10/24 and discharged home on 6/7/24. A review of R501's Minimum Data Set (MDS) assessment dated 5/17/24 revealed R501 had intact cognition. A review of R501's progress notes revealed a note dated 5/27/24 at 5:10 AM, written by Licensed Practical Nurse (LPN) 'C', that noted, "Resident was awaken by another		resident incidents/accidents are reviewed in daily am clinical meeting for adherence to facility abuse/neglect policy and reporting. By 7/8/24 the facility administrator and DON will be educated on Abuse and Neglect, specifically on the reporting of all allegations of abuse/neglect per State reporting guidance. By 7/8/24 all staff will be educated on Abuse and Neglect, with emphasis of the timely notification of the abuse coordinator of any occurrences per State guidelines, education will include who to report any allegations of abuse in the event staff are unable to reach the abuse coordinator. The RNC/designee will review weekly reportable logs to ensure that facility reported allegations are reported to the State agency in a timely manner. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction and for sustained compliance thereafter. With plan of correction date of 7/8/24.	

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	resident. Resident stated, 'There resident demanded to get in her bed'. She told the resident 'No' that is when the resident hit (R501) in the face with his fist...DON (Director of Nursing), ADON (Assistant Director of Nursing)...notified. Pain medications given for the complaint of headache..." On 6/17/24 at 11:06 AM, a telephone interview was attempted with R501. R501 was not available for interview prior to the end of the survey. A review of R502's clinical record revealed R502 was admitted into the facility on 4/15/24 and discharged to the hospital on 5/27/24 with diagnoses that included: dementia with behavioral disturbance. A review of a MDS assessment dated 4/18/24 revealed R502 had severely impaired cognition. A review of R502's progress notes revealed R502 had wandering behaviors, was previously aggressive toward his wife prior to coming to the facility, was threatening and aggressive with staff, and had been found in beds that were not his on multiple occasions. A review of a progress note dated 5/27/24 at 5:41 AM, written by LPN 'C', revealed R502 entered another resident's room (R501) and demanded the resident to get out of his bed. When R501 said 'No', R502 hit the resident in the face with his fist. It was documented the DON and ADON were contacted about the allegation. A review of a progress note dated 5/27/24 at 11:00 AM, written by RN 'H', revealed, "Police arrived at the facility related to			

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	incident that occurred. After speaking with the female resident (R501) who was involved, the police decided to petition the resident out related to aggressive behaviors..." On 6/17/24 at 11:33 AM, an interview with LPN 'C' was conducted via the telephone. When queried about what happened between R501 and R502 on 5/27/24, LPN 'C' reported R502 woke up to use the bathroom at 4:00 AM and instead left his room and entered R501's room and asked her to move over so he could get into her bed. R501 told R502 no and R502 "struck (R501) with his fist". LPN 'C' reported R502 had a history of being physically aggressive with his wife who was also a resident at the facility, prior to admission into the facility. LPN 'C' reported the Certified Nursing Assistants (CNAs) assigned to the unit notified LPN 'C' of what happened. LPN 'C' explained she successfully contacted the DON and ADON and they were to notify the Administrator. LPN 'C' did not contact the police and reported she heard they came some time after her shift was over. LPN 'C's shift ended at 7:00 AM. When queried about anything put into place to prevent any further abuse by R502, LPN 'C' reported once R502 was redirected to his room, he went to sleep for the resident of the shift. On 6/17/24 at 1:27 PM, an interview with RN 'H' was conducted via the telephone. RN 'H' was the oncoming day shift nurse on 5/27/24. RN 'H' reported LPN 'C' gave report of R502 going into R501's room and "punched her a few times in the face". RN 'H' was not sure if LPN 'C' contacted the Administrator/Abuse Coordinator. RN 'H' contacted the DON and implemented one on			

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	one supervision for R502. RN 'H' explained the police were contacted by the DON and when they came to the facility they ended up petitioning R502 to the hospital for a psychiatric evaluation. A review of the facility's investigation into the resident to resident incident between R502 and R501 on 5/27/23 revealed the following: "...Date/Time Incident Discovered: 5/27/24 8:30 AM...Incident Summary: (R501) alleged that (R502) hit her in her face..." The investigation summary noted that LPN 'C' reported in a statement that the alleged incident occurred at approximately 4:00 AM and LPN 'C' documented in the clinical record about the allegation at 5:41 AM. It was documented that the State Agency was contacted on 5/27/24 at 10:33 AM, approximately six and a half hours after R501 alleged R502 punched her in the face. On 6/17/24 at 2:54 PM, an interview was conducted with the DON. The DON reported she found out about R501's allegation of abuse by R502 at approximately 9:00 AM on 5/27/24 after she discovered a missed call from the ADON. The DON reported the ADON did not leave a message and when she called the ADON back she was informed of the allegation of abuse. The DON reported she notified the police and the Administrator immediately after she became aware. On 6/17/24 at 3:07 PM, an interview with the Administrator, who was the Abuse Coordinator for the facility, was conducted. When queried about the facility's protocol when staff become aware of an allegation of abuse, the Administrator reported whomever was aware of the allegation was required to contact him immediately and the DON if he			

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	did not answer. The Administrator explained they had two hours to report allegations of abuse to the State Agency. When queried about why the allegation of abuse reported by R501 was not reported to the State Agency until 10:33 AM, the Administrator reported he was contacted by the ADON at 4:30 AM, but he did not answer the call and a message was not left. The Administrator reported at that time he did not have access to the State system used to report allegations of abuse, but the DON did have access. A review of a facility policy titled, "Abuse and Neglect", updated on 3/24/23, revealed, in part, the following, "...All allegations an/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee...All allegations of abuse will be reported to the appropriate State Agencies immediately after the initial allegation is received..."			
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00144772. Based on interview and record review, the facility failed to implement adequate	F0689	F689 Free of Accident/Hazards/Supervision Residents #501 and 502 no longer reside in the facility. All residents have the potential to be affected. Nurse C, CNA F and CNA G were educated on the abuse policy and prevention, actions to take if abuse is suspected, and how to manage residents with aggressive behaviors, including wandering, combative residents. An audit was completed to identify residents with aggressive behaviors and then broken down to also identify wandering residents with behaviors. Identified residents' behavior/mood care plans were reviewed and updated to ensure appropriate interventions are in place. Residents identified with behaviors were	7/8/2024

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	supervision for one (R502) of four residents reviewed for supervision, who had a history of wandering into other residents' rooms and aggressive behaviors, resulting in R502 entering R501's room multiple times, attempting to get into her bed, and punching her in the face multiple times. Findings include: A review of a complaint submitted to the State Agency revealed "...On 05/27/2024 around 4 AM, (R501) was assaulted by (R502)...(R502) attacked (R501) twice by going into (R501's) room and punching her in the face. Night shift was present and did nothing to stop the assault. (R502) continued to enter the room of (R501) two more times. Day shift staff (Registered Nurse - RN 'H')...called the local police regarding the matter around 10:30 AM...It is unknown why staff did not report the allegations or intervened to prevent further harm to (R501). (R501) does not have visible bruises or injuries but her face does hurt. (R501) was alert and oriented to everything around her..." On 6/17/24, an unannounced onsite investigation was conducted. A review of a "Case Report" (police report) dated 5/27/24 at 10:36 AM revealed, "On 05/27/2024 at approximately 10:36 AM, I was dispatched to (facility), in reference to a battery between two resident which had happened earlier in the morning...Interview with (R501): I interviewed (R501) in her room. At approximately 4:00 AM, (R501) was asleep and awoken by the sound of someone in her room and saw an elderly man, later identified as (R502) near her window. (R501) hit her call button at this time. (R502) then came and sat at the foot of		reviewed with the social worker and Behavioral Health services to aid in the implementation of appropriate measures for the adequate supervision of residents with aggressive behaviors. It is the intent of the facility to ensure the safety of all residents and staff. The Administrator and DON will provide special focus and oversight for the supervision of residents with aggressive behaviors, wandering, combative residents by reviewing admission referrals for such behaviors, coordinating with psych services for assessment, treatment and monitoring, also monitoring the EMR dashboard for documentation and alerts of resident behaviors for quick and timely response and management. By 7/8/24 all staff will be educated on the abuse management policy and prevention, actions to take if abuse is suspected, and how to manage residents with aggressive behaviors, including wandering combative residents. The DON/designee will audit the medical records of 5 residents identified with behaviors weekly times 4 weeks and then monthly times 3 months or until substantial compliance has been maintained to ensure that residents with aggressive behaviors have measures in place for adequate supervision. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 7/8/24 and for sustained compliance thereafter	

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	(R501's) bed. (R501) told (R502) he was not in his room. (R502) then moved a bedside table and told (R501) to 'move over so I can get in bed with you'. (R501) told (R502) 'no' and he responded to her, 'bitch I said move over'. (R502) then punched (R501). (R501) put her hands up to fight (R502) off... ...(R502) then left (R501's) room and was heard arguing with an unknown aide outside of the room. (R502) re-entered (R501's) room and closed the door. (R501) again told (R502) it was not his room. (R502) punched (R501) in her face a second time. (R502) then left out of the room and was again heard yelling at one of the aides... ...(R502) came back into (R501's) room a third time and went into her bathroom. (R502) exited and was heard yelling at the aides. (R502) re-entered (R501's) room a fourth time. (R501) again told (R502) it was not his room and he then left for a final time... ...(R501) told me she was struck in the center of her face, near the bridge of her nose, and near her right eye. (R501) did not have any obvious marks on her face but did complain of pain. (R502) declined being evaluated at the hospital...(R501) was concerned for her safety moving forward as (R502) came in and out of her room four times during the incident despite aides being aware of (R502's) behavior...While speaking with (R501), she was alert and aware. (R501) did not seem confused about (R501) battering her earlier that morning... ...Interview with (R502): I attempted to interview (R502), but it was obvious he suffered from dementia...did not recall anything happening during the early hours of			

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	the morning... ...Contact with (Director of Nursing - DON): I spoke to (DON)...by phone and explained what (R501) told me. (DON) was aware of the incident but was unaware (R502) had entered and exited (R501's) room multiple times and interacted with aides. I explained to (DON) because (R502) had assaulted another resident due to his mental state, I would be petitioning him for a mental health evaluation...(DON) further explained (R502's) wife is also a resident at (facility) and there is prior history of domestic violence between the two... ...Based on my investigation, it appears aides were aware of (R502) being in (R501's) bedroom in an agitated state and failed to act allowing (R502) to return to (R501's) room and batter her a second time..." A review of R501's clinical record revealed R501 was admitted into the facility on 5/10/24 and discharged home on 6/7/24. A review of R501's Minimum Data Set (MDS) assessment dated 5/17/24 revealed R501 had intact cognition. A review of R501's progress notes revealed a note dated 5/27/24 at 5:10 AM, written by Licensed Practical Nurse (LPN) 'C', that noted, "Resident was awaken by another resident. Resident stated, 'There resident demanded to get in her bed'. She told the resident 'No' that is when the resident hit (R501) in the face with his fist...DON (Director of Nursing), ADON (Assistant Director of Nursing)...notified. Pain medications given for the complaint of headache..."			

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	On 6/17/24 at 11:06 AM, a telephone interview was attempted with R501. R501 was not available for interview prior to the end of the survey. A review of R502's clinical record revealed R502 was admitted into the facility on 4/15/24 and discharged to the hospital on 5/27/24 with diagnoses that included: dementia with behavioral disturbance. A review of a MDS assessment dated 4/18/24 revealed R502 had severely impaired cognition. A review of a progress note dated 5/27/24 at 5:41 AM, written by LPN 'C', revealed R502 entered another resident's room (R501) and demanded the resident to get out of his bed. When R501 said 'No', R502 hit the resident in the face with his fist. It was documented the DON and ADON were contacted about the allegation. A review of a progress note dated 5/27/24 at 11:00 AM, written by RN 'H', revealed, "Police arrived at the facility related to incident that occurred. After speaking with the female resident (R501) who was involved, the police decided to petition the resident out related to aggressive behaviors..." Further review of R502's progress notes revealed the following documentation regarding his behaviors: On 4/20/24 at 1:06 AM, it was documented in a progress note that R502 took another resident's walker and was found lying in a bed of another resident. It was documented he was redirected to his room and "less than two minutes later he was back wandering in			

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	the hallways". On 4/22/24 at 4:03 PM, it was documented R502 was observed wandering into other resident's rooms. ON 5/3/24 at 5:00 AM, it was documented R502 was not in his room and was found in another room, seated in a chair without pants or a brief on. When asked to exit, R502 became combative and threatened the staff stating he would "whoop your ass". After R502 exited the room, he continued to follow the nurse up and down the hallway threatening her. On 5/6/23 at 3:57 AM, it was documented R502 was verbally abusive toward staff and threatened to his an aide. R502 made threatening gestures by putting his fists up. On 5/23/24 at 2:10 AM, it was documented R502 wandered into an unoccupied room and laid in the bed. On 6/17/24 at 11:33 AM, an interview with LPN 'C' was conducted via the telephone. When queried about what happened between R501 and R502 on 5/27/24, LPN 'C' reported R502 woke up to use the bathroom at 4:00 AM and instead left his room and entered R501's room and asked her to move over so he could get into her bed. R501 told R502 know and R502 "struck (R501) with his fist". LPN 'C' reported R502 had a history of being physically aggressive with his wife who was also a resident at the facility, prior to admission into the facility. LPN 'C' reported the Certified Nursing Assistants (CNAs) assigned to the unit notified LPN 'C' of what happened. When asked what was reported, LPN 'C' explained that R502 went into			

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	R501's room and hit her, per R501. LPN 'C' reported she was not aware that R502 entered R501's room multiple times. When queried about anything put into place to prevent any further incidents of wandering or physical abuse by R502, LPN 'C' reported once R502 was redirected to his room, she had an aide "watch him" but he went to sleep for the rest of the shift. On 6/17/24 at 11:47 AM, the Administrator was asked to provide any video footage of the 1 East Unit hallway from the midnight shift on 5/27/24. The Administrator reported he would try to obtain the footage but due to Administrative changes, the facility had been unable to access video footage from the cameras. The camera footage was not provided prior to the end of the survey. On 6/17/24 at 12:57 PM, an interview was conducted with CNA 'F' who was the CNA assigned to R502 and R501 on 5/27/24 during the midnight shift. When queried about what happened between the residents on that date, CNA 'F' reported R501 put her call light, CNA 'F' heard R501 yelling and when CNA 'F' entered her room R502 was "standing over" R501 who was on the bed. R501 was yelling, "Help! Help!" according to CNA 'F' and R502 wore only an incontinence brief. CNA 'F' explained she told R502 to get out of the room and he became "very combative" and "tried to slam the door in my face". CNA 'F' reported R502 was on the other side of the door (inside the room) and would not come out and every time CNA 'F' opened the door he tried to close it again. Eventually R502 went back to his room. According to CNA 'F', R502 had a history of wandering into other residents' rooms, but was not aware of him ever hitting another			

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	resident. On 6/17/24 at 2:19 PM, an interview was conducted with CNA 'G' who was the other CNA assigned to R502 and R501's unit on 5/27/24 midnight shift. When queried about what happened between R501 and R502 that shift, CNA 'G' reported she was on break around 4:00 AM and CNA 'F' stayed on the floor. CNA 'F' messaged CNA 'G' and asked for help managing R502's behaviors. When CNA 'G' got to R501's room, R502 was in the hallway in front of R501's room. Later in the interview, CNA 'G' reported R502 was inside of R501's room and he kept closing the door and blocking it. CNA 'G' reported they just tried to keep eyes on him to ensure he was away from R501 and eventually R502 went back to his room. CNA 'G' explained R502 had a history of wandering and threatening behaviors toward the staff. CNA 'G' stated, "He wandered into other residents' rooms and we got a lot of complaints about that". A review of R502's care plans revealed a care plan initiated on 4/22/24 that noted R502 exhibited wandering behaviors related to impaired safety awareness and a dementia diagnosis. There were no new interventions after 4/22/24. Another care plan created on 5/12/24 revealed R502 had "a behavior concern" but it did not specify what that concern was. On 6/17/24 at 2:54 PM, an interview was conducted with the DON. When queried about what should be in place for residents with repeated wandering and aggressive behaviors, the DON reported residents should have increased monitoring if they exhibit those behaviors. When queried about R502, the DON reported she was not aware			

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	that he had gotten into any other residents' beds previously or that he was aggressive. When queried about how R502 got into R501's room multiple times on 5/27/24, the DON reported she was not aware of that and was told that he was redirected out of R501's room after she alleged he hit her.			