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| SOUTH SUBURBAN REHAB CENTER | 19000 SOUTH HALSTED HOMEWOOD, IL 60430 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>Complaint Investigation<br><br>2096427/IL125777<br><br>A partial extended survey was conducted. | F 000 | | |
| F 600 SS=J | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to protect and prevent a resident (R2) from being abused by another resident (R1). The facility also failed to prevent R1 for possessing a firearm while residing in the facility. As a result, R1 fatally shot R2 with a firearm he possessed while in the facility. R2 later died from multiple gunshot wounds to the chest, arms, and legs. This was identified as an Immediate Jeopardy.<br><br>The Immediate Jeopardy began on 08/08/2020 around 3:00 AM when R1 shot and killed R2. V1 | F 600 | F 600 Freedom from Abuse, Neglect and Exploitation<br>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of any guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br><br>What corrective action will be accomplished for those residents found to | 9/8/20 |

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

Electronically Signed | 09/04/2020

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| F 600 | Continued From page 1<br>(Assistant Administrator), V10 (Administrator) and V4 (Assistant Director of Nursing) were notified of the Immediate Jeopardy on 08/12/2020. The Immediate Jeopardy was removed on 08/14/2020. However, the non-compliance remains at a level three until the facility evaluates the effectiveness of the removal plan implemented.<br><br>Findings include:<br><br>1. According to the face sheet R1 a 32-year-old male resident admitted to the facility on 7/28/2020 due to open wound of right buttock. R1's diagnoses included but were not limited to unspecified open wounds of right buttock, lower back and pelvis; sleep apnea and paraplegia.<br><br>A Brief Interview for Mental Status (BIMS) assessment dated 7/31/2020 indicated his cognitive function was intact.<br><br>According to a R1's criminal background data, R1 had convictions for possession of controlled substance, domestic battery with bodily harm, aggravated battery of officials and the unlawful possession of a weapon.<br><br>2. According to the face sheet R2 was 77-year-old male resident with diagnoses including but were not limited to unspecified mood disorder and Alzheimer's disease. R2 was admitted to the facility on 6/12/2020. The last re-admission was on 7/28/2020.<br><br>R2's progress note dated 7/13/2020 indicated R2 was being petitioned out to a local hospital due to recent behaviors. On 08/10/2020, at 11:43AM, V20 (Registered Nurse) stated, "R2 needed | F 600 | have been affected by the alleged deficient practice?<br>• R1 and R2 are no longer in the facility.<br>• R3, R4, R5, R6 and R7 remain in the facility without concern for abuse or neglect.<br><br>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?<br><br>• All residents in the facility have the potential to be affected by the alleged deficient practice.<br>• The facility has identified residents with aggressive behaviors.<br>• The facility has identified residents with criminal backgrounds / Identified Offender status.<br><br>What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not reoccur?<br>• The facility management team completed a house-wide search of resident rooms and personal property on 8/9/2020 in effort to identify if any resident had contraband items in his/her possession. Any items identified as contraband were immediately removed and secured. No weapons were discovered during the search.<br>• Facility Reception staff will continue to conduct inventory and search of all resident personal belongings brought into the facility in accordance with Contraband and Search policy.<br>• The facility has developed and | |

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| F 600 | Continued From page 2<br>increased supervision due to his verbal and physical aggression. R2's agitation would come out of nowhere; it was very sporadic."<br><br>3. The State Agency was notified about a shooting involving two residents, but no reported incident was received from the facility. The surveyor conducted interviews regarding the incident that occurred on 8/08/2020 involving R1 and R2; the following was indicated:<br><br>On 08/08/2020, at 10:00AM, R3 stated, "I was asleep, and the noise woke me up. I heard the gunshot. I could not see who it was; it was a man. The door was open. R2 was lying on the floor when I left the room after the police came. There was a lot of blood."<br><br>On 08/08/2020, at 10:15AM, R4 stated, "On 08/08/2020 at 3:01AM, I heard three-gun shots. It sounded like it was right at the door, but it was behind me in the other room. R1 was in and out of the room all night. I heard the three-gun shots and then R1 returned to the room. R1 told me he shot someone. Then R1 said it was someone else who had shot someone. I have never seen R1 or R2 talk to each other. I know staff heard the shots and no one did anything. I never saw R1 with a gun. I keep to myself. R1 was always on the go, like he was on drugs, everyday all day."<br><br>On 08/08/2020, at 10:20AM, R5 stated he heard two pops because his door was wide open.<br><br>On 08/08/2020, at 10:30AM, R6 stated, "I heard 3 gun shots early this morning. I heard that the police found a gun on R1. I used to tell R4 that R1 acted like he was on drugs. I thought | F 600 | implemented a Contraband policy in effort of identifying if contraband items are brought into the facility.<br>• Facility staff have been educated on the Contraband policy. All new employees will be educated on the policy upon hire.<br>• Facility residents have been education on the Contraband policy. All new residents will be educated upon admission to facility.<br><br>• All resident family members / representatives have been notified of the facility's Contraband & Search policy and received a copy of the same. Family members and representatives of newly admitted residents will receive notification and copy of policy upon resident admission.<br>• The facility completed an audit of all pre and post admission background checks to ensure compliance with facility's background check and Identified Offenders policies. Facility Administrator / designee will continue to audit resident pre and post admission screenings within 72 hours of resident admission, to ensure compliance.<br>• The facility SSD conducted a review of all care plans for residents identified with aggressive behaviors. Care plans have been updated for those residents identified to ensure that appropriate interventions are in place.<br>• The facility Social Services Director conducted a review of all Identified Offender care plans. The care plans have been updated to ensure that appropriate | |

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| F 600 | Continued From page 3<br>something was wrong with him because of how he acted."<br><br>On 08/09/2020, at 10:22AM, V3 (Licensed Practical Nurse/LPN) stated, "On 08/08/2020, around 3:00AM, I heard 2 gun shots. V2 (LPN) and I went and looked for help. R1 would be roaming the halls going to visit other residents all the time. I did not notice that he left the floor on 08/08/2020, because I was working on the other unit. V2 and another certified nursing assistant (CNA) worked the entire floor. There are usually two CNAs, but one CNA had to be pulled to another floor. There is no type of security. The receptionist is there until 11:30pm. After that, there is no one. The facility is always short staffed. I believe that R1 got the firearm when he eloped because he was determined to get outside of the facility."<br><br>On 08/09/2020, at 10:49AM, R7 stated, "On 08/06/2020, R1 came to my room flashing a gun around the room. R1 would not tell me where or how he got the gun. I told R1 that he could be locked up for having a gun. R1 said that he didn't care about being locked up or being in jail. R1 stated that my roommate was bothering him (R2), and they had gotten into it. I am not sure what they had gotten into it about. R1 told me that 'he was taking care of business like he always does. R1 has gotten aggressive with me before. I was scared to death when R1 showed me the gun. I was not sure if he was going to pull the trigger on me or what he was going to do. Immediately, I told V12 (CNA). V12 told me not to worry about it; he would take care of it. On 08/07/2020 in the morning, I told V11 (LPN). Staff do not always pay attention to us or care to get involved. I do not feel safe in the facility because something like | F 600 | interventions are in place.<br>• The SSD / designee will conduct 5 random, weekly audits of the care plans for residents who are Identified Offenders to ensure that care plans are comprehensive, individualized and updated in accordance with residents' assessed needs.<br><br>What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent?<br>¿ A monthly summary of all audit results will be completed and submitted in the Quality Assurance Process Improvement (QAPI) meeting for review and follow for three months, or as long as needed as determined by the committee.<br><br>Completion Date: September 8, 2020 | |

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| F 600 | Continued From page 4 | F 600 | | |

this happened once and it could happen again."

On 08/09/2020, at 11:14AM, V11 (Unit Supervisor/LPN) stated, "No one ever came to me and said that a resident had a gun. No one has ever reported anything like that to me."

On 08/09/2020, at 11:27AM, V12 (CNA) stated, "No resident has ever told me that another resident had a gun.

On 08/08/2020, at 2:04PM, V7 (LPN) stated, "On 08/07/2020 at 11:15PM. the alarms on the first floor were going off on my unit. I thought the receptionist was there, but she is only there until 11:30PM. R1 was always roaming the building due to his insomnia. R1 was like this every night. I asked R1 why the alarms were going off. R1 stated he wanted to get some fresh air. I took R1 back upstairs to his unit. A few minutes later, the alarm went off again. When I went out by the outside doors of the facility, I saw R1 was outside of the building hiding. I called staff upstairs. R1 saw me and came to the door. I told R1 that he is not allowed out of the building. I took R1 back upstairs and re-educated him that residents cannot be outside. A few minutes later, the alarm goes off for a third time. This time, V2 (LPN) was with R1. R1 was wandering the building and kept on going right through the front doors. I don't recall if V2 tried to stop R1. V2 took R1 back to the unit. About 3:00AM, V3 (LPN) came down from the second floor of the unit. She asked if I heard a noise. She wasn't sure if it was gunshots. We went upstairs; all the lights were off. R1 told me that two women had been shot on the first floor. The police were called. The police arrived and told us that R2 had been shot. Chest compressions were being performed on R2 as his

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| F 600 | Continued From page 5<br>body was being taken out of the facility."<br><br>On 08/09/2020, at 2:52PM, V2 stated, "V3 (LPN) and I heard gunshots. We took off running from the gun shots to a secure unit downstairs and called 911. I told 911 that there were gunshots and an active shooter. I told police that we were not comfortable returning to the unit until they arrived. R1's behavior was never like this before. The police told us that R1 had shot another resident. Police took over everything after that."<br><br>4. Ambulance records dated 08/08/2020 documented the following: R2 found unresponsive and not breathing. Ambulance crew found multiple gunshot wounds on the resident. Medical records from the local hospital emergency room dated 08/08/2020 documented R2 expired from multiple gunshot wounds and cardiac trauma.<br><br>On 08/08/2020, at 11:56AM, V6 (Detective) stated, "The firearm was located in the back of R1's personal wheelchair. When paramedics arrived at the scene, R2's body was on the ground. They stated that there were no signs of life. R2 was transported to a local hospital. R2 was pronounced dead at 4:11AM."<br><br>On 08/09/2020, at 12:54PM, V16 (R2's family member) stated, "I talked to the doctor that treated R2. The doctor said that R2 had been shot six times: twice in the arm; twice in the chest; twice in the leg. The physician told me R2 did not survive."<br><br>Facility policy titled Abuse Prevention Policy documents "The facility is committed to protecting our residents from abuse by anyone including, | F 600 | | |

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| F 600 | Continued From page 6<br>other residents. The facility affirms the right of our residents to be free from abuse."<br><br>5. In the absence of V10 (Administrator), V1 (Assistant Administrator) was notified the immediacy was removed on 8/14/2020 after the surveyor verified through interviews and record review of implementation of an acceptable removal plan which included the following:<br><br>On 08/09/2020, the facility's management team initiated and completed an hours-wide search of resident rooms and personal property in an effort to identify if any resident had contraband items in his/her possession. Any items identified as contraband were immediately removed and secured. No weapons were discovered during the search.<br><br>The facility developed a Contraband and Search policy on 08/11/20 in effort of identifying if contraband items are brought into the facility. The policy was reviewed and approved by facility Medical Director on 08/11/2020.<br><br>Staff training on the Contraband and Search policy was initiated on 08/11/2020, on the facility's 2nd shift. Training will continue until all staff have been in-serviced, with anticipated completion date of 8/14/20. Employees not available to receive training due to extended time off (vacation, sick, leave etc.) will be trained on policy upon return to work.<br><br>Resident education on the Contraband and Search policy was initiated on 08/12/2020 via individual visits and review of policy. This was conducted room to room by the facility's Activity staff. Education for all residents with the ability to | F 600 | | |

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| F 600 | Continued From page 7<br>comprehend policy and acknowledge the same will be completed by 08/14/20. Facility administration will send all resident's responsible parties and families a copy of the policy via email or postal mail by 08/14/2020.<br><br>The facility's Admission Staff initiated an audit of all resident's pre- and post-admission background checks on 08/10/2020 to ensure timely completion and identification of residents with criminal backgrounds (identified offenders). The full audit of resident background checks will be completed by 08/14/2020.<br><br>The facility's Social Services Director initiated a care plan review of residents with criminal background (identified offenders/IO) on 08/12/2020. All IO care plans will be reviewed and updated as needed by 8/14/2020 to ensure that appropriate interventions are in place.<br><br>The facility's Social Services Director has identified residents with aggressive behaviors and initiated review of the care plans for all identified residents on 08/12/2020. The review of all identified residents will be completed by 08/14/2020. | F 600 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. | F 655 | | 9/8/20 |

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| F 655 | Continued From page 8<br>The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to provide a baseline care plan for R1 related to his felony offenses and criminal | F 655 | F 655 Baseline Care Plan<br>Please accept the following as the facility's credible allegation of compliance. | |

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| F 655 | Continued From page 9<br>behaviors. This failure affects one of two residents (R1) reviewed for care plans in a total sample of seven residents.<br><br>Findings include:<br><br>On 07/28/2020 R1 was admitted to the facility. The facility initiated a criminal background check on R1. The results of the criminal background check were available 08/05/2020. The criminal background check documents unlawful possession of a firearm by a felon, aggravated battery, and possession of substances. The shooting incident occurred on 08/08/2020.<br><br>Review of R1's current plan of care showed there was no plan for monitoring behavior and prevention of criminal activity. The care plan did not get completed upon receipt of the criminal background information.<br><br>On 08/10/2020, at 9:25AM, V17 (Admissions Director) stated, "When the background check is received, I give it to social services. Social services then gives it to the identified offenders program."<br><br>On 08/10/2020, at 10:23AM, V14 (Social Worker) stated, "I received an email from the admissions department that the background check was in my mailbox on the evening of August 6th. I left early on August 7th. I put the background check on my desk to be completed upon my return. No one completes documentation for identified offenders when I am absent. I have no idea why no one completes them in my absence. R1 identified that he was sad, had loss of appetite, and just wanted to leave. R1 reported that he had been in a mental institution at one point in his life. The | F 655 | This plan of correction does not constitute an admission of any guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br><br>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?<br><br>• R1 is no longer in the facility.<br><br>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?<br><br>• The facility has identified residents with criminal backgrounds / Identified Offender status.<br><br>What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not reoccur?<br>• The facility's Admissions and Social Services staff have been re-educated on the facility's admission screening and Identified Offenders policies and related protocols.<br>• The facility completed an audit of all pre and post admission background checks to ensure compliance with facility's background check and Identified Offenders policies.<br>• Completion of admission screenings and Identified Offender processes will be documented by the facility Admissions Director and Social Services Director. The | |

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| F 655 | Continued From page 10<br>mental institution where R1 resided is known for treating patients with conduct and behavior issues."<br><br>Facility Policy titled Identified Offender Facility Policy and Procedure, undated, documents "Upon admission of an identified offender or the decision to retain an identified offender, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care. The facility shall remain responsible for continuously evaluating the identified offender and for making any changes in the care plan that are necessary to ensure the safety of the residents." | F 655 | facility Administrator / designee will review documentation on a weekly basis to ensure compliance.<br>• The facility Social Services Director conducted a review of all Identified Offender care plans. The care plans have been updated to ensure that appropriate interventions are in place.<br>• The SSD / designee will conduct 5 random, weekly audits of the care plans for residents who are Identified Offenders to ensure that care plans are comprehensive, individualized and updated in accordance with residents' assessed needs.<br><br>What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent?<br>¿ A monthly summary of all audit results will be completed and submitted in the Quality Assurance Process Improvement (QAPI) meeting for review and follow for three months, or as long as needed as determined by the committee. | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. | F 689 | | 9/8/20 |

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| F 689 | Continued From page 11<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to supervise and monitor residents who had potential to bring and/or use a weapon into the facility. The facility also failed to plan and implement individualized monitoring and supervision interventions to address a resident's negative behavior or the potential to have negative behaviors. As a result, R1 fatally shot R2 with a firearm he possessed while in the facility. R2 later died from multiple gunshot wounds to the chest, arms and legs. This was identified as an Immediate Jeopardy.<br><br>The Immediate Jeopardy began on 08/08/2020 around 3:00 AM when R1 shot and killed R2. V1 (Assistant Administrator), V10 (Administrator) and V4 (Assistant Director of Nursing) were notified of the Immediate Jeopardy on 08/12/2020. The Immediate Jeopardy was removed on 08/14/2020. However, the non-compliance remains at a level three until the facility evaluates the effectiveness of the removal plan implemented.<br><br>Findings include:<br><br>1. According to the face sheet R1 a 32-year-old male resident who was admitted to the facility on 7/28/2020 due to an open wound of the right buttock. R1's diagnoses included but were not limited to unspecified open wounds of right buttock, lower back and pelvis; sleep apnea and paraplegia.<br><br>A Brief Interview for Mental Status (BIMS) assessment dated 7/31/2020 indicated his cognitive function was intact. | F 689 | F 689 Free of Accident Hazards / Supervision / Devices<br>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of any guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br><br>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?<br>• R1 and R2 are no longer in the facility.<br><br>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?<br><br>• All residents in the facility have the potential to be affected by the alleged deficient practice.<br>• The facility has identified residents with aggressive behaviors.<br>• The facility has identified residents with criminal backgrounds / Identified Offender status.<br><br>What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not reoccur?<br>• The facility management team completed a house-wide search of resident rooms and personal property on 8/9/2020 in effort to identify if any resident | |

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| F 689 | Continued From page 12<br><br>The facility initiated a criminal background check on R1. The result of R1's criminal background check was available 08/05/2020. According to a R1's criminal background data, R1 had convictions for possession of controlled substance, domestic battery with bodily harm, aggravated battery of officials and the unlawful possession of a firearm.<br><br>On 08/10/2020, at 10:23 AM, V14 (Social Worker) stated, "I received an email from the admissions department that the background check was in my mailbox on the evening of August 6th. I left early on August 7th. I put the background check on my desk to be completed upon my return. No one completes documentation for identified offenders when I am absent. I have no idea why no one completes them in my absence. R1 indicated he was sad, had a loss of appetite, and just wanted to leave. R1 reported that he had been in a mental institution at one point in his life. The facility that the resident was in usually deals with conduct and behaviors."<br><br>R1's comprehensive care plan that correlated with the last care conference dated 8/03/2020 did not contain a potential for criminal behavior based on R1's criminal history for monitoring and supervision of R1's activities.<br><br>2. According to the face sheet R2 was 77-year-old male with diagnoses including but were not limited to unspecified mood disorder and Alzheimer's disease. R2 was admitted to the facility on 6/12/2020. The last re-admission was on 7/28/2020. R2's progress notes note dated 7/13/2020 indicated R2 was being petitioned out | F 689 | had contraband items in his/her possession. Any items identified as contraband were immediately removed and secured. No weapons were discovered during the search.<br>• Facility Reception staff will continue to conduct inventory and search of all resident personal belongings brought into the facility in accordance with Contraband and Search policy.<br>• The facility has developed and implemented a Contraband policy in effort of identifying if contraband items are brought into the facility.<br>• Facility staff have been educated on the Contraband policy. All new employees will be educated on the policy upon hire.<br>• Facility residents have been education on the Contraband policy. All new residents will be educated upon admission to facility.<br><br>• All resident family members / representatives have been notified of the facility's Contraband & Search policy and received a copy of the same. Family members and representatives of newly admitted residents will receive notification and copy of policy upon resident admission.<br>• The facility completed an audit of all pre and post admission background checks to ensure compliance with facility's background check and Identified Offenders policies. Facility Administrator / designee will continue to audit resident pre and post admission screenings within 72 hours of resident admission, to ensure | |

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| F 689 | Continued From page 13<br>to a local hospital due to recent behaviors.<br><br>R2's admission Minimum Data Set (MDS) assessment dated 6/23/2020 indicated R2 was moderately cognitively impaired with a BIMS score of 8. R2 was noted to have verbal behavioral symptoms directed toward others (e.g. threatening, screaming, cursing). R2 had a history of being significantly disruptive in his living environment. R2 also had a history of wandering, placing him at risk for potential elopement.<br><br>On 08/10/2020, at 11:43AM, V20 (Registered Nurse) stated, "R2 needed increased supervision due to his verbal and physical aggression. R2's agitation would come out of nowhere. It was very sporadic."<br><br>R2's progress notes contained the following regarding behaviors:<br><br>06/14/2020, R2 continually pushes on all alarmed doors attempting to get out of the facility. R2 refuses to be re-directed, uses continuous belligerent behavior toward staff and uses curse words. V16 (R1's family member) called in attempt to calm R2; stated leaving facility now. The psychologist was notified and R2 petitioned to local hospital. On 06/14/2020, at 1:03PM, facility was notified R2 would be returning to the facility because the doctor did not see any reason to keep or medicate R2. The psychologist stated he would not prescribe any medication at this time because he does not think R2 liked the facility and medication would not solve the issue. Social workers need to follow up with R2 the next day.<br><br>06/14/2020, at 6:35PM, R2 noted getting out of | F 689 | compliance.<br>• The facility's Social Services staff have been re-educated on providing and documenting follow-up, including assessment, interventions and care plan updates related to resident presentation of problematic behaviors and/or behavioral incidents.<br>• The facility SSD conducted a review of all care plans for residents identified with aggressive behaviors. Care plans have been updated for those residents identified to ensure that appropriate interventions are in place.<br>• The facility Social Services Director conducted a review of all Identified Offender care plans. The care plans have been updated to ensure that appropriate interventions are in place.<br>• The SSD / designee will conduct 5 random, weekly audits of the care plans for residents who are Identified Offenders to ensure that care plans are comprehensive, individualized and updated in accordance with residents' assessed needs.<br><br>What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent?<br>¿ A monthly summary of all audit results will be completed and submitted in the Quality Assurance Process Improvement (QAPI) meeting for review and follow for three months, or as long as needed as determined by the committee. | |

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bed and continuously trying to exit the facility, being belligerent, and using curse words when staff try to redirect R2. The psychologist was notified and R2 was again petitioned to a local hospital. On 06/17/2020, R2 returned to the facility.

06/22/2020, R2 required frequent redirecting, and up all through the night with short periods of sleep.

06/23/2020, R2 displayed impulsive behavior related to running out of the facility and attempting to leave the facility unauthorized. R2 is also verbally aggressive towards staff, threatening to become physical. R2 does not yield to redirection.

06/24/2020, at 9:30AM, R2 observed pushing bar to gain access outside to exit the facility. R2 stated to not worry about what he is doing and leave him alone. R2 redirected and eventually moved from the door. At 10:35AM, R2 observed trying to exit the facility, using profanity, and holding up balled fists. R2 redirected away from the area. At 11:00AM, door alarm was beeping. R2 observed standing outside the door. Social services noted of an attempt to elope. At 11:10AM, R2 noted with multiple attempts to elope, verbal and physical aggression towards staff. R2 was sent to local hospital for psychological evaluation.

06/26/2020, R2 returned to the facility. On 06/26/2020, at 9:30PM, R2 observed with increased agitation, stating he wants to leave the facility, pushing exit doors in an attempt to leave the facility. Several attempts made to redirect. The psychologist did not prescribe any

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medication at this time because he believes the behavior stems from R2 not wanting to be in the facility. Gave orders to petition out R2 out to local hospital. On 06/27/2020, R2 returned to the facility.

On 07/02/2020, at 9:17AM, R2 observed pushing the exit doors and went outside. V20 (Registered Nurse) attempted to bring R2 back into the facility and R2 began to hit, punch, and choke V20, along with digging his nails into V20's skin. V20 was able to bring R2 back into the building with the help of a nurse's aide. At 9:53AM, R2 presented with aggressive and impulsive behaviors. R2 attempted to leave the facility. When staff tried to redirect R2 back into the facility, R2 became combative, punching, choking and scratching staff being very irate and aggressive. R2 would not yield to redirection. The psychologist was made aware and R2 was sent out to local hospital for psychological evaluation. On 07/02/2020, V20 stated that R2 quickly has aggressive behaviors and then reverts to a calm state. R2's calm state is for a short period of time and then the aggressive behavior would return.

On 07/07/2020, R2 was readmitted to the facility. On 07/11/2020, R2 observed going through roommate's belongings. Staff attempted to redirect R2 and R2 became aggressive. Psychotropic medications given. On 07/13/2020, R2 was observed walking the halls demanding to call his job and tell them that he would be late. Staff tried to redirect R2 numerous times.

07/13/2020, at 1:31PM, V14 (Social Worker) informed V16 that R2 would be involuntary admitted to the hospital, due to R2's recent behaviors. On 07/28/2020, R2 was readmitted

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back to the facility to a new room on the second floor of the nursing facility.

Record review of R2's comprehensive care plan dated 6/18/2020 noted the behavior problem of episodes of verbal/physical behavioral symptoms directed toward other. The interventions included the following:
-Anticipate resident's needs in order to decrease verbal/physical behavioral symptoms. Re-direct and intervene during periods of increased agitation
-Refer to psychologist/psychiatrist for behavior management as needed.
-Social Services to assess for aggression.

There were no changes in these interventions after any of R2's hospitalizations for behaviors, nor was there any individualized monitoring or supervision care plan for R2.

3. The State Agency was notified about a shooting involving two residents, but no initial reported incident was received from the facility. The surveyor conducted interviews regarding the incident that occurred on 8/08/2020 involving R1 and R2. The following was indicated:

On 08/08/2020, at 10:00AM, R3 stated, "I was asleep, and the noise woke me up. I heard the gunshot. I could not see who it was; it was a man. The door was open. R2 was lying on the floor when I left the room after the police came. There was a lot of blood."

On 08/08/2020, at 10:15AM, R4 stated, "On 08/08/2020 at 3:01AM, I heard 3 gun shots. It sounded like it was right at the door, but it was behind me in the other room. R1 was in and out

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of the room all night. I heard the 3 gun shots and then R1 returned to the room. R1 told me he shot someone. Then R1 said it was someone else who had shot someone. I have never seen R1 or R2 talk to each other. I know staff heard the shots and no one did anything. I never saw R1 with a gun. I keep to myself. R1 was always on the go like he was on drugs, everyday all day."

On 08/08/2020, at 10:20AM, R5 stated he heard two pops because his door was wide open.

On 08/08/2020, at 10:30AM, R6 stated, "I heard 3 gun shots early this morning. I heard that the police found a gun on R1. I used to tell R4 that R1 acted like he was on drugs. I thought something was wrong with him because of how he acted."

On 08/09/2020, at 10:22AM, V3 (Licensed Practical Nurse/LPN) stated, "On 08/08/2020, around 3:00AM, I heard 2 gun shots. V2 (LPN) and I went and looked for help. R1 would be roaming the halls going to visit other residents all the time. I did not notice that he left the floor on 08/08/2020, because I was working on the other unit. It was just V2 and another certified nursing assistant (CNA) for the entire floor. There is usually two CNAs, but one CNA had to be pulled to another floor. There is no type of security. The receptionist is there until 11:30pm. After that, there is no one. The facility is always short staffed. I believe that R1 got the firearm when he eloped because he was determined to get outside of the facility."

On 08/09/2020, at 10:49AM, R7 stated, "On 08/06/2020, R1 came to my room flashing a gun around the room. R1 would not tell me where or

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how he got the gun. I told R1 that he could be locked up for having a gun. R1 said that he didn't care about being locked up or being in jail. R1 stated that his roommate (R2) was bothering him, and they had gotten into it. I am not sure what they had gotten into it about. R1 told me that he was taking care of business like he always does. R1 has gotten aggressive with me before. I was scared to death when R1 showed me the gun. I was not sure if he was going to pull the trigger on me or what he was going to do. Immediately, I told V12 (Certified Nursing Assistant/CNA). V12 told me not to worry about it; he would take care of it. On 08/07/2020 in the morning, I told V11 (LPN). Staff do not always pay attention to us or care to get involved. I do not feel safe in the facility because something like this happened once and it could happen again."

On 08/09/2020, at 11:14AM, V11 (LPN) stated, "No one ever came to me and said that a resident had a gun. No has ever reported anything like that to me."

On 08/09/2020, at 11:27AM, V12 (CNA) stated, "No resident has ever told me another resident had a gun."

On 08/08/2020, at 2:04PM, V7 (LPN) stated, "On 08/07/2020 at 11:15PM. the alarms on the first floor were going off on my unit. I thought the receptionist was there, but she is only there until 11:30PM. R1 was always roaming the building due to his insomnia. R1 was like this every night. I asked R1 why the alarms were going off. R1 stated he wanted to get some fresh air. I took R1 back upstairs to his unit. A few minutes later, the alarm went off again. When I went out by the outside doors of the facility, I saw R1 outside of

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the building hiding. I called staff upstairs. R1 saw me and came to the door. I told R1 that he is not allowed out of the building. I took R1 back upstairs and re-educated him that residents cannot be outside. A few minutes later, the alarm goes off for a third time. This time, V2 (LPN) was with R1. R1 was wandering the building and kept on going right through the front doors. I don't recall if V2 tried to stop R1. V2 took R1 back to the unit. About 3:00AM, V3 (LPN) came down from the second floor of the unit. She asked if I heard a noise. She wasn't sure if it was gunshots. We went upstairs; all the lights were off. R1 told me that two women had been shot on the first floor. The police were called. The police arrived and told us that R2 had been shot. Chest compressions were being performed on R2 as his body was being taken out of the facility."

08/09/2020, at 2:52PM, V2 stated, "V3 and me heard gunshots. We took off running away from the gun shots to a secure unit downstairs and called 911. I told 911 that there were gunshots and an active shooter. I told police that we were not comfortable returning to the unit until they arrived. R1's behavior was never like this before. The police told us that R1 had shot another resident. Police took over everything after that."

4. Ambulance records dated 08/08/2020 documented the following: R2 found unresponsive and not breathing. Ambulance crew found multiple gunshot wounds on the resident. Medical records from the local hospital emergency room dated 08/08/2020 documented the following: R2 expired from multiple gunshot wounds and cardiac trauma.

On 08/08/2020, at 11:56AM, V6 (Detective)

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stated, "The firearm was located in the back of R1's personal wheelchair. When paramedics arrived at the scene, R2's body was on the ground. They stated that there were no signs of life. R2 was transported to a local hospital. R2 was pronounced dead at 4:11AM."

On 08/09/2020, at 12:54PM, V16 (R2's family member) stated, "I talked to the doctor that treated R2. The doctor said that R2 had been shot six times: twice in the arm; twice in the chest; twice in the leg. The physician told me R2 did not survive."

On 08/10/2020, V1 (Assistant Administrator) stated, "We do not have a contraband policy."

On 08/10/2020, at 11:46, V10 (Administrator) stated, "There is no failure; we are doing what we are supposed to be doing, in regard to screening the residents."

5. In the absence of V10 (Administrator), V1 (Assistant Administrator) was notified the immediacy was removed on 8/14/2020 after the surveyor verified through interviews and record review of implementation of an acceptable removal plan that included the following:

On 08/09/2020, the facility's management team initiated and completed an hours-wide search of resident rooms and personal property in an effort to identify if any resident had contraband items in his/her possession. Any items identified as contraband were immediately removed and secured. No weapons were discovered during the search.

The facility developed a Contraband and Search

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| F 689 | Continued From page 21<br>policy on 08/11/20 in effort of identifying if contraband items are brought into the facility. The policy was reviewed and approved by facility Medical Director on 08/11/2020.<br><br>Staff training on the Contraband and Search policy was initiated on 08/11/2020, on the facility's 2nd shift. Training will continue until all staff have been in-serviced, with anticipated completion date of 8/14/20. Employees not available to receive training due to extended time off (vacation, sick, leave etc.) will be trained on policy upon return to work.<br><br>Resident education on the Contraband and Search policy was initiated on 08/12/2020 via individual visits and review of policy. This way conducted room to room by the facility's Activity staff. Education for all residents with ability to comprehend policy and acknowledge the same will be completed by 08/14/20. Facility administration will send all residents' responsible parties and families a copy of the policy via email or postal mail by 08/14/2020<br><br>The facility's Admission Staff initiated an audit of all resident's pre- and post-admission background checks on 08/10/2020 to ensure timely completion and identification of residents with criminal backgrounds (identified offenders). The full audit of resident background checks will be completed by 08/14/2020.<br><br>The facility's Social Services Director initiated a care plan review of residents with criminal background (identified offenders/IO) on 08/12/2020. All IO care plans will be reviewed and updated as needed by 8/14/2020 to ensure that appropriate interventions are in place. | F 689 | | |

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| F 689 | Continued From page 22<br><br>The facility's Social Services Director has identified residents with aggressive behaviors and initiated review of the care plans for all identified residents on 08/12/2020. The review of all identified residents will be completed by 08/14/2020. | F 689 | | |
| F 725 SS=E | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced | F 725 | | 9/8/20 |

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| F 725 | Continued From page 23<br>by:<br>Based on interview and record review, the facility failed to provide sufficient nursing staff to the residents for supervision and care of residents. This failure has the potential to affect 54 residents residing on the facility's second floor.<br><br>Findings include:<br><br>On 08/08/2020, at 2:04PM, V7 (Licensed Practical Nurse/LPN) stated, "On 08/07/2020 at 11:15PM. the alarms on the first floor were going off on my unit. I thought the receptionist was there, but she is only there until 11:30PM. R1 was always roaming the building due to his insomnia. R1 was like this every night. I asked R1 why the alarms were going off. R1 stated he wanted to get some fresh air. I took R1 back upstairs to his unit. A few minutes later, the alarm went off again. When I went out by the outside doors the facility, I saw R1 was outside of the building hiding. I called staff upstairs. R1 saw me and came to the door. I told R1 that he is not allowed out of the building. I took R1 back upstairs and re-educated him that residents cannot be outside. A few minutes later, the alarm goes off for a third time. This time, V2 (LPN) was with R1. R1 was wandering the building and kept on going right through the front doors. I don't recall if V2 tried to stop R1. V2 took R1 back to the unit. About 3:00AM, V3 (LPN) came down from the second floor of the unit. She asked if I heard a noise. She wasn't sure if it was gunshots. We went upstairs; all the lights were off. R1 told me that two women had been shot on the first floor. The police were called. The police arrived and told us that R2 had been shot. Chest compressions were being performed on R2 as his body was being taken out of the facility." | F 725 | F 725 Sufficient Nursing Staffing<br>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of any guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br><br>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?<br>• R1 and R2 are no longer in the facility.<br><br>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?<br><br>• All residents in the facility have the potential to be affected by the alleged deficient practice.<br><br>What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not reoccur?<br>• The facility staffing coordinator and nursing management team have been re-educated on ensuring sufficient staffing in accordance with the facility's census and acuity levels on each unit.<br>• The facility DON/designee will review staffing daily to ensure that facility is sufficiently staffed in accordance with each unit's census and acuity; and as needed to meet the basic needs of the residents. | |

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| F 725 | Continued From page 24<br>On 08/09/2020, at 2:52PM, V2 stated, "V3 and I heard gunshots. We took off running from the gun shots to a secure unit downstairs and called 911. I told 911 that there were gunshots and an active shooter. I told police that we were not comfortable returning to the unit until they arrived. R1's behavior was never like this before. The police told us that R1 had shot another resident. Police took over everything after that."<br><br>On 08/09/2020, at 10:22AM, V3 (LPN) stated, "It was just V2 (LPN) and another certified nursing assistant (CNA) for the entire floor. There is usually two CNAs, but one CNA had to be pulled to another floor. The facility is always short staffed."<br><br>Review of the facility staffing for the unit on which the incident occurred, on the 11:00PM to 7:00AM shift, from July 26th, 2020 to August 9th, 2020, documents the following:<br><br>07/26/2020, two nurses and two certified nursing assistants (CNAs); 07/27/2020, two nurses and one CNA; 07/28/2020, two nurses and two CNAs;<br>07/29/2020, two nurses and two CNAs;<br>07/30/2020, two nurses and two CNAs;<br>07/31/2020, two nurses and two CNAs;<br>08/01/2020, two nurses and two CNAs;<br>08/02/2020, two nurses and two CNAs;<br>08/03/2020, two nurses and two CNAs;<br>08/04/2020; two nurses and two CNAs;<br>08/05/2020, two nurses and two CNAs;<br>08/06/2020, two nurses and two CNAs;<br>08/07/2020, two nurses and one CNA;<br>08/08/2020, two nurses and one CNA;<br>08/09/2020, one nurse and two CNAs.<br><br>On 08/13/2020, at 11:39AM, V22 (Scheduler) | F 725 | • The facility DON / designee will conduct a census / acuity review 2 times monthly to ensure that staffing and assignments are being appropriately developed in accordance with residents' needs.<br>• The facility has signed contracts with multiple staffing agencies to ensure adequate staffing<br>• The facility has started using contract nurses to ensure required staffing levels are met.<br><br>What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent?<br>¿ A monthly summary of all audit results will be completed and submitted in the Quality Assurance Process Improvement (QAPI) meeting for review and follow for three months, or as long as needed as determined by the committee. | |

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| F 725 | Continued From page 25<br>stated, "On the 11:00PM to 7:00AM shifts, the facility prefers three CNAs (Certified Nursing Assistants), but it can work with two. With only two CNAs, the CNAs will have 22 residents a piece, but we ask that the nurses step into help. If there is one only CNA, that will leave he/she with 54 residents, but the nurses have to help with the resident's care. I have had the CNAs complain about the nurses not helping and that it is hard to provide care to the residents." | F 725 | | |
| F 744 SS=D | Treatment/Service for Dementia<br>CFR(s): 483.40(b)(3)<br><br>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to modify interventions and provide services to prevent or decrease aggressive behaviors for a resident (R2) with dementia who returned from the hospital due to behaviors. This failure affects one of seven residents reviewed for behaviors in a total sample of seven.<br><br>Findings include:<br><br>R2 has diagnoses of Alzheimer's disease and dementia. R2 was readmitted to the facility on 07/28/2020.<br><br>On 08/10/2020, at 11:43AM, V20 (Registered Nurse) stated, "R2 needed increased supervision due to his verbal and physical aggression. R2's agitation would come out if now where. It was | F 744 | F 744 Treatment / Services for Dementia<br>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of any guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br><br>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?<br><br>• R2 is no longer in the facility.<br><br>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? | 9/8/20 |

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| F 744 | Continued From page 26<br>very sporadic."<br><br>On 08/10/2020, at 11:56AM, V19 (former Director of Nursing) stated, "R2 was trying to get out of the memory care unit many times; when he was redirected, he got aggressive. R2 was sent out to a local hospital for aggression. R2 returned to the memory care unit when he came back from the hospital. R2 tried to go out again, and a nurse tried to redirect him and he got aggressive. I said let's put R2 on the second floor so he would not be so close to the doors. The second-floor unit was recommended because a private room was available."<br><br>Review of R2's progress notes documents various behaviors which included the following:<br><br>Progress note dated 06/14/2020 notes R2 continually pushes on all alarmed doors attempting to get out of the facility. R2 refuses to be redirected, uses continuous belligerent behavior toward staff and uses curse words. V16 (R2's family member) called in attempt to calm down R2. R2 stated leaving facility now. The psychologist was notified and R2 petitioned to local hospital.<br><br>On 06/14/2020, at 1:03PM, facility notified that R2 will be returning to the facility because the doctor did not see any reason to keep or medicate R2. The psychologist stated he would not prescribe any medication at this time because he does not think R2 liked the facility and medication would not solve the issue. Social workers need to follow up with R2 the next day.<br><br>On 06/14/2020, at 6:35PM, R2 noted getting out of bed and continuously trying to exit the facility, | F 744 | • The facility has identified residents with aggressive behaviors.<br><br>What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not reoccur?<br>• The facility's Nursing and Social Services staff has been re-educated on managing residents with aggressive behaviors and documentation of appropriate follow-up and interventions.<br>• The facility's Social Services staff has been re-educated on providing and documenting follow-up, including assessment, interventions and care plan updates related to resident presentation of problematic behaviors and/or behavioral incidents.<br>• The facility SSD conducted a review of all care plans for residents identified with aggressive behaviors. Care plans have been updated for those residents identified to ensure that appropriate interventions are in place.<br>• The SSD / designee will conduct 5 random, weekly audits of the care plans for aggressive residents to ensure that they are comprehensive, individualized and updated in accordance with residents' assessed needs.<br><br>What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent?<br>¿ A monthly summary of all audit results will be completed and submitted in the | |

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| F 744 | Continued From page 27<br>being belligerent, and using curse words when staff try to redirect R2. The psychologist was notified and R2 was again petitioned to a local hospital. On 06/17/2020, R2 returned to the facility.<br><br>Progress note dated 06/22/2020, notes R2 required frequent redirecting, and up all through the night with short periods of sleep. On 06/23/2020, R2 displayed impulsive behavior related to running out of the facility and attempting to leave the facility unauthorized. R2 is also verbally aggressive towards staff, threatening to become physical. R2 does not yield to redirection. As needed medication given.<br><br>The facility follow-up report dated 06/23/2020 notes no follow-up with R2 or power of attorney; no indication of care plan update.<br><br>On 06/24/2020, at 9:30AM, R2 observed pushing bar to gain access outside to exit the facility. R2 stated to not worry about what he is doing and leave him alone. R2 redirected and eventually moves from the door. At 10:35AM, R2 observed trying to exit the facility, using profanity, and holding up balled fists. R2 redirected away from the area. At 11:00AM, door alarm was beeping. R2 observed standing outside the door. Social services notified of an attempt to elope. At 11:10AM, R2 noted with multiple attempts to elope, verbal and physical aggression towards staff. R2 was sent to local hospital for psychological evaluation. On 06/26/2020, R2 returned to the facility.<br><br>On 06/26/2020, at 9:30PM, R2 noted with increased agitation, stating he wants to leave the facility, pushing exit doors in an attempt to leave | F 744 | Quality Assurance Process Improvement (QAPI) meeting for review and follow for three months, or as long as needed as determined by the committee. | |

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| F 744 | Continued From page 28 | F 744 | | |

the facility. Several attempts made to redirect. The psychologist did not prescribe any medication at this time because he believes the behavior stems from R2 not wanting to be in the facility. Orders given to petition R2 out to local hospital. On 06/27/2020, R2 returned to the facility.

On 07/02/2020, at 9:17AM, R2 observed pushing the exit doors and went outside. V20 (Registered Nurse) attempted to bring R2 back into the facility and R2 began to hit, punch, and choke V20, along with digging his nails into V20's skin. V20 was able to bring R2 back into the building with the help of a nurse's aide. At 9:53AM, R2 presented with aggressive and impulsive behaviors. R2 attempted to leave the facility. When staff tried to redirect R2 back into the facility, R2 became combative, punching, choking and scratching staff, being very irate and aggressive. R2 would not yield to redirection. The psychologist was made aware and R2 was sent out to local hospital for psychological evaluation. On 07/02/2020, V20 stated R2 quickly has aggressive behaviors and then reverts to a calm state. R2's calm state is for a short period of time and then aggression returns.

Three day follow up report 07/08/2020 does not indicate care plan updates.

On 07/07/2020, R2 was readmitted to the facility. On 07/11/2020, R2 observed to be going through roommate's belongings. Staff attempted to redirect R2 and R2 became aggressive. Psychotropic medications given. On 07/13/2020, R2 was observed walking the halls demanding to call his job and tell them that he would be late. Staff tried to redirect R2 numerous times. On

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| F 744 | Continued From page 29<br>07/13/2020, at 1:31PM, V14 (Social Worker) informed V16 that R2 would be involuntary admitted to the hospital due to R2's recent behaviors. On 07/28/2020, R2 was readmitted back to the facility to a new room on the second floor of the nursing facility.<br><br>On 08/11/2020, R2's care plan was reviewed. No care plan updates, interventions, or initiation dates documented. No new interventions or modifications were documented. | F 744 | | |
| F 835 SS=F | Administration<br>CFR(s): 483.70<br><br>§483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility administration failed to have policies and procedures in place to prevent a resident (R1) from bringing in and possessing a gun while in the facility. This failure has the potential to affect all residents residing in the facility.<br><br>Findings include:<br><br>On 07/28/2020, R1 was admitted to the facility. The facility initiated a criminal background check on R1. The results of the criminal background check were available 08/05/2020. According to a R1's criminal background data, R1 had convictions for possession of controlled substance, domestic battery with bodily harm, | F 835 | F 835 Administration<br>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of any guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br><br>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?<br>• R1 and R2 are no longer in the facility.<br><br>How will the facility identify other residents | 9/8/20 |

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| F 835 | Continued From page 30<br>aggravated battery of officials and the unlawful possession of a weapon. The shooting incident occurred on 08/08/2020.<br><br>Progress notes dated 08/08/2020, at 3:04 AM, document sounds of gunshots heard on R1 and R2's unit.<br><br>On 08/08/2020, at 10:00AM, R3 stated, "I was asleep and the noise woke me up. I heard the gunshot. I could not see who it was; it was a man. The door was open. R2 was lying on the floor when I left the room after the police came. There was a lot of blood."<br><br>On 08/08/2020, at 10:15AM, R4 stated, "On 08/08/2020, at 3:01AM, I heard 3 gun shots. It sounded like it was right at the door, but it was behind me in the other room. R1 was in and out of the room all night. I heard the 3 gun shots and then R1 returned to the room. R1 told me he shot someone. Then R1 said it was someone else who had shot someone. I know staff heard the shots and no one did anything."<br><br>On 08/08/2020, at 10:20AM, R5 stated he heard two pops because his door was wide open.<br><br>On 08/08/2020, at 10:30AM, R6 stated, "I heard 3 gun shots early this morning. I heard that the police found a gun on R1. I used to tell R4 that R1 acted like he was on drugs. I thought something was wrong with him because of how he acted."<br><br>On 08/08/2020, at 2:04PM, V7 (Licensed Practical Nurse/LPN) stated, "R1 was always roaming the building due to his insomnia. R1 was like this every night. About 3:00AM, V3 (LPN) | F 835 | having the potential to be affected by the same alleged deficient practice?<br><br>• All residents in the facility have the potential to be affected by the alleged deficient practice.<br><br>What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not reoccur?<br>• The facility management team completed a house-wide search of resident rooms and personal property on 8/9/2020 in effort to identify if any resident had contraband items in his/her possession. Any items identified as contraband were immediately removed and secured. No weapons were discovered during the search.<br>• Facility Reception staff will continue to conduct inventory and search of all resident personal belongings brought into the facility in accordance with Contraband and Search policy.<br>• The facility has developed and implemented a Contraband policy in effort of identifying if contraband items are brought into the facility.<br>• Facility staff have been educated on the Contraband policy. All new employees will be educated on the policy upon hire.<br>• Facility residents have been education on the Contraband policy. All new residents will be educated upon admission to facility.<br>• All resident family members / representatives have been notified of the | |

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| F 835 | Continued From page 31<br>came down front the second floor of the unit. She asked if I heard a noise. She wasn't sure if it was gunshots. We went upstairs; all the lights were off. R1 told me that two women has been shot on the first floor. The police were called. The police arrived and told us that R2 had been shot. Chest compressions were being performed on R2 as his body was being taken out of the facility."<br><br>On 08/09/2020, at 10:22AM, V3 (LPN) stated, "On 08/08/2020, around 3:00AM, I heard 2 gun shots. V2 (LPN) and myself went and looked for help. R1 would be roaming the halls going to visit other residents all the time. I did not notice that he left the floor on 08/08/2020, because I was working on the other unit. It was just V2 and another certified nursing assistant (CNA) for the entire floor. There is usually two CNAs, but one CNA had to be pulled to another floor. There is no type of security. The receptionist is there until 11:30pm. After that, there is no one. The facility is always short staffed. I believe that R1 got the firearm when he eloped because he was determined to get outside of the facility."<br><br>On 08/08/2020, at 2:35PM, V8 (CNA) stated, "On 08/08/2020, at 3:00AM, I was doing my rounds. I saw R1 in the hallway looking at what I was doing. It looked like he was going to go out the side door. R1 then went back to his room. I heard 2 shots. I wondered what it was. The nurses called administration and I started closing residents' doors."<br><br>08/09/2020, at 2:52PM, V2 stated, "V3 and myself heard gunshots. We took off running away from the gun shots to a secure unit downstairs and called 911. I told 911 that there were gunshots and an active shooter. I told police that | F 835 | facility's Contraband & Search policy and received a copy of the same. Family members and representatives of newly admitted residents will receive notification and copy of policy upon resident admission.<br>What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent?<br>¿ A monthly summary of all audit results will be completed and submitted in the Quality Assurance Process Improvement (QAPI) meeting for review and follow for three months, or as long as needed as determined by the committee. | |

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we were not comfortable returning to the unit until they arrived. R1's behavior was never like this before. The police told us that R1 had shot another resident. Police took over everything after that."

On 08/09/2020, at 12:54PM, V16 (R2's family member) stated, "The facility told me one time that R2 had gotten into a verbal altercation with staff and a resident. I received a call from a local hospital, not from the nursing facility about R2 being shot. I talked to the police. I talked to the doctor that treated R2. The doctor said that R2 had been shot six times: twice in the arm; twice in the chest; twice in the leg. The physician told me R2 did not survive."

On 08/09/2020, at 10:49AM, R7 stated, "On 08/06/2020, R1 came to my room flashing a gun around the room. R1 would not tell me where or how he got the gun. I told R1 that he could be locked up for having a gun. R1 said that he didn't care about being locked up or being in jail. R1 stated that his roommate was bothering him and they had gotten into it. I am not sure what they had gotten into it about. R1 told me that he was taking care of business like he always does. R1 has gotten aggressive with me before. I was scared to death when R1 showed me the gun. I was not sure if he was going to pull the trigger on me or what he was going to do. Immediately, I told V12 (CNA). V12 told me not to worry about it; he would take care of it. On 08/07/2020 in the morning, I told V11 (LPN). Staff do not always pay attention to us or care to get involved. I do not feel safe in the facility because something like this happened once and it could happen again."

On 08/09/2020, at 11:14AM, V11 stated, "No one

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| F 835 | Continued From page 33 | F 835 | | |

ever came to me and said that a resident had a gun. No one has ever reported anything like that to me."

On 08/09/2020, at 11:27AM, V12 stated, "No resident has ever told me that another resident had a gun."

On 08/08/2020, at 11:56AM, V6 (Detective) stated, "The firearm was located in the back of R1's personal wheelchair." V6 provided photo evidence of the gun found in the wheelchair and obtained by the police officers.

Police report dated 08/08/2020 documents the police were notified by the facility that gunshots were heard around 3:00AM. Police officers arrived at the facility and found R1 laying in his bed. Police also found R2 in his room laying on the ground in a pool of blood. R2 did not show any signs of life. The ambulance was called to the facility. R1's personal wheelchair was searched. The police found a handgun with three rounds of ammunition, with one in the chamber. The firearm was found in the backrest of R1's personal wheelchair. Shell casings and spent projectiles were located inside R2's room. Police were advised by crime scene investigation that the same ammunition located on the floor of R2's room is the same that was loaded into the firearm. R2 was transported to a local hospital and ultimately succumbed to his injuries at 4:11AM. R1 was charged with first degree murder on 08/08/2020 and was transported to the local courthouse for processing.

On 08/10/2020, at 10:30AM, V1 (Assistant Administrator) stated, "We do not have a contraband policy."

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| F 835 | Continued From page 34<br><br>On 08/10/2020, at 11:46AM, V10 (Administrator) stated, "There is no failure; we are doing what we are supposed to be doing, related to screening the residents. I do not recall who looked at the criminal background check. There was a lapse in time. I don't know if the residents are told about contraband."<br>Based on interview and record review, the facility administration failed to have policies and procedures in place to prevent a resident (R1) from bringing in and possessing a gun while in the facility. This failure affects two (R1, R2) of seven residents reviewed for policy and procedure in a total sample of seven.<br><br>Findings include:<br><br>On 07/28/2020, R1 was admitted to the facility. The facility initiated a criminal background check on R1. The results of the criminal background check were available 08/05/2020. According to a R1's criminal background data, R1 had convictions for possession of controlled substance, domestic battery with bodily harm, aggravated battery of officials and the unlawful possession of a weapon. The shooting incident occurred on 08/08/2020.<br><br>Progress notes dated 08/08/2020, at 3:04 AM, document sounds of gunshots heard on R1 and R2's unit.<br><br>On 08/08/2020, at 10:00AM, R3 stated, "I was asleep and the noise woke me up. I heard the gunshot. I could not see who it was; it was a man. The door was open. R2 was lying on the floor when I left the room after the police came. There was a lot of blood." | F 835 | | |

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| F 835 | Continued From page 35 | F 835 | | |

On 08/08/2020, at 10:15AM, R4 stated, "On 08/08/2020, at 3:01AM, I heard 3 gun shots. It sounded like it was right at the door, but it was behind me in the other room. R1 was in and out of the room all night. I heard the 3 gun shots and then R1 returned to the room. R1 told me he shot someone. Then R1 said it was someone else who had shot someone. I know staff heard the shots and no one did anything."

On 08/08/2020, at 10:20AM, R5 stated he heard two pops because his door was wide open.

On 08/08/2020, at 10:30AM, R6 stated, "I heard 3 gun shots early this morning. I heard that the police found a gun on R1. I used to tell R4 that R1 acted like he was on drugs. I thought something was wrong with him because of how he acted."

On 08/08/2020, at 2:04PM, V7 (Licensed Practical Nurse/LPN) stated, "R1 was always roaming the building due to his insomnia. R1 was like this every night. About 3:00AM, V3 (LPN) came down front the second floor of the unit. She asked if I heard a noise. She wasn't sure if it was gunshots. We went upstairs; all the lights were off. R1 told me that two women has been shot on the first floor. The police were called. The police arrived and told us that R2 had been shot. Chest compressions were being performed on R2 as his body was being taken out of the facility."

On 08/09/2020, at 10:22AM, V3 (LPN) stated, "On 08/08/2020, around 3:00AM, I heard 2 gun shots. V2 (LPN) and myself went and looked for help. R1 would be roaming the halls going to visit other residents all the time. I did not notice that

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he left the floor on 08/08/2020, because I was working on the other unit. It was just V2 and another certified nursing assistant (CNA) for the entire floor. There is usually two CNAs, but one CNA had to be pulled to another floor. There is no type of security. The receptionist is there until 11:30pm. After that, there is no one. The facility is always short staffed. I believe that R1 got the firearm when he eloped because he was determined to get outside of the facility."

On 08/08/2020, at 2:35PM, V8 (CNA) stated, "On 08/08/2020, at 3:00AM, I was doing my rounds. I saw R1 in the hallway looking at what I was doing. It looked like he was going to go out the side door. R1 then went back to his room. I heard 2 shots. I wondered what it was. The nurses called administration and I started closing residents' doors."

08/09/2020, at 2:52PM, V2 stated, "V3 and myself heard gunshots. We took off running away from the gun shots to a secure unit downstairs and called 911. I told 911 that there were gunshots and an active shooter. I told police that we were not comfortable returning to the unit until they arrived. R1's behavior was never like this before. The police told us that R1 had shot another resident. Police took over everything after that."

On 08/09/2020, at 12:54PM, V16 (R2's family member) stated, "The facility told me one time that R2 had gotten into a verbal altercation with staff and a resident. I received a call from a local hospital, not from the nursing facility about R2 being shot. I talked to the police. I talked to the doctor that treated R2. The doctor said that R2 had been shot six times: twice in the arm; twice in

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the chest; twice in the leg. The physician told me R2 did not survive."

On 08/09/2020, at 10:49AM, R7 stated, "On 08/06/2020, R1 came to my room flashing a gun around the room. R1 would not tell me where or how he got the gun. I told R1 that he could be locked up for having a gun. R1 said that he didn't care about being locked up or being in jail. R1 stated that his roommate was bothering him and they had gotten into it. I am not sure what they had gotten into it about. R1 told me that he was taking care of business like he always does. R1 has gotten aggressive with me before. I was scared to death when R1 showed me the gun. I was not sure if he was going to pull the trigger on me or what he was going to do. Immediately, I told V12 (CNA). V12 told me not to worry about it; he would take care of it. On 08/07/2020 in the morning, I told V11 (LPN). Staff do not always pay attention to us or care to get involved. I do not feel safe in the facility because something like this happened once and it could happen again."

On 08/09/2020, at 11:14AM, V11 stated, "No one ever came to me and said that a resident had a gun. No one has ever reported anything like that to me."

On 08/09/2020, at 11:27AM, V12 stated, "No resident has ever told me that another resident had a gun."

On 08/08/2020, at 11:56AM, V6 (Detective) stated, "The firearm was located in the back of R1's personal wheelchair." V6 provided photo evidence of the gun found in the wheelchair and obtained by the police officers.

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| F 835 | Continued From page 38<br>Police report dated 08/08/2020 documents the police were notified by the facility that gunshots were heard around 3:00AM. Police officers arrived at the facility and found R1 laying in his bed. Police also found R2 in his room laying on the ground in a pool of blood. R2 did not show any signs of life. The ambulance was called to the facility. R1's personal wheelchair was searched. The police found a handgun with three rounds of ammunition, with one in the chamber. The firearm was found in the backrest of R1's personal wheelchair. Shell casings and spent projectiles were located inside R2's room. Police were advised by crime scene investigation that the same ammunition located on the floor of R2's room is the same that was loaded into the firearm. R2 was transported to a local hospital and ultimately succumbed to his injuries at 4:11AM. R1 was charged with first degree murder on 08/08/2020 and was transported to the local courthouse for processing.<br><br>On 08/10/2020, at 10:30AM, V1 (Assistant Administrator) stated, "We do not have a contraband policy."<br><br>On 08/10/2020, at 11:46AM, V10 (Administrator) stated, "There is no failure; we are doing what we are supposed to be doing, related to screening the residents. I do not recall who looked at the criminal background check. There was a lapse in time. I don't know if the residents are told about contraband." | F 835 | | |