DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/18/2004
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465110	A. BUILDING ______ B. WING ______	C 8/25/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSLANDS HEALTH CARE CTR	575 EAST 11000 SOUTH SANDY, UT 84070

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F 514 SS=D	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility did not maintain medical records that were accessible for 1 of 6 residents reviewed. Resident 1. Findings include: Resident 1 was admitted to the facility on 5/28/04 and readmitted, following a brief hospitalization, on 7/26/04. Resident 1's current medical records were reviewed on 8/25/04. The current medical records did not contain data from resident 1's initial admission until the resident's temporary discharge to the hospital. During an abbreviated survey to investigate a complaint allegation, the surveyors requested the facility to provide resident 1's previous medical record. The information should have contained pertinent background documentation from the resident's initial admission to the facility. The facility was not able to provide the medical record. The missing record should have contained documentation regarding at least one incident, dated 7/16/04, of resident 1 a striking a female resident. On 8/25/04 at 11:00 AM, an interview was conducted with the facility Administrator. The	F 514 POC accepted 11/8/04 [signature]	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F-514-D Administration **Corrective action for identified resident/chart** Resident #1 was discharged on 8-30-04. The medical record for resident #1 prior stay was not located and closed as incomplete after consulting with the medical records consultant. **Identification of resident/charts with potential to be affected** All residents/charts discharged from the facility have the potential to be affected. Utah Dept. of Health [illegible] 510783 NOV 03 2004 Bureau of [illegible] Program	10/11/04

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D. Wayne Barney — TITLE: Administrator — (X6) DATE: 10/29/04

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

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F 514	Continued From page 1 Administrator stated that the initial set of medical records for resident 1 was missing. The Administrator stated a thorough search of the facility had been conducted, but the records had not been located. The Administrator stated they had talked with their medical records consultant and decided not to try to obtain copies of any of the missing documents.	F 514	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 698 SS=J	This REQUIREMENT is not met as evidenced by: Past Non-Compliance 42 CFR 483.13(c)(1)(i) Requirement F - 224 Scope/Severity - J The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.) This REQUIREMENT is not met as evidenced by: Based on observation, interviews with facility staff, and record review, it was determined the facility failed to ensure that 4 of 111 residents were free from physical abuse by resident 1. (Residents 2, 4, 5, and 6.) On 8/18/04, resident 2 suffered facial contusions with precautions for a	F 698	**Corrective action to prevent recurrence** The facility's licensed nurses and medical records staff will be inserviced by 10-04-04 on the practice of placing all discharged resident charts in the locked medication room at each nurses station. Medical records will then pickup the discharged charts from the nursing staff the following day. **Monitoring/ quality assurance** The Administrator or designee Will develop an audit tool to Audit compliance of the safety Of the discharged medical Records.	

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F 698	Continued From page 2 possible closed head injury when staff left her alone in a room with resident 1. This incident was preceeded by three other incidents in which resident 1 physically abused three female residents. The facility's failure consituted a finding of Immediate Jeopardy. Following the incident of physical abuse of resident 2, by resident 1, and prior to the State Survey Agency investigation on 8/25/04, the facility increased monitoring of resident 1's behaviors. Additionally, on 8/18/04, the facility's Interdisciplinary team revised resident 1's plan of care to include one to one visits, increased supervision, and further assessment of antecedents to resident 1's aggressive behaviors. Facility staff were also working with resident 1's family representative to find other placement for the resident. The State Survey Agency determined, upon investigation on 8/25/04, that facility staff had implemented corrective measures to ensure residents were free from abuse and that conditions that lead to the determination of Immediate Jeopardy had been removed. The facility removed Immediate Jeopardy on 8/18/04. Findings include: Resident 1, an 83 year-old male, originally admitted to the facility on 5/28/04, was transferred to an acute care hospital on 7/19/04, and readmitted to the facility on 7/26/04. Resident 1's diagnoses included dementia and diabetes. Resident 1 resided on the 300 hall, which was outside of the secured Special Care Unit (SCU). On 8/25/04, surveyors requested resident 1's medical record, from 5/28/04 through his transfer	F 698	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Audits will be done weekly for six weeks by the Administrator or designee with the results reported to the Performance Improvement Committee (quality assurance). Audits and reports will then continue as may be directed by the PI committee. The Administrator will be Responsible for continued Compliance. Completion date: 10/11/2004	

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F 698	Continued From page 3 to an acute care hospital on 7/19/04. The administrator informed the surveyors that resident 1's medical record, from 5/28/04 through 7/19/04, was missing. The surveyors reviewed resident 1's medical record, from his readmission on 7/26/04 through 8/24/04. One document, dated prior to 7/19/04, had been carried over to resident 1's current medical record. Resident 1's plan of care, dated 7/18/04, revealed the facility was aware resident 1 had a problem of "ALTERATION IN BEHAVIORAL PATTERNS R/T (related to)" cognitive loss, low frustration tolerance, wandering with no rational purpose, cursing, threatening, screaming at others, physically striking out at others, inappropriate in group settings by yelling out for help, verbally abusive, rude remarks, and wandering in and out of other's rooms. The goals for resident 1's plan of care included, "Will show appropriate behavior to others by not hitting or yelling" and "Will not harm self or others on any given activity / interaction." Approaches for this assessed problem included: use re-direction and re-focusing from behavior to structured activity on any given incident; set firm limits and do not allow behavior that is abusive to others; involve in daily structured program to help limit wandering; and, seat out of reach of others during activities involvements. Resident 1's plan of care was updated on 8/18/04, to include a second concern regarding the resident's behavior of swearing, yelling and physically striking out at peers and staff. Approaches for this assessed problem included: increase supervision of resident and monitor whereabouts to decrease aggressive behaviors; one to one visits as needed; involve outside professionals as needed; ensure that everyone is	F 698		

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F 698	Continued From page 4	F 698		

safe and ok; and, involve in one to one activity or low stimulating activity.

On 8/18/04 at 6:00 AM, resident 1 physically assaulted resident 2, while the two residents were left unsupervised in the SCU dining room. Resident 2 suffered facial contusions with precautions for a possible closed head injury.

On 8/25/04 at 8:20 AM, an interview was conducted with nursing assistant 1. Nursing assistant 1 stated she had witnessed resident 1 hit resident 2 on the morning of 8/18/04 at approximately 6:00 AM. Nursing assistant 1 stated that she was reporting to work for the day when she observed resident 1, sitting in his wheelchair, in the SCU dining room. Nursing assistant 1 stated that resident 1 was holding resident 2 by her wrist with one hand, while resident 1 punched resident 2 in her face with his other hand. Nursing assistant 1 stated that resident 2 was standing with a walker and was unable to escape resident 1's grasp. Nursing assistant 1 stated resident 2 was repeating, "Let me loose. Let me loose." Nursing assistant 1 stated she had to pry resident 1's fingers from around resident 2's wrist. Nursing assistant 1 took resident 2 from the dining room and applied ice to resident 2's face, and resident 1 was taken from the SCU back to his unit. Nursing assistant 1 stated resident 2 was sent to the hospital for evaluation.

A telephone interview was conducted on 8/31/04 at 12:40 PM, with nurse 1. Nurse 1 was assigned both resident 1 and resident 2 on the night shift, beginning the evening of 8/17/04 through the morning of 8/18/04. Nurse 1 stated that she was working at the East nurses' station, which had a

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F 698	Continued From page 5	F 698		

view of the SCU dining room, from the east side, and a partial view down the hallway of the SCU, from the north side.

Nurse 1 stated that resident 1 had been restless and climbing out of his bed during the night of 8/17/04. Nurse 1 stated that resident 1 was allowed to wander in the halls "like always." Nurse 1 stated that resident 1 repeatedly went in and out of other residents' rooms and was "aggravating" other staff members. Nurse 1 stated that she had resident 1 taken to the SCU dining room, where he could watch television and be monitored. Nurse 1 stated resident 1 was provided with snacks and drinks while he was in the SCU dining room. She stated staff made several attempts to return resident 1 to his bed. Nurse 1 stated resident 1 continued to attempt to climb out of bed and he had to be returned to the SCU dining room. Nurse 1 was asked why resident 1 had not been returned to his own unit when the other residents began getting up. Nurse 1 stated, "I just hadn't gotten around to it."

Nurse 1 stated that there was one nursing assistant (nursing assistant 2) assigned to the SCU throughout the night shift, ending the morning of 8/18/04. Nurse 1 stated that nursing assistant 2 sat in the dining room with resident 1 during the night. Nurse 1 stated that nursing assistant 2 was responsible for going in to each residents' room to check on them every hour on the SCU and on the Step-Down unit (400 hall). Nurse 1 stated the nursing assistant rounds took ten minutes for the quick rounds and approximately sixty minutes to ensure residents were repositioned and changed the following rounds. Nurse 1 stated that it was her responsibility to keep an eye on the residents while nursing assistant 2 was completing her

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F 698	Continued From page 6	F 698		

Continued From page 6

rounds.

Nurse 1 stated that nursing assistant 2 was completing her final rounds and getting residents up, when the incident between resident 1 and resident 2 occurred on 8/18/04. Nurse 1 stated she did not think anything of it when she saw resident 2 enter the SCU dining room where resident 1 was sitting alone. Nurse 1 stated that when she heard nursing assistant 1 "hollering 'Stop that! Stop that! Stop that!'", nurse 1 "Got up and went to the window [of the East nursing station]" to see what was happening.

A telephone interview was conducted with nursing assistant 2 on 8/25/04 at 3:20 PM. Nursing assistant 2 stated she had worked the night shift, ending in the morning of 8/18/04, and had been assigned to work on the SCU. Nursing assistant 2 stated, during that shift, she sat in the dining room with resident 1 between her rounds. Nursing assistant 2 stated that in the morning she had assisted resident 2 to get up and dressed for the day. Nursing assistant 2 stated that after getting dressed, resident 2 went into the SCU dining room. Nursing assistant 2 stated she had to leave the SCU to do rounds on the Step-Down Unit (400 hall). The Step-Down Unit was the East hall, outside the doors to the SCU. Nursing assistant 2 stated that all the nursing assistance in the building did rounds at the same time and that no staff was on the SCU when she left to do rounds on the Step-Down Unit. Nursing assistant 2 stated she was finishing her morning rounds on the Step-Down Unit when she heard nursing assistant 1 yelling, "Stop that! Stop that!" Nursing assistant 2 stated that when she got to the SCU dining room, nursing assistant 1 told her what had happened.

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F 698	Continued From page 7 An interview was conducted with nurse 2 on 8/25/04 at 8:20 AM. Nurse 2 stated that she was the nurse who relieved nurse 1, on the morning of 8/18/04. Nurse 2 stated she had asked nurse 1, "Why in the world" resident 1 was put in the SCU during the night. Nurse 2 stated nurse 1 replied that it was because resident 1 had been awake, disruptive and wandering. Nurse 2 stated she had been informed that resident 1 was alone in the SCU dining room when resident 2 came in, and that there was no staff present. An interview was conducted with nurse 3 on 8/25/04 at 8:30 AM. Nurse 3 stated that he was familiar with resident 1's care needs and has been assigned his cares on several occasions. He stated that resident 1 had hit five or six people, including residents and staff. Nurse 3 stated that resident 1 did not seek out residents to hit, but would strike out if he felt his space was invaded, just in passing or even more so when he felt trapped. Nurse 3 stated that he did not know why resident 1 was put on the SCU, on the morning of 8/18/04, but that it was "not a wise decision." On 8/18/04 at 9:00 AM, a facility registered nurse completed two Resident Event Report Worksheets. These two worksheets documented a suspected resident to resident altercation and suspected verbal abuse between resident 1 and resident 2. The registered nurse documented that resident 2's "Event Adverse Effect" was bruising to her right eye and forehead. The registered nurse documented the incident had occurred in the dining room at 6:00 AM on 8/18/04, and was a 3 on a scale of 1 to 4 for severity. The worksheet included documentation that a level 3 severity was "Moderate to Serious Adverse Outcome".	F 698		

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F 698	Continued From page 8 On 8/18/04, a facility social service staff member documented in resident 1's medical record that, "This is fourth report of resident hitting female resident." On 8/18/04 at 6:00 AM, a nurse documented, " resident [1] struck a female resident in her face [with] his fist twice, causing hematomas X [times] 2 in frontal area [and] [right] eye. It is not known why he did this, but has acted aggressive several times before this." Resident 2 was a 76 year-old female, who had been admitted to the facility on 1/8/04, with diagnoses that included Alzheimer's dementia and cerebral vascular accident. On 8/25/04 at 8:30 AM, two surveyors observed resident 2. The resident was observed to have purple bruising, approximately two inches in diameter, below her right eye. Fading green and yellow bruising was observed across the resident's forehead. The medical record for resident 2 was reviewed on 8/25/04. On 8/18/04 at 6:00 AM, a nurse documented that resident 2 had been struck in the face by another resident's fist. The documentation revealed resident 2 had hematomas to "a frontal area" measuring approximately 3 cm (centimeters) by 4 cm. The documentation revealed resident 2 had another hematoma on her lower right eye lid. On 8/18/04, a facility nurse documented, on the Transfer Form that was sent to the hospital with resident 2, that the resident was "Struck in face by another resident [with] closed fist."	F 698		

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F 698	Continued From page 9	F 698		

A physician's emergency department report, dated 8/18/04, included documentation that resident 2 had been diagnosed as having a "facial contusions and precautions for possible closed head injury".

From 7/16/04 until the incident in which resident 1 physically assaulted resident 2, on 8/18/04, he had physically assaulted three other female residents and attempted to hit a fourth female resident; resident 3, 4, 5 and 6. Prior to 7/16/04, resident 1 had hit a female nursing assistant in the face; nursing assistant 3. Additionally, resident 1's medical record included documentation that he had also been verbally abusive; target(s) of resident 1's verbal abuse were not identified.

Resident 5 was a 97 year-old female who had been admitted to the facility 3/14/01 with diagnoses that included seizure disorder and hypertension.

On 7/19/04 at 10:40 AM, a nurse documented a nursing note entry in resident 5's medical record. The nurse documented that resident 5 was involved in an altercation with a resident in the corridor, on 7/16/04. The nurse documented the incident was witnessed by a facility nurse. The nurse documented the incident was provoked by the other resident, had been reported to the Interdisciplinary Team, and would be followed up

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F 698	Continued From page 10 on by social services. On 7/19/04, a facility social service staff member documented a Social Services Progress Note in resident 5's medical record. The staff member documented, "Nurse reported on 7/16/04 a male resident grabbed [resident 5]'s arm, she pushed him away afterwards, no injury to [resident 5], incident reported to APS [Adult Protective Services]." On 7/19/04 at 9:00 AM, a facility registered nurse completed a Resident Event Report Worksheet for an incident involving resident 5. The registered nurse documented the incident occurred on 7/16/04 at 7:30 AM, in a common corridor. The registered nurse documented the incident was a resident to resident altercation with no injuries to resident 5. An Incident Tracking Log, dated July 2004, revealed resident 5 was struck by resident 1, on 7/16/04 at 7:30 AM, in the cross hall. There were no injuries to either resident documented on the Incident Tracking Log. The State Survey Agency received, from Adult Protective Services, a report regarding a physical altercation between resident 1 and resident 5. Per documentation on this report, the incident occurred on 7/16/04 at 9:30 AM, when, "[Resident 1] reached out and grabbed [resident 5]'s arm. [Resident 5] pushed him away from her." This report included documenation that resident 1 experienced a skin tear. Note: The APS report indicated the incident occurred at 9:30 AM. All other documents relating to this incident documented it occurred at 7:30 AM. Resident 4 was an 89 year-old female who was	F 698		

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F 698	Continued From page 11	F 698		

admitted to the facility on 11/24/00 with diagnoses which included dementia, Parkinson's disease, anxiety and cancer.

On 8/4/04 at 6:30 PM, a nurse documented a nursing note entry in resident 1's medical record. The nurse documented that resident 1 was witnessed striking another resident in the face with his fist.

On 8/4/04 at 6:30 PM, a nurse documented a nursing note entry in resident 4's medical record. The nurse documented, "While eating dinner in the West D.R. [dining room] Resident [resident 4] was struck in the face by another male resident. Careful check of her mouth revealed no bleeding, no lacerations visible. . . ." Previous nursing note entries, dated 8/1/04 and 8/2/04, revealed resident 4 had been experiencing mouth pain related to the resident's recent tooth extraction.

On 8/5/04 a facility registered nurse completed a Resident Event Report Worksheet for an incident involving resident 1. The registered nurse documented the incident occurred on 8/4/04 at 6:30 PM, in the hallway.

On 8/12/04, the State Survey Agency received, from Adult Protective Services, a report regarding a physical altercation between resident 1 and resident 4. Per documentation on this report, the incident occurred on 8/4/04 at 6:30 PM, when, "In the hallway, [Resident 1] hit [resident 4] in the face." The report revealed resident 4 sustained a bruised cheek.

An interview was held with nursing assistant 3 on 8/25/04 at 10:00 AM. Nursing assistant 3 stated she was present when resident 1 hit resident 4. Nursing assistant 3 stated the incident occurred in

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 12	F 698		

the West dining room and that resident 1 was in the back corner of the room. Nursing assistant 3 stated resident 1 did not like to be trapped in the corner of the room.
She stated resident 1 was trying to get out and resident 4 was in his way.

Nursing assistant 3 stated resident 4 was "freaking out" after resident 1 hit her. Nursing assistant 3 stated that resident 4 had just had oral surgery and her mouth was still sore at the time resident 4 was hit. The nursing assistant stated that resident 4 kept calling out, "Call 911, I need to go to the E.R." Note: Nursing assistant 3 stated the incident between resident 1 and resident 4 occurred in the West dining room. Other documentation related to this incident indicated it occurred in a hallway.

Nursing assistant 3 stated that some staff think resident 1 should be seated at the back of the dining room so that he can not get out to wander. Nursing assistant 3 stated that she, as well as other staff, believed resident 1 should be seated near the door to the dining room so that he could get out. Nursing assistant 3 stated that resident 1 "eats fairly fast" and usually wanted to leave the dining room before his nursing assistant(s) were finished assisting other residents and able leave the room.

Resident 6 was a 92 year-old female who had been admitted to the facility 5/21/04 with diagnoses that included anxiety disorder and arthritis.

On 8/7/04, a nurse documented a nursing note entry in resident 1's medical record. The nurse documented that resident 1 was passing a female resident in the hallway; both in wheelchairs. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465110	A. BUILDING ______ B. WING ______	C 8/25/2004

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F 698	Continued From page 13	F 698		

nurse documented that the female resident said "Hi" and resident 1 punched her in the face.

On 8/7/04, a facility staff member completed a Resident Event Report Worksheet for an incident involving resident 1 on 8/7/04 at 4:30 PM. The staff member documented, "resident [1] punched a female resident face while they were passing each other in hall. Female resident just said 'hi' when she was hit." No injuries were documented.

On 8/12/04, the State Survey Agency received, from Adult Protective Services, a report regarding a physical altercation between resident 1 and resident 6. Per documentation on this report, the incident occurred on 8/7/04 at 4:30 PM, when, "[Resident 6] came up to [resident 1] and [resident 1] hit her in the face."

Resident 3 was a 58 year-old female, who had been admitted to the facility on 6/27/00, with diagnoses that included right side hemiparesis, chronic pain and depression.

An interview was held with nursing assistant 4 on 8/25/04 at 8:37 AM. Nursing assistant 4 stated he has been assigned resident 1 frequently. Nursing assistant 4 stated that he had recently intervened when he witnessed resident 1 attempt to hit resident 3, as she passed resident 1 in the hallway. Nursing assistant 4 stated that resident 1 had been "real aggressive with staff when he first came." Nursing assistant 4 stated that resident 1 had become "okay with staff", but that he did not like people around him. Nursing assistant 4 stated resident 1 would try to grab and hit other residents when they passed by. Nursing assistant 4 stated he had heard of four or five other incidents of resident 1 hitting female residents. Nursing assistant 4 named resident 2

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F 698	Continued From page 14	F 698		

and resident 4 as individuals who had been physically assaulted by resident 1.

On 8/25/04 at 10:00 AM, nursing assistant 3 was interviewed. Nursing assistant 3 stated that about a month ago, during resident 1's previous admission, resident 1 had "socked" her in the face. Nursing assistant 3 stated that resident 1 had been in the dining room, calling out for help when the incident occurred. She stated that she stooped down in front of resident 1 to ask how she could help. Nursing assistant 3 stated that, without warning, resident 1 "socked" her in the cheek. Nursing assistant 3 stated that she reported the incident to a nurse 4. Nursing assistant 3 stated she was told by nurse 4 that resident 1 was just confused.

The surveyors attempted to review resident 1's medical record for details relating to the incident when resident 1 hit nursing assistant 3; however, the facility's administrator stated that particular medical record could not be located. There was no documentation regarding the incident in resident 1's active medical record. The incident was not documented in the facility's Incident Tracking Log.

In addition to the incidents in which resident 1 physically assaulted other female residents, the following information was obtained relating to resident 1's aggressive behaviors:

a) An interview was held with the facility's Social Service Director on 8/25/04 at 9:15 AM. She stated resident 1 needed procedures explained to him before they were performed. She also stated that she was responsible to investigate incidents involving residents, and did investigate them when they were reported. She

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F 698	Continued From page 15 stated that she was worried too many incidents went unreported. The Social Services Director stated that she was preparing an inservice that she would provide for staff regarding how to provide care for resident 1 without causing the resident to become agitated. b) On 7/30/04, a registered nurse documented in resident 1's medical record, "Resident has furrowed brow frequently, Res [resident] verbally abusive but easily directed. . . ." c) On 8/8/04, a facility staff member documented a Weekly Medicare Charting entry in resident 1's medical record that read, "[Resident 1] is combative." d) On 8/20/04, resident 1's physician documented in a Physician Progress Note, "Has been combative - striking out [at] female residents [and] staff. Doesn't target males." e) On 8/22/04, a facility nurse documented in resident 1's medical record that resident 1, "Threatened another resident that he would hit her." The resident to whom the threat was made was not identified.	F 698		