STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265437	A. Building B. Wing	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon View Health and Wellness	1200 West College Street Liberty, MO 64068

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44939 Based on observation, interview, and record review, the facility failed to implement interventions for two residents (Resident #1 and Resident #2) who displayed physically aggressive behaviors towards staff and other residents, when Resident #1 pushed another resident down (Resident #3) who sustained a fractured hip, and when Resident #2 pushed Resident #4 down causing a laceration to the residents forehead. The facility census was 87. Review of the facility's Dementia Care policy, dated 10/18/2022, showed: -It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. -Dementia is defined as a general term to describe a group of symptoms related to loss of memory, judgement, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons. However, dementia is not a specific disease. There are many types and causes of dementia with varying symptomology and rates of progression. -The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible. -The care plan goals will be achievable and the facility will provide resources necessary for the resident to be successful in meeting their goals. -The care plan interventions will be related to each resident's individual symptomology and rate of dementia (or related disease) progression with the end result being noted improvement or maintained of the expected stable rate of decline associated with dementia and dementia-like illness. -Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well being. -The care plan goals and interventions will be monitored on an ongoing basis for effectiveness and will be reviewed/revised as necessary. (continued on next page)

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.

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

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F 0744 Level of Harm - Actual harm Residents Affected - Few	-Appropriate referrals will be made if current interventions are ineffective or resident shows a decline in psychosocial, mood, or behavioral status (i.e. physician, mental health provider, licensed counselor, pharmacist, social worker). -All staff will be trained on dementia and dementia care practices upon hire, annually, and as needed to ensure they have the appropriate competencies and skill sets to ensure residents' safety and help residents attain or maintain the highest practicable physical, mental, and psychosocial well-being. 1. Review of Resident #1's Admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 9/1/22, showed: -The resident had clear speech, usually makes self understood and usually understands others. -Score of 7 on the Brief Interview for Mental Status (BIMS), a structured evaluation aimed at evaluating aspects of cognition in elderly patients. The score of 7 indicates severely impaired cognitive abilities. -Behaviors not directed at others, such as rummaging and wandering, were present daily. -The resident wandered daily. -Required limited to extensive assistance with activities of daily living, including dressing, bathing, and personal hygiene. -Received antipsychotic medication (are a class of psychotropic medication primarily used to manage psychosis) daily. -Diagnoses of encephalopathy (A broad term for any brain disease that alters brain function or structure), Type I Diabetes Mellitus (a chronic condition in which the pancreas produces little or no insulin), psychosis (a mental disorder characterized by a disconnection from reality), wandering, dementia (dementia is not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with agitation, psychotic disorder with delusions. Review of the resident's base line care plan, dated 8/25/2022, showed: -Admitting diagnoses of altered mental status, dementia, diabetes mellitus. -Hearing impairment to both ears. -The resident had impaired cognition. Staff will administer medications as ordered, ask yes or no questions, and keep the resident's routine consistent. -The resident displays being easily distracted, wandering, restlessness, abusive/refuses cares, combative/severely agitated. Review of the resident's August to October 2022 progress notes showed: (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	8/25/2022 at 10:00 P.M.: During 9:38 P.M. blood sugar check, the resident was resting in bed and had stripped down. The nurse and a nursing staff member tried to get the resident dressed but he/she got combative and starting swinging and kicking, yelling get the fuck out of here. Will continue to monitor. 8/30/22 at 8:46 A.M.: Social Services Note: admitted from a local hospital with a primary diagnoses of encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition (such as viral infection or toxins in the blood)), unspecified. He/she presents alert and oriented with forgetfulness and confusion. He/she was able to make needs known. Mental function was noted with variability. BIMS score of 7 with difficulty exhibited knowing the month, day of the week, and remembering 3 words. Resident denied any problems with mood or depression. Resident denied any suicidal or homicidal ideation's and had not displayed any delusions or hallucinations. He/she was prescribed denepozil (a medication used to treat dementia), memantine (a medication used to treat dementia), and haloperidol (a medication used to treat certain mood or mental disorders) for mood. A consult for psychological evaluation had been initiated. 9/9/22 4:29 P.M.: New order to increase haloperidol to 2 milligrams (mg) at bedtime by the psychiatrist, for psychosis/agitation. 9/25/22 6:05 A.M.: Resident anxious, hand wringing, paces, had prancing in place foot movements, wanders into other's rooms, tearful, took sink apart in room, took air conditioner cover off, turned furniture over. 9/26/22 at 5:29 P.M.: Resident was seen by the psychiatrist. New order to add haloperidol 1 mg at 8:00 A.M. and 12:00 P.M., then take haloperidol 2 mg dose at bed time. 9/29/22 at 5:20 P.M.: Nurse went to check on patient to collect blood glucose. The patient was found on the floor, wobbly and trying to get up. This nurse notices bleeding coming from left arm with a big hematoma (a collection of blood outside of blood vessels). Hematoma also noted to right side forehead and new skin tear noted to right forearm. Patient was unable to give a description as to what happened due to history of dementia per baseline. Physician notified and order to transfer to emergency room . 9/29/22 9:17 P.M.: Spoke with nurse at local hospital. Hematoma to forehead. CT scan (medical imaging technique used to obtain detailed internal images of the body) and x-ray (painless test that produces images of the structures inside the body), are all negative, will return to the facility, no new orders. 10/8/22 6:16 P.M.: This writer attempted to stick this resident's finger for a glucose reading. The first attempt, the resident became agitated and started swinging at the writer and trying to push the writer away. The second attempt, the resident again became agitated and started swinging and pushing the writer away. Last attempt was made and behavior had not changed. 10/9/22 1:00 P.M.: Resident had an episode where he/she was attempted to come behind the desk. When redirected, he/she became angry/aggressive and said what the fuck are you doing and I'll knock the shit out of you. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	10/11/22 8:50 P.M.: Resident was reported by Resident #3 that the resident hit Resident #3 in the face and pushed him/her to the floor because he/she told Resident #1 to get out of the roommate's bed. Resident #1 was found in his/her own bed. He/she had short and long term memory deficits and does not recall what happened. Received order to send out to emergency room for change in mental status. 10/12/22 4:16 A.M.: Resident got up from resting in bed at approximately 3:45 A.M. and took his/her television from the stand in the room and put it on his/her bed. Resident also took mattress from the other bed in the room and put it on the floor in the room. Resident denied pain. Resident was given food and resident ate. This nurse went to another hall and requested for a second certified nurses assistant (CNA) to come and do 1 on 1 observation with the resident. 10/12/22 8:38 A.M.: Social Services Note: This writer attempted to meet with the resident to discuss events from the night before. Resident appeared to lack insight and judgement into the events of the previous night. This writer spoke with the staff on the floor and they said that resident appears to be in no distress surrounding the events of the previous night. 10/17/22 6:50 A.M.: The resident had mattresses off the beds, blinds are broken, food on the floor and under bed. Chair is across the room. Staff put mattress on bed and resident laid down and went to sleep. Review of the resident's comprehensive care plan, dated 10/18/22, showed: -Resident had a behavior problem: removes clothing, wanders, urinates on doors, exit seeking, wanders into peers rooms/sleeps in peers beds, tears up room, combative, yells/curses at staff, tries to go behind nurses desk, physical aggression toward female peer/pushed her down, removes television from stand and puts mattress on the floor, refuses to be toileted/brief change/combative with cares, delusions, breaks blinds/rearranges room/puts food on the floor. -The resident will have fewer behaviors by review date. -10/11/22: Sent to emergency room for evaluations due to aggression/mental status change; returned with no new orders. -Administer medication as ordered. -Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. -Do cares with 2 people assist due to combativeness with cares. Offer food and drink to attempt to redirect. -Explain all procedures to the resident. -Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternative location as needed. -Redirect when he/she attempts to enter other's rooms. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	-Resident required assist to find the bathroom. When resident was taking clothes off and wandering around, ask if the resident needs to use the toilet. Review of the resident's behavior intervention report showed: -The report asks what interventions were attempted when a behavior is noted. -10/1/22 4:04 A.M.: No interventions attempted. -10/2/22 3:51 A.M.: No interventions attempted. -10/2/22 12:04 P.M.: No interventions attempted. -10/2/22 11:17 P.M.: Provided Calm Environment, improved. -10/3/22 10:43 A.M.: Redirect, improved. -10/4/22 11:52 A.M.: Redirect, improved. -10/4/22 4:25 P.M.: No interventions attempted. -10/5/22 2:22 A.M. No interventions attempted. -10/5/22 1:13 P.M.: Redirect, unchanged. -10/6/22 4:46 A.M.: No interventions attempted. -10/6/22 10:22 A.M.: Redirect, improved. -10/6/22 10:29 P.M.: Provided Calm Environment, unchanged. -10/7/22 3:59 A.M.: No interventions attempted. -10/7/22 1:24 P.M.: Redirect, unchanged. -10/8/22 3:27 A.M.: No interventions attempted. -10/8/22 1:45 P.M.: Provided Calm Environment, unchanged. -10/9/22 9:18 A.M.: No interventions attempted. -10/10/22 4:28 A.M.: No interventions attempted. -10/10/22 10:36 A.M.:No interventions attempted. -10/11/22 12:43 P.M.: No interventions attempted. -10/12/22 4:46 A.M.: Redirect, improved. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	-10/12/22 10:43 A.M.: No interventions attempted. -10/13/22 4:56 A.M.: No interventions attempted. -10/13/22 9:55 A.M.: Redirect, unchanged. -10/14/22 4:41 A.M.: Redirect, unchanged. -10/14/22 11:27 A.M.: Redirect, unchanged. -10/15/22 11:23 A.M.: No interventions attempted. -10/16/22 6:17 A.M.: No interventions attempted. -10/16/22 11:02 A.M.: Redirect, improved. -10/17/22 4:45 A.M.: Removed from Situation, worsened. -10/17/22 7:17 A.M.: No interventions attempted. -10/17/22 9:05 P.M.: No interventions attempted. Observation of the Resident #1 on 10/18/22 at 10:52 A.M., showed: -The resident was awake, standing near the bed in his/her room. No staff are present. The resident has bruising to the right side of the face and forehead, fading to a yellow color. 2. Review of Resident #3's quarterly MDS, dated [DATE], showed: -Understands others and was able to make self understood. -Experiences delusions. -Scored 14 on BIMS. This score indicates intact cognitive abilities. -Required supervision with activities of daily living, including bathing, dressing, toileting and personal hygiene. -Diagnoses of dementia with behaviors, osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases, or when the quality or structure of bone changes.) Review of the resident's progress notes, dated 10/11/22 at 9:02 P.M., showed: (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	- Certified Medication Technician (CMT) reported that the resident was found on the floor. The resident reported that another resident hit him/her and pushed him/her to the floor. The resident stated that he/she yelled at Resident #1 to get out of Resident #3's roommate's bed. Resident #1 got up from the roommate's bed and hit Resident #3 and pushed him/her to the floor. The resident complained of right hip pain and had an abrasion with a hematoma above the right eye. The resident's right leg had external rotation noted. Resident was sent to the emergency room for evaluation and treatment. Review of the resident hospital record, dated 10/13/22, showed: -X-ray of the right hip showed a fractured femur. -The resident had been evaluated by the orthopedic surgeon and will be having surgery this afternoon to repair the fractured hip. During an interview on 10/18/22 at 1:45 P.M., the resident's family member said: -The resident did well in surgery. -The resident is discharging from this facility to a different facility nearer the family. -The family member said that he/she only knew other resident pushed Resident #3 down, resulting in the broken hip. 3. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Rarely/never understands others, rarely/never makes self understood and had hearing impairment. -Scored 4 on BIMS. The score of 4 indicates severely impaired cognitive skills. -Behaviors were present, including physical, verbal, and behavior not directed at others. This includes rejection of care, striking out at staff. -Required extensive assistance with all activities of daily living, including dressing, bathing, toileting, and personal hygiene. -Received antipsychotic, antianxiety, antidepressant medication 6 out of 7 days of the week. -Diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), vascular dementia (a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations) and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of the resident's baseline care plan, dated 8/12/22, showed: -admitted diagnosis was Vascular Dementia. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	-Reason for admission was aggressive behaviors and inability to remain in current situation. -Resident was confused/disoriented. He/she was easily distracted, experiences restlessness, wanders, and was abusive/resistive to care. -No interventions listed on the base line care plan for the residents aggressive behaviors. Review of the resident's August through October progress notes showed: -8/12/22 9:55 P.M.: The resident refused a physical assessment by the nurse. He/she attempted to strike the nurse when the nurse attempted to conduct a TB test (a test performed by injecting a small amount of fluid (called tuberculin) into the skin on the lower part of the arm to test for tuberculosis, a potentially serious infectious disease that mainly affects the lungs). The resident liked to sit on the floor and will not get up. The resident did not like to take showers. He/she did have aggressive behaviors, difficult to redirect. He/she had attempted to go in other resident's room and attempting to fidget with items on the nurse cart. -8/13/22 5:12 A.M.: Resident had been in others rooms all night, wanders, very difficult to redirect, takes things from others, been aggressive with others, attempted to kick other residents. During redirection, he/she kicked staff in the left leg and in the abdomen, and punched left side of jaw. -8/15/22 9:05 A.M.: Resident refusing to put clothes on. When CNA attempted to assist the resident, he/she became upset and shouting. -8/15/22 3:17 P.M.: Resident was becoming increasingly agitated after lunch. Resident removed his/her shoe and began to charge another resident. Staff were able to intervene before any contact was made. Staff attempted to redirect resident to his/her room and give a snack. Resident became angry and called the nurse a fucking bitch and charged at the nurse. No contact was made. The nurse had staff stay with the resident while the nurse spoke with the assistant director of nursing (ADON), who contacted the physician. An order for haldol injection 2 mg every 6 hours as needed for psychosis and aggression. This nurse was assisted by staff and the injection was given in the resident's left buttock. Resident continued to act out and walk through he/she halls. 8/18/22 10:29 A.M.: Resident was agitated and refusing care. He/she was on the floor and refused to get up. 8/18/22 1:47 P.M.: Resident had remained on the sofa in the dining room since before the shift started, sleeping off/on. Staff has attempted to get him/her to go to his/her bedroom. Resident became aggressive and verbally stated I will beat the crap out of you. Staff were instructed to leave him/her alone. 8/18/22 9:46 P.M.: Resident fell while trying to swing arms and hands out at staff. fell on left side. Resident had skin tear on right forearm. Continued to be combative on the floor and refused assessment. Staff cleaned skin and got resident up from the floor. Resident continued to refuse vital signs the tells staff to get away. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	8/19/22 9:19 A.M.: Resident up and out of his/her room at this time. Clothing was wet with urine. He/she was hostile and would not be redirected. Told staff I will knock you the fuck out and was aggressive and combative. When told clothing needed to be changed, he/she walked away into other resident's room and got into the other resident's bed. Staff members were collected and were able to get the resident into the shower and changed. He/she was trying to hit and kick staff. Resident also refused to take meds and haldol injection was given. 8/20/223 7:35 P.M.: Resident was in another resident's room, laying in a bed, when staff approached to help him/her up, the resident became combative and made a close fist and started chasing staff to try and hit them. Staff walked away and left this resident for ten minutes to give a time to calm down. Staff approached this resident again and tried to help him/her up from the bed. Resident started pulling the staff's hair and hit them in the face. ADON was contacted and haldol injection was given. 8/20/22 8:37 P.M.: Staff attempted change bandage and clean wound, but the resident refused and tried to knock the staff down. Staff waited until the resident was ready for bed and tried again but there was no change. 9/1/22 6:22 P.M.: The resident was seen going into a female resident's room, trying to shut the door behind him. The nurse redirected the resident with a struggle to his/her room. Moments later the resident was seen going into several different resident's rooms, moving furniture in and out of rooms. Nurse tried to redirect the resident but it was ineffective. The resident seemed agitated and anxious. The nurse administered haldol. 9/1/22 9:53 P.M.: Nurse was in a resident's room when the nurse heard screaming. Staff started opening resident doors and found the resident in another resident's room in bed with another resident. He/she was not attacking the other resident nor did he/she appear aggressive. The other resident reported Resident #2 came into the room shut the door and approached the bed. Resident #2 called the other resident a name and started punching at the other resident. Resident #2 could not reach the other resident as the bed side table was in the way. He/she moved the bed side table and hit the other resident in the face. Resident #2 was escorted from the room. When the nurse manager approached Resident #2, he/she was shaking the central bathroom door and picking at the seams in the wall. He/she did not appear to be aggressive. The other resident was assessed and had not signs or symptoms of injury. Resident #2 was placed on constant observation. 9/2/22 1:31 P.M.: The resident was sent out per the Director of Nursing (DON) request to be re-evaluated due to increased agitation and aggression towards staff and residents. 9/2/22 6:03 P.M.: Staff spoke to nurse at the psychiatric unit and faxed requested information. The emergency department was continuing to look for psychiatric placement. 9/2/22 6:37 P.M.: Psychiatrist was informed of resident's increased aggression and outbursts and that the resident was sent to the emergency department with intentions for an evaluation and placement. In the event the resident was readmitted to the facility, the psychiatrist gave orders to increase haldol and the psychiatrist will see the resident when he/she returns. The resident was currently being held in the emergency room , who states psychiatric placement was still being sought. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	9/2/22 9:47 P.M.: Nurse called the local emergency room to check the status of the resident. Informed that he/she was still in the emergency and placement was still being sought. 9/4/22 4:37 P.M.: Received call from nurse with the local emergency room . Stated the resident remained in the emergency room the entirety of the stay and was assessed by the psychiatric department several times. Resident was found to be safe to to return to the facility. No medication changes were reported. 9/4/22 6:28 P.M.: Resident returned to the facility. 9/9/22 4:46 P.M.: Seen by psychiatrist. Increased order for haldol for psychosis and aggression. 9/11/22 8:15 P.M.: When staff tried to give this resident medication, the resident grabbed the staff's arm and pulled the staff's hair. Staff was able to break free from the resident's grip, the resident then balled up a fist and stated he/she was going to knock the staff out. Staff gave the medication to the charge nurse. Charge nurse attempted to give the medication to the resident, who became aggressive again. 9/15/22 5:46 A.M.: Resident was covered in feces. Fighting, hitting, kicking at staff, would not let staff help. Given haldol injection. 9/18/22 4:05 P.M.: Staff attempted to give resident care, he/she had feces all over pants. Staff explained the care they were about to give this resident and the resident responded okay. As soon as staff went to assist the resident, he/she became agitated and started swinging at staff with a closed hand. Staff walked away and tried again in 10 minutes but the resident then pushed staff and hit staff with closed hand and pulled hair of staff member. Haldol was given. 9/21/22 1:06 P.M.: Resident observed wandering, going in and out of other resident's rooms, rummaging in other's belongings. 9/26/22 7:46 P.M.: The resident was demonstrating aggression and pushed another resident resulting in an injury to the other resident. 10/14/22 5:45 P.M.: While feeding this resident, resident yelled, grabbed styrofoam container on lap and swinging arm agitated with this staff. Review of the resident's comprehensive care plan, dated 9/28/22, showed: -Resident to resident, Resident #2 was aggressor. 9/26/22 Resident pushed another resident. Attempt to engage resident in activities to keep occupied. Medication as ordered. Psychiatry evaluation pending. Check on resident every 15 minutes for 24 hours. Frequent monitoring for location and behaviors. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Actual harm Residents Affected - Few	-Resident has behavior problem related to vascular dementia. Attempts to hit/kick staff and peers. No boundaries with other's personal space. Delusional. Removes clothes and comes out in hallway. Becomes physically and verbally aggressive with cares. Charges at staff and peers, attempts to hit. Removes silver sewer covers and peels wallpaper from walls. Places self on floor. Increased depakote. Order for haldol. Administer medications as ordered. After altercations, placed on close observation. Anticipate and meet resident's needs. Approach in a non-confrontational manner. Explain all procedures to the resident before starting. Face resident when speaking to. Hears better in left ear. Divert attention. Remove from situation as needed. Perform cares with 2 people. Provide a program of activities. During an interview on 10/18/22 at 11:03 A.M., Licensed Practical Nurse (LPN) A said: -Resident #1 was no longer on one to one supervision. Observation was lifted the evening of 10/15/22. There was no other monitoring in place for the resident, but LPN A tries to keep an eye on the resident. -The resident was declining physically and acts like he/she was scared. LPN A had been observing this since the resident's recent fall with head injury. LPN A had noticed increased difficulty walking and talking, and seems more scared and paranoid. -The physician has evaluated the resident and recommended palliative care/hospice. The wife was still trying to decide on a hospice company. -LPN A was not working the day the resident pushed another resident to the floor. Prior to the resident's fall, LPN A had not observed any aggression in the resident toward others. -LPN A had received training on working with residents with dementia and behaviors. This was in March 2022 when he/she was hired. He/she also received training last week, conducted by the DON, about approaching a resident. -LPN A is unsure that the resident can be cared for appropriately in the facility due to his/her behaviors. LPN A had never taken care of a resident with similar behaviors of Resident #1. -Resident #2 was brought back to the unit by the former administrator and DON, who instructed staff to watch due to the resident being exit seeking. They failed to mention to the staff that the resident was very aggressive towards staff and other residents. -Staff could not approach Resident #2 quickly, the resident did not understand what the staff was saying or what they wanted him/her to do; -Resident #2 was severely cognitively impaired, he/she did not understand what you were saying to him/her; -Resident #2 would get very agitated and was physically aggressive towards staff and other residents; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265437	A. Building B. Wing	10/18/2022

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Avalon View Health and Wellness	1200 West College Street Liberty, MO 64068

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Actual harm Residents Affected - Few	- On 9/26/22 Resident #2 went into another residents room and when that resident told him/her to get out, he/she pushed the other resident down causing a laceration to the other residents forehead, the other resident went to the hospital and received sutures; -The staff was afraid of Resident #2, you did not know what he/she was going to do. During an interview on 10/18/22 at 2:00 P.M. Certified Nurse Aide (CNA) A said: -Resident #2 would try to hit staff when you attempted to change him/her or redirect him/her; -He/she was aggressive towards other residents; -He/she had not received any special training on how to deal with residents with aggressive behaviors; -He/she would try to redirect the residents and notify the charge nurse if this did not work. During an interview on 10/18/22 at 2:30 P.M., the Social Services Director (SSD) said: -He/she does not have a role in the pre-admission process for a resident; -He/she does not prescreen the residents for any behaviors; -Residents who do have behaviors with be discussed in the Risk Management Meetings to discuss the behaviors and will put interventions on the care plans; -The Risk Management team will discuss the effectiveness of the interventions; -If a behavior was severe enough, the resident will be put on one on one observations; -He/she was unsure who determines when the resident comes off the one on one observations; -He/she has not provided any special in-servicing for the staff on resident behaviors, one hospice provider had given some education on how to deal with resident behaviors. During an interview on 10/18/22 at 4:23 P.M., the Administrator and DON said: -The staff should be receiving continuing education on dementia, including at orientation, annually, and as needed. If a resident has increased behaviors, additional education should be provided to staff. -Evaluation of staff's understanding of the education can be difficult due to the particular behaviors and how often the behaviors occurred. -The DON has dementia education resources and plans to provide ongoing education to staff. -The DON expects staff to approach residents in a calm manner and distract with activities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265437	A. Building B. Wing	10/18/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Actual harm Residents Affected - Few	-The facility is working on having consistent staff on the locked unit. MO207573 and MO208484