P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically Delivered
January 21, 2022

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: CCN: 245218
Cycle Start Date: December 9, 2021

Dear Administrator:

On January 13, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 22, 2021

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: CCN: 245218
Cycle Start Date: December 9, 2021

Dear Administrator:

On December 9, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 9, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 9, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING ______ B. WING ______	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET LAKE CITY, MN 55041**

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F 000	INITIAL COMMENTS On 12/8/21 and 12/9/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints was found to be SUBSTANTIATED: H5218040C (MN00079076), with deficiencies cited at F604, and F758. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse,	F 604		1/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/30/2021

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 604	Continued From page 1 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. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R1) right to be free from physical/chemical restraints when staff surrounded R1 preventing freedom of movement, held R1's arms and injected an antipsychotic medication without R1's consent nor attempting any non-pharmacological interventions prior to the administration of the medication. Findings include Facility Reported Incident (FRI) submitted to the State Agency on 12/6/21, at 1:34 p.m. alleged use of manual or physical restraint. The description of the incident included, "2 nurses held resident [R1] while another nurse gave injection through clothing, did not explain to resident injection taking place."	F 604	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and	

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F 604 Continued From page 2

Facility investigative summary submitted to the State Agency on 12/10/21, included R1 had diagnosis of anxiety, major depression, dementia with behavioral disturbance, confusional arousals, and restlessness and agitation. On 12/4/21, R1 became angry that she could not talk to her son, this anger and swearing began at 6:00 a.m. Registered nurse (RN)-A asked R1 to go back to her room until after morning report, R1 did not and followed a night nurse down hallway as he was leaving. R1's behavior continued with yelling and swearing to the point a 1:1 was decided by RN-A. R1 was calm for a period of time with a 1:1, R1 was ambulating with walker towards dining room when licensed practical nurse (LPN)-A redirected R1 into the activity room so R1 could eat breakfast. No behavior outburst while eating breakfast. After R1 was done eating, R1 attempted to go into the dining room, R1 was swearing and yelling about not talking with her son. LPN-A redirected R1 to her room for toileting, R1 complied but was yelling and swearing during this time. Other residents on the R1's unit began having concerns for their safety at this time. RN-A obtained an order for Haldol (anti-psychotic) intramuscular (IM) and send to emergency room (ER). As R1 came out of the room, RN-A and LPN-A took hold of R1's arms while LPN-B administered the IM Haldol through R1's clothing. After the injection R1 began swinging her walker striking LPN-A and RN-A. The report indicated staff had informed R1 her son was in the ER to see R1, R1 calmly walked to the ER with staff.

R1's quarterly Minimum Data Set (MDS) dated 11/4/21, indicated R1's brief interview for mental status score was 12, which indicated moderate

F 604

Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this timeframe should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs.

R1, care plan reviewed and revised.
Education provided to nursing staff on 12/7/2021 regarding documentation of the electronic behavior note , and policies which included Vulnerable Adult and Restraint which included physical and chemical restraint. 12/21/2021 behavioral education regarding documentation of the behavior note template.
Education continues to be provided to all staff regarding restraints policy and Vulnerable adult policy.
Lake City Care Center to monitor its corrective actions by conducting weekly psychotropic interdisciplinary meeting with review of identified residents which includes ensuring consents, non-pharm medications, effectiveness, behavioral documentation, prn and scheduled psychotropic medications. Findings from

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F 604	Continued From page 3	F 604		

cognitive impairment. The MDS indicated R1 did not have symptoms of delirium and did not have verbal or physical behaviors. The MDS identified R1 did not require staff assistance for bed mobility, walking, and locomotion on and off the unit. The MDS also indicated R1 was administered antidepressant and antipsychotic medications daily during the assessment period.

R1's physician orders on 12/4/21, included the STAT doses of Seroquel and Haldol, physician orders did not include orders for physically restraining R1 for the administration.

R1's care plan dated 11/11/21, identified individualized behavioral interventions; the care plan did not include, identify, or instruct staff to use intimidation and/or restraints to administer antipsychotic medication, and did not direct staff to give medications without first obtaining R1's consent prior to administering. The care plan included, "[R1] may refuse her medications at times when she becomes agitated. Staff are to utilize physicians' orders or call on call provider for follow up." and "If [R1] becomes physically violent and un-redirectable, staff are to call security or the local police department to assist her to the ER for evaluation. Charge nurse to assess and determine when necessary."

R1's behavior note dated 12/4/21, indicated at 7:00 a.m. R1 was agitated, yelling/screaming at staff wanting to talk to her son. The nurse called the on-call physician at 7:15 a.m. when the behavior continued; physician gave order to increase Seroquel and add as needed dose. The note included, "Resident did take increased dose." The note indicated R1 continued to yell loudly that she wanted to see her son, and R1

Provider's plan of correction (F 604):

the meeting will be reported at the QAPI meeting for evaluation and feedback.
Deficiency to be corrected on January 11th, 2022.
Director of Nursing responsible to ensure compliance.

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F 604	Continued From page 4 started to yell at residents as R1 walked down hallways. In addition, R1 threatened staff by holding her fist up and pushed staff with her walker. "On call [physician] was called and updated with new order of IM [intramuscular] injection to be administered STAT. 4 staff was able to give injection." During entrance conference on 12/8/21, at 10:23 a.m. the administrator and interim director of nursing (IDON) were interviewed regarding the submitted FRI. The IDON stated she had come into work the morning of 12/6/21, and was looking for a report for stand-up meeting and saw that R1 had transferred to the hospital. IDON stated she looked for more specific information and found a progress note that it took four nurses to administer an IM injection. IDON stated she started investigating immediately and once she interviewed and found out what happened, she knew it was a vulnerable adult incident and made a report to the State Agency as quickly as possible. IDON stated the incident happed on 12/4/21, and stated the progress notes lacked specific information about the timing of the sequence of events. IDON indicated so far in her investigation she had found, R1's behaviors started at 6:15 a.m., RN-A had obtained an order for an extra dose of Seroquel around 7:15 a.m., LPN-A administered the medication without R1's consent and without attempt of care plan interventions, R1's behaviors of yelling continued and became increasingly agitated, RN-A obtained IM Haldol order, and while 3 other nurses surrounded her by the entrance of her room, RN-B injected the Haldol into R1's buttock through her clothing without R1's knowledge and two nurses held R1's arms. IDON indicated the time in which Haldol was administered was not	F 604		

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F 604	Continued From page 5	F 604		

clear and the time that R1 transferred to the hospital was not identified in the record. IDON indicated RN-B was the nurse who stood in front of R1, RN-A and LPN-A were the nurses who physically restrained R1's arms. IDON stated she asked LPN-B what R1 was doing at the time that warranted the injection, and IDON stated , "Was not enough to give a Haldol injection. Honestly there was no redirection, she was cursing and yelling, she [R1] didn't start hitting until after injection was given." IDON indicated the three nurses involved reported they had not recognized that using physical restraints was not in accordance with the standards of practice and against facility policy because that was not the standard that was set by the previous DON. IDON stated the facility does not endorse or use physical restraints and if staff thought R1 was in jeopardy of harming herself and others they should have called 911 for assistance. IDON stated the Seroquel and IM Haldol should not have been administered without R1's consent and a means to attempt to control R1's behaviors, instead care plan interventions should have been offered and attempted first.

During an interview on 12/8/21, at 11:30 a.m. LPN-A stated around 7:00 a.m. he had been informed R1 required direct supervision (1:1) because she was having behaviors. LPN-A stated R1 was very agitated, she woke up mad, angry about wanting to call her son, yelling as she walked down hallways. LPN-A stated the staff could not allow R1 to talk to her son per R1's care plan. LPN-A indicated he had attempted to calm R1 down by telling her he would look for the phone number, however, this did not work. LPN-A indicated R1's yelling behaviors were starting to upset and scare other residents. LPN-A stated as

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F 604	Continued From page 6 R1 walked around yelling, he followed from a distance to make sure R1 did not physically or verbally assault residents. LPN-A indicated when R1 went to her room, they [RN-A, LPN-B, and RN-B] walked down to R1's room, as R1 walked out of her room. LPN-A indicated staff had surrounded R1 outside her doorway and were trying to get her back into her room. LPN-A stated he was on R1's right side, thought RN-A was on R1's left side, and LPN-B was behind R1. LPN-A indicated R1 had been pushing her walker in an aggressive manner towards RN-B who he thought was standing in front of R1. LPN-A indicated at some point he physically grabbed R1's arm to prevent movements and was not sure if the hold happened before or after LPN-B administered the medication for sure because it all happened so fast. LPN-A indicated after the injection was given R1 continued to yell/scream, however, staff were able to escort R1 to the adjacent emergency department. LPN-A indicated while R1 was surrounded by staff, R1's care plan interventions for behavioral management were not offered or attempted. LPN-A indicated an unawareness and did not identify that surrounding R1 and preventing her from walking away to give the injection was a type of restraint. LPN-A indicated he did not think holding onto R1's arms was a manual physical restraint because R1 was standing up and not lying down in bed. LPN-A stated a similar practice had been used before on R1 when the previous DON was there (about a year ago) and thought the practices were acceptable until 12/6/21, when he was informed and provided re-education by the IDON. During an interview on 12/8/21, at 12:45 p.m. LPN-B stated on 12/4/21, she had arrived at the facility at 6:30 a.m. LPN-B indicated R1 was	F 604		

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F 604	Continued From page 7 walking around her unit and the other unit yelling and screaming about not being able to call her son, R1 was scaring other residents. LPN-A was providing 1:1 to make sure other residents were safe from R1. LPN-A thought R1's behaviors were directed toward staff and did not observe R1 physically and/or verbally abusing other residents. LPN-B stated RN-A had obtained an order for IM Haldol between 7:30 a.m. and 8:30 a.m.. LPN-B stated she drew the medication up and volunteered to give it which made her nervous and scared. LPN-B stated R1 had gone into her room, and they (RN-A, LPN-A, and RN-B) were trying to get R1 to go back into her room, which made R1 get even madder. LPN-B indicated RN-A was on R1's right side and LPN-A was on her left side, RN-A was in front. LPN-B stated RN-A directed her to come around the doorway and give R1 the injection. LPN-B indicated she gave R1 the injection in her left buttock through her pants. LPN-B stated she did not ask or inform R1 of the injection first and stated R1 tried to turn around with her walker. LPN-B stated an awareness that RN-A and LPN-A held onto R1 but was not able to articulate how or at what point LPN-A and RN-A had restrained R1's arms. LPN-B indicated at the time she did not identify wrong doing by surrounding R1, physically restraining R1's arms, and injecting medication through R1's pants because that had been the previous practice. LPN-A stated she was not aware until Monday 12/6/21, when administration had provided education and informed her of the policy. During an interview on 12/8/21, at 1:47 p.m. RN-A stated she was the charge nurse working on 12/4/21. RN-A stated R1 got up angry and was yelling and screaming. RN-A stated R1 verbally	F 604		

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F 604	Continued From page 8 assaulted a nurse as they left the building around 6:30 a.m. RN-A indicated R1's behaviors continued, RN-A indicated R1 had not physically assaulted and/or harmed other residents but, R1 was disruptive and scaring other residents as she walked around her unit and the other unit. RN-A indicated around 7:15 she had administered the Seroquel without R1 knowing, it seemed to have no effect, she called the physician a second time and got an order for IM Haldol. RN-A indicated R1 went into her room to use the bathroom, and as R1 started exiting her room, that is when LPN-B went behind R1 and gave R1 the injection, which startled R1. R1 picked up her walker and turned back toward LPN-B. RN-A and LPN-B laced their arms around R1's arms preventing her from striking out. RN-A stated they held R1's arms for 15 to 30 seconds. RN-A stated R1 continued to yell/scream at staff for about 20-30 minutes, however, R1 was agreeable to walk to the adjacent emergency room after staff informed R1 that her son was waiting for her there. RN-A indicated an unawareness of the facility's restraint policies pertaining to medication administration and manual holds because it had been an acceptable practice of the previous DON. RN-A stated she had received re-education on 12/6/21. During an observation and interview on 12/8/21, at 4:30 p.m. R1 sat in a chair in her room. R1 stated things were going fine except she had a fall the other day while at the hospital, did not mention her son and/or of verbal/physical behaviors. R1 stood up with socks on, grabbed her walker, and walked out into the hallway. An unidentified nurse, walked down the hallway to R1, explained she was concerned because R1 did not have shoes on and did not want her to fall. R1 willingly allowed the nurse to escort her back	F 604		

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F 604	Continued From page 9	F 604		

into her room.

During an interview on 12/8/21, at 6:37 p.m. RN-B stated on 12/4/21, she had started work at 6:00 a.m. and was not sure what time R1's yelling behaviors had started because she was not on R1's unit. RN-B indicated around 7:30 a.m. R1 had walked over to the unit she was working on and saw/heard R1 yelling at LPN-A. RN-B stated R1 was walking around the nursing units yelling and screaming at staff about wanting to talk to her son. RN-B indicated because of R1's disruptive and aggressive behaviors toward staff, staff had provided 1:1 supervision to assure other residents were not harmed. RN-B indicated around 8:30 a.m. R1 continued to yell/scream and RN-A had obtained an order for IM Haldol. RN-B stated when she got over to R1's unit with LPN-B with the Haldol injection, R1 was walking down the hallway back to her room with RN-A following her from a short distance. RN-B stated when R1 was exiting her room and staff were standing around her. RN-B asked R1 to go back in her room, and R1 told her no. RN-B stated she then asked R1 why she was so upset with them, and R1 got in her face. R1 did not hit her but she thought she was going to. RN-B stated that is when LPN-B must have given R1 the injection, as R1 turned and looked down and asked LPN-B if she had given her a shot. RN-B indicated LPN-A and RN-A had grabbed R1's arms to keep her from striking out or to stabilize her.

Facility policy Restraint-Physical Device, Use of dated 4/2018 included, It is the policy of the facility to ensure a restraint is utilized for the shortest duration possible, resident is comfortable and review of devices on admission, quarterly, annually, with change in status, and when a

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F 604	Continued From page 10 therapeutic is being considered and trialed. NOTE: RESTRAINTS OF ANY TYPE WILL NOT BE USED AS PUNISHMENT OR AS A SUBSTITUTE FOR MORE EFFECTIVE MEDICAL AND NURSING CARE OR FOR THE CONVENIENCE OF FACILITY STAFF. The procedure directed the following: 1) if the device use is deemed necessary, the goal will be to use the least restrictive type of device for the shortest period of time possible. 3) A physician's order for a physical device restraint is required and must specify the type of device, specific reason (medical symptom) and duration of application.	F 604		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		1/11/22

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F 758	Continued From page 11 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to document, monitor, and evaluate the effectiveness of non-pharmacological behavioral management interventions for target behaviors that were identified for antipsychotic medications for 2 of 3 residents (R2, R3) reviewed for behavioral management. Findings include R2's quarterly Minimum Data Set dated 11/10/21, indicated R2 had moderate cognitive impairment,	F 758	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of	

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F 758	Continued From page 12 did not have signs/symptoms of delirium, and had rejection of care behaviors. The MDS identified R2 was administered antipsychotic and antidepressant medications during the assessment period. R2's care plan dated 11/15/21, indicated R2 had diagnoses of major depressive disorder, dementia with behavioral disturbance, and anxiety disorder. R2's care plan identified R2 used psychotropic medications for the aforementioned diagnosis and identified R2's target behaviors; Target behaviors: Trazodone 1. sleeplessness Cymbalta 2. drinking poorly 3. c/o pain Seroquel 4. hollering out 5. hitting out at others 6. delirious statements. The psychotropic care plan directed staff to follow non-pharmacological interventions under the mood/behavior plan of care and administer, monitor, and evaluate medications for side effects and effectiveness. R2's care plan did not include a "mood and behavior" focus and did not clearly identify non-pharmacological interventions for R2's target behaviors. R2's care plan indicated R2 had delirium or acute confusional episodes in which the care plan directed staff to redirect and provide gentle reality orientation as required. Reorient to person, place, time, situation as required. R2's depression plan of care directed staff to administer medications as ordered and encourage activities that R2 enjoyed participating in. R2's physician order report dated 12/10/21, identified R2's current medications which included: -Seroquel (antipsychotic medication) 12.5 milligrams (mg) twice per day for dementia with behavioral disturbance.	F 758	any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this timeframe should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs. R2 care plan updated to include mood and behavior, non-pharmacological interventions for target behaviors, triggers. R3 Care plan and medical record reviewed and updated to reflect care plan medication consistent with physician orders and target behaviors. EHR list of residents receiving psychotropic medication ensure resident etar includes behaviors, non pharmacological interventions. Review of resident behavioral communication between shift to shift. Education to continue with additional all	

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-Buspirone (anxiolytic medication) 30 mg two times a day for anxiety.
-Duloxetine (antidepressant medication) 30 mg two times a day for anxiety.
-Trazodone (antidepressant medication) 25 mg one time a day for insomnia/depression.

R2's physician orders also identified target behaviors with chart codes for staff to monitor/document for associated psychotropic medications.

R2's physician note dated 11/16/21 included, "Nursing to chart on patient's mood and behaviors qshif [every shift], with specific examples of agitation, or any behaviors that may be harmful to resident, staff or other residents, or that cause interference in caring for the patient. Review with NP/PA [nurse practitioner/physician assistant] in 2 weeks."

R2's behavioral record was reviewed between 11/19/21 to 12/9/21, although the record reflected documentation of R2's behaviors, the record lacked evidence non-pharmacological interventions were consistently attempted or offered and when interventions were documented, the record lacked evaluation of effectiveness. Examples from R2's record included:
-Progress note dated 11/19/21, included, "Resident is unhappy with staying here, wants to go home. Refused to eat dinner and refused to drink any ensure [dietary nutritional supplement], only water.
-Progress note dated 11/21/21, included, "No observed anxiousness. Resident withdrawn. Up in w/c [wheelchair] for a short time."
-Progress note dated 11/23/21, at 3:20 a.m.

F 758

staff VA education. Additional policy psychopharmacologic drug use.
At least quarterly comprehensive psychotropic assessments of residents receiving psychotropic medications.
Lake City Care Center to monitor its corrective actions by conducting weekly psychotropic interdisciplinary meeting with review of identified residents which includes ensuring consents, non-pharm medications, effectiveness, behavioral documentation, prn and scheduled psychotropic medications. Findings from the meeting will be reported at the QAPI meeting for evaluation and feedback.
Random audits to include POC behavioral documentation, behavioral monitoring and interventions report, behavioral nurses note up to 3x a week x 3 months. Finding from audits will be reported at the monthly QAPI meeting for additional feedback and evaluation.
Deficiency to be corrected on January 11th, 2022
Director of nursing responsible to ensure compliance.

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F 758	Continued From page 14 included, "This resident has been very resistive and hitting out when staff attempt to help her. Staff have attempted to redirect but she continued to yell at staff attempt to hit staff. Being changed required assist of 2 this shift." -Progress note dated 11/23/21 at 1:41 p.m. included, "Resident refused to eat lunch this shift." -Progress note dated 11/23/21, at 10:17 p.m. included, R2 was "listless, tired, obstinate but not anxious." -Progress note dated 11/24/21, at 2:42 a.m. included. "This resident has been very resistive to staff assist and has refused to let staff check her vitals this shift." -Progress note dated 11/25/21, at 2:31 p.m. included, "Resident has been refusing to let staff help with cares." -Progress note dated 11/26/21, at 3:22 a.m. included, "Resident hit staff during noc [night] rounds check and change." -Progress note dated 12/1/21, at 3:09 a.m. included, "Resident was combative with staff when assisting with brief change." R2's Point of Care (POC-nursing assistant documentation) was reviewed between 12/1/21 to 12/9/21, the documentation only identified a behavior by a numerical code in a box. POC documentation lacked evidence of non-pharmacological interventions attempted or offered when there was charting of a behavior. The record also identified multiple blank boxes. Examples included: -On 12/1/21, POC documentation for night shift identified R2 had behaviors of rejection of care, kicking/hitting and pinching/scratching/spitting. -On 12/2/21, boxes for day/evening/night shift were blank.	F 758		

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-On 12/3/21, boxes for day and evening shift were blank.
-On 12/4/21, boxes for day and evening shift were blank.
-On 12/5/21, boxes for all shifts were blank.
-On 12/6/21, boxes for all shifts were blank.
-On 12/7/21, box for night shift was blank.
-On 12/8/21, POC documentation for night shift identified R2 had behaviors of kicking/hitting and pinching/scratching/spitting.

R2's record lacked evidence of a comprehensive assessment and evaluation of R2's behaviors and effectiveness of non-pharmacological behavioral interventions in combination with effectiveness of psychotropic medications to ensure necessity or lowest therapeutic dose of psychotropic medications.

During an interview on 12/9/21, at 12:14 p.m. registered nurse (RN)-B reviewed R2's behavioral documentation and confirmed the record did not identify non-pharmacological interventions offered or attempted. RN-B stated the behaviors were not very descriptive and should be, interventions were supposed to be documented in a progress note and if those interventions worked or not.

During an observation on 12/9/21, at 12:22 p.m. R2 sat at the dining room table in her wheelchair, R2 did not display any behaviors.

During an interview on 12/9/21, at 12:25 interim director of nursing (IDON) indicated the facility currently did not have a psychotropic interdisciplinary committee that reviewed medications and/or behaviors, however, indicated the facility worked with a pharmacist. IDON stated they encourage the least amount of psychotropic

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medication use. IDON indicated an expectation that nursing assess the resident and evaluate for the root cause of what is causing the behavior. IDON stated nurses should be documenting interventions that were utilized so it could be determined if the interventions were working.

R3's quarterly MDS dated 11/24/21, indicated R3 had severe cognitive impairment with no signs/symptoms of delirium, did not have hallucinations or delusions and did not have behaviors. The MDS identified R3 was administered antipsychotic and antidepressant medications during the assessment period.

R3's care plan dated 11/30/21, indicated R3 had diagnoses of major depressive disorder, anxiety disorder, and dementia with behavioral disturbance. R3's mood and behavior care plan included, "I have history of depression and anxiety for which I receive medication for these conditions." R3's care plan identified R3's target behaviors for psychotropic medications which included, Target behaviors to observe for Seroquel: A) Behaviors B) Hallucinations C) Delirium D) Wandering status. Bupropion: E) crying F) sad faces G) Isolating self. Buspirone: H) calling out I) verbalizations of anxiety Rivastigmine: J) Changes in cognition K) None. The mood and behavior plan of care included individualized non-pharmacological interventions associated with the target behaviors. The care plan directed staff to monitor/document side effects and effectiveness of medication

R3's physician orders dated 12/9/21, was inconsistent with the medications that were identified in the care plan. Medication orders

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F 758	Continued From page 17 included: -Seroquel (antipsychotic medication) 12.5 milligrams (mg) in the morning and 25 mg at bedtime for dementia with behavioral disturbance. -Zoloft (antidepressant medication) 100 mg once per day for depression. -Buspirone (anxiolytic medication) 20 mg twice per day for anxiety. R3's physician orders also identified target behaviors with chart codes for staff to monitor/document for associated antipsychotic medications. Medications associated with target behaviors were consistent with the physician orders, however, were inconsistent with care plan medications and the target behaviors. The physician order with a start date of 7/19/21, included charting codes for target behaviors to observe for Seroquel: 1) hallucinations 2) yelling 3) wandering 4) Crying Buspar 5) restlessness Zoloft 6) withdrawn 7) anxious behavior 8) sexual statements directed towards others 0) no behaviors occurred. R3's behavioral record was reviewed between 11/28/21 to 12/9/21, although the record reflected documentation of R3's behaviors, the record lacked evidence that non-pharmacological interventions were consistently attempted or offered and when interventions were documented, the record lacked evaluation of effectiveness. Examples from R3's record included: -Progress note dated 12/3/21, at 10:30 p.m. included, "Resident became agitated toward another resident in the dining room. Per "RNA [sic] resident threatened to cut the resident's throat. Resident had no sharp objects within reach. The other resident was yelling out loudly	F 758		

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causing this resident agitation. Resident was taken back to the unit for supper meal. Charge nurse updated."

R3's Point of Care (POC-nursing assistant documentation) was reviewed between 11/28/21 to 12/9/21, the documentation only identified a behavior by a numerical code in a box. POC documentation lacked evidence of non-pharmacological interventions attempted or offered when there was charting of a behavior. The record also identified multiple blank boxes. Examples included:
-On 11/28/21, POC documentation for day shift identified R3 had behaviors of yelling/screaming and pushing.
-On 12/3/21, POC documentation for evening shift identified R3 had behaviors of pushing
-On 12/6/21, POC documentation for night shift identified R3 had behaviors of pushing.
-On 12/7/21, POC documentation for evening shift identified R3 had behaviors of yelling/screaming.

R3's progress notes did not mention and/or address or further define the behaviors that were documented in POC on 11/28/21, 12/6/21, and 12/7/21.

R3's record lacked evidence of a comprehensive assessment and evaluation of R3's behaviors and effectiveness of non-pharmacological behavioral interventions in combination with effectiveness of psychotropic medications to ensure necessity or lowest therapeutic dose of psychotropic medications.

During an interview on 12/9/21, at 12:14 p.m. RN-B reviewed R3's behavioral documentation

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and confirmed the record did not identify non-pharmacological interventions offered or attempted. RN-B stated the behaviors were not very descriptive and should be, interventions were supposed to be documented in a progress note and if those interventions worked or not.

During an observation on 12/9/21, at 12:22 p.m. R3 sat at the dining room table in her wheelchair, R3 did not display any behaviors.

During an interview on 12/9/21, at 12:25 IDON, indicated the facility currently did not have a psychotropic interdisciplinary committee that reviewed medications and/or behaviors, however, indicated the facility worked with a pharmacist. DON stated they encourage the least amount of psychotropic medication use. IDON indicated an expectation that nursing assess the resident and evaluate for the root cause of what is causing the behavior. IDON stated nurses should be documenting interventions that were utilized so it could be determined if the interventions were working.

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
December 22, 2021

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

Re: State Nursing Home Licensing Orders
Event ID: 56J411

Dear Administrator:

The above facility was surveyed on December 8, 2021 through December 9, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00770	A. BUILDING: ______ B. WING ______	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET LAKE CITY, MN 55041**

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On 12/8/21 and 12/9/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.

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2 000	Continued From page 1	2 000		
	The following complaint was found to be SUBSTANTIATED: H5218040C (MN00079076) with a licensing order issued at 0505 and 1535. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.			

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints. B. "Chemical restraints" means any psychopharmacologic drug that is used for	2 505		1/11/22

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discipline or convenience and is not required to treat medical symptoms.

C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident.

D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest.

E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R1) right to be free from physical/chemical restraints when staff surrounded R1 preventing freedom of movement, held R1's arms and injected an antipsychotic medication without R1's consent nor attempting any non-pharmacological interventions prior to the administration of the medication.

Findings include

Facility Reported Incident (FRI) submitted to the State Agency on 12/6/21, at 1:34 p.m. alleged use of manual or physical restraint. The description of the incident included, "2 nurses held resident [R1] while another nurse gave injection through clothing, did not explain to resident injection taking place."

Facility investigative summary submitted to the State Agency on 12/10/21, included R1 had diagnosis of anxiety, major depression, dementia

Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation

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2 505	Continued From page 4 with behavioral disturbance, confusional arousals, and restlessness and agitation. On 12/4/21, R1 became angry that she could not talk to her son, this anger and swearing began at 6:00 a.m. Registered nurse (RN)-A asked R1 to go back to her room until after morning report, R1 did not and followed a night nurse down hallway as he was leaving. R1's behavior continued with yelling and swearing to the point a 1:1 was decided by RN-A. R1 was calm for a period of time with a 1:1, R1 was ambulating with walker towards dining room when licensed practical nurse (LPN)-A redirected R1 into the activity room so R1 could eat breakfast. No behavior outburst while eating breakfast. After R1 was done eating, R1 attempted to go into the dining room, R1 was swearing and yelling about not talking with her son. LPN-A redirected R1 to her room for toileting, R1 complied but was yelling and swearing during this time. Other residents on the R1's unit began having concerns for their safety at this time. RN-A obtained an order for Haldol (anti-psychotic) intramuscular (IM) and send to emergency room (ER). As R1 came out of the room, RN-A and LPN-A took hold of R1's arms while LPN-B administered the IM Haldol through R1's clothing. After the injection R1 began swinging her walker striking LPN-A and RN-A. The report indicated staff had informed R1 her son was in the ER to see R1, R1 calmly walked to the ER with staff. R1's quarterly Minimum Data Set (MDS) dated 11/4/21, indicated R1's brief interview for mental status score was 12, which indicated moderate cognitive impairment. The MDS indicated R1 did not have symptoms of delirium and did not have verbal or physical behaviors. The MDS identified R1 did not require staff assistance for bed mobility, walking, and locomotion on and off the	2 505	in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this timeframe should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs. R1, care plan reviewed and revised. Education provided to nursing staff on 12/7/2021 regarding documentation of the electronic behavior note , and policies which included Vulnerable Adult and Restraint which included physical and chemical restraint. 12/21/2021 behavioral education regarding documentation of the behavior note template. Education continues to be provided to all staff regarding restraints policy and Vulnerable adult policy. Lake City Care Center to monitor its corrective actions by conducting weekly psychotropic interdisciplinary meeting with review of identified residents which includes ensuring consents, non-pharm medications, effectiveness, behavioral documentation, prn and scheduled psychotropic medications. Findings from the meeting will be reported at the QAPI meeting for evaluation and feedback. Deficiency to be corrected on January 11th, 2022. Director of Nursing responsible to ensure	

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unit. The MDS also indicated R1 was administered antidepressant and antipsychotic medications daily during the assessment period.

compliance.

R1's physician orders on 12/4/21, included the STAT doses of Seroquel and Haldol, physician orders did not include orders for physically restraining R1 for the administration.

R1's care plan dated 11/11/21, identified individualized behavioral interventions; the care plan did not include, identify, or instruct staff to use intimidation and/or restraints to administer antipsychotic medication, and did not direct staff to give medications without first obtaining R1's consent prior to administering. The care plan included, "[R1] may refuse her medications at times when she becomes agitated. Staff are to utilize physicians' orders or call on call provider for follow up." and "If [R1] becomes physically violent and un-redirectable, staff are to call security or the local police department to assist her to the ER for evaluation. Charge nurse to assess and determine when necessary."

R1's behavior note dated 12/4/21, indicated at 7:00 a.m. R1 was agitated, yelling/screaming at staff wanting to talk to her son. The nurse called the on-call physician at 7:15 a.m. when the behavior continued; physician gave order to increase Seroquel and add as needed dose. The note included, "Resident did take increased dose." The note indicated R1 continued to yell loudly that she wanted to see her son, and R1 started to yell at residents as R1 walked down hallways. In addition, R1 threatened staff by holding her fist up and pushed staff with her walker. "On call [physician] was called and updated with new order of IM [intramuscular] injection to be administered STAT. 4 staff was

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able to give injection."

During entrance conference on 12/8/21, at 10:23 a.m. the administrator and interim director of nursing (IDON) were interviewed regarding the submitted FRI. The IDON stated she had come into work the morning of 12/6/21, and was looking for a report for stand-up meeting and saw that R1 had transferred to the hospital. IDON stated she looked for more specific information and found a progress note that it took four nurses to administer an IM injection. IDON stated she started investigating immediately and once she interviewed and found out what happened, she knew it was a vulnerable adult incident and made a report to the State Agency as quickly as possible. IDON stated the incident happed on 12/4/21, and stated the progress notes lacked specific information about the timing of the sequence of events. IDON indicated so far in her investigation she had found, R1's behaviors started at 6:15 a.m., RN-A had obtained an order for an extra dose of Seroquel around 7:15 a.m., LPN-A administered the medication without R1's consent and without attempt of care plan interventions, R1's behaviors of yelling continued and became increasingly agitated, RN-A obtained IM Haldol order, and while 3 other nurses surrounded her by the entrance of her room, RN-B injected the Haldol into R1's buttock through her clothing without R1's knowledge and two nurses held R1's arms. IDON indicated the time in which Haldol was administered was not clear and the time that R1 transferred to the hospital was not identified in the record. IDON indicated RN-B was the nurse who stood in front of R1, RN-A and LPN-A were the nurses who physically restrained R1's arms. IDON stated she asked LPN-B what R1 was doing at the time that warranted the injection, and IDON stated , "Was

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not enough to give a Haldol injection. Honestly there was no redirection, she was cursing and yelling, she [R1] didn't start hitting until after injection was given." IDON indicated the three nurses involved reported they had not recognized that using physical restraints was not in accordance with the standards of practice and against facility policy because that was not the standard that was set by the previous DON. IDON stated the facility does not endorse or use physical restraints and if staff thought R1 was in jeopardy of harming herself and others they should have called 911 for assistance. IDON stated the Seroquel and IM Haldol should not have been administered without R1's consent and a means to attempt to control R1's behaviors, instead care plan interventions should have been offered and attempted first.

During an interview on 12/8/21, at 11:30 a.m. LPN-A stated around 7:00 a.m. he had been informed R1 required direct supervision (1:1) because she was having behaviors. LPN-A stated R1 was very agitated, she woke up mad, angry about wanting to call her son, yelling as she walked down hallways. LPN-A stated the staff could not allow R1 to talk to her son per R1's care plan. LPN-A indicated he had attempted to calm R1 down by telling her he would look for the phone number, however, this did not work. LPN-A indicated R1's yelling behaviors were starting to upset and scare other residents. LPN-A stated as R1 walked around yelling, he followed from a distance to make sure R1 did not physically or verbally assault residents. LPN-A indicated when R1 went to her room, they [RN-A, LPN-B, and RN-B] walked down to R1's room, as R1 walked out of her room. LPN-A indicated staff had surrounded R1 outside her doorway and were trying to get her back into her room. LPN-A stated

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he was on R1's right side, thought RN-A was on R1's left side, and LPN-B was behind R1. LPN-A indicated R1 had been pushing her walker in an aggressive manner towards RN-B who he thought was standing in front of R1. LPN-A indicated at some point he physically grabbed R1's arm to prevent movements and was not sure if the hold happened before or after LPN-B administered the medication for sure because it all happened so fast. LPN-A indicated after the injection was given R1 continued to yell/scream, however, staff were able to escort R1 to the adjacent emergency department. LPN-A indicated while R1 was surrounded by staff, R1's care plan interventions for behavioral management were not offered or attempted. LPN-A indicated an unawareness and did not identify that surrounding R1 and preventing her from walking away to give the injection was a type of restraint. LPN-A indicated he did not think holding onto R1's arms was a manual physical restraint because R1 was standing up and not lying down in bed. LPN-A stated a similar practice had been used before on R1 when the previous DON was there (about a year ago) and thought the practices were acceptable until 12/6/21, when he was informed and provided re-education by the IDON.

During an interview on 12/8/21, at 12:45 p.m. LPN-B stated on 12/4/21, she had arrived at the facility at 6:30 a.m. LPN-B indicated R1 was walking around her unit and the other unit yelling and screaming about not being able to call her son, R1 was scaring other residents. LPN-A was providing 1:1 to make sure other residents were safe from R1. LPN-A thought R1's behaviors were directed toward staff and did not observe R1 physically and/or verbally abusing other residents. LPN-B stated RN-A had obtained an order for IM Haldol between 7:30 a.m. and 8:30 a.m.. LPN-B

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stated she drew the medication up and volunteered to give it which made her nervous and scared. LPN-B stated R1 had gone into her room, and they (RN-A, LPN-A, and RN-B) were trying to get R1 to go back into her room, which made R1 get even madder. LPN-B indicated RN-A was on R1's right side and LPN-A was on her left side, RN-A was in front. LPN-B stated RN-A directed her to come around the doorway and give R1 the injection. LPN-B indicated she gave R1 the injection in her left buttock through her pants. LPN-B stated she did not ask or inform R1 of the injection first and stated R1 tried to turn around with her walker. LPN-B stated an awareness that RN-A and LPN-A held onto R1 but was not able to articulate how or at what point LPN-A and RN-A had restrained R1's arms. LPN-B indicated at the time she did not identify wrong doing by surrounding R1, physically restraining R1's arms, and injecting medication through R1's pants because that had been the previous practice. LPN-A stated she was not aware until Monday 12/6/21, when administration had provided education and informed her of the policy.

During an interview on 12/8/21, at 1:47 p.m. RN-A stated she was the charge nurse working on 12/4/21. RN-A stated R1 got up angry and was yelling and screaming. RN-A stated R1 verbally assaulted a nurse as they left the building around 6:30 a.m. RN-A indicated R1's behaviors continued, RN-A indicated R1 had not physically assaulted and/or harmed other residents but, R1 was disruptive and scaring other residents as she walked around her unit and the other unit. RN-A indicated around 7:15 she had administered the Seroquel without R1 knowing, it seemed to have no effect, she called the physician a second time and got an order for IM Haldol. RN-A indicated R1

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went into her room to use the bathroom, and as R1 started exiting her room, that is when LPN-B went behind R1 and gave R1 the injection, which startled R1. R1 picked up her walker and turned back toward LPN-B. RN-A and LPN-B laced their arms around R1's arms preventing her from striking out. RN-A stated they held R1's arms for 15 to 30 seconds. RN-A stated R1 continued to yell/scream at staff for about 20-30 minutes, however, R1 was agreeable to walk to the adjacent emergency room after staff informed R1 that her son was waiting for her there. RN-A indicated an unawareness of the facility's restraint policies pertaining to medication administration and manual holds because it had been an acceptable practice of the previous DON. RN-A stated she had received re-education on 12/6/21.

During an observation and interview on 12/8/21, at 4:30 p.m. R1 sat in a chair in her room. R1 stated things were going fine except she had a fall the other day while at the hospital, did not mention her son and/or of verbal/physical behaviors. R1 stood up with socks on, grabbed her walker, and walked out into the hallway. An unidentified nurse, walked down the hallway to R1, explained she was concerned because R1 did not have shoes on and did not want her to fall. R1 willingly allowed the nurse to escort her back into her room.

During an interview on 12/8/21, at 6:37 p.m. RN-B stated on 12/4/21, she had started work at 6:00 a.m. and was not sure what time R1's yelling behaviors had started because she was not on R1's unit. RN-B indicated around 7:30 a.m. R1 had walked over to the unit she was working on and saw/heard R1 yelling at LPN-A. RN-B stated R1 was walking around the nursing units yelling and screaming at staff about wanting to talk to

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her son. RN-B indicated because of R1's disruptive and aggressive behaviors toward staff, staff had provided 1:1 supervision to assure other residents were not harmed. RN-B indicated around 8:30 a.m. R1 continued to yell/scream and RN-A had obtained an order for IM Haldol. RN-B stated when she got over to R1's unit with LPN-B with the Haldol injection, R1 was walking down the hallway back to her room with RN-A following her from a short distance. RN-B stated when R1 was exiting her room and staff were standing around her. RN-B asked R1 to go back in her room, and R1 told her no. RN-B stated she then asked R1 why she was so upset with them, and R1 got in her face. R1 did not hit her but she thought she was going to. RN-B stated that is when LPN-B must have given R1 the injection, as R1 turned and looked down and asked LPN-B if she had given her a shot. RN-B indicated LPN-A and RN-A had grabbed R1's arms to keep her from striking out or to stabilize her.

Facility policy Restraint-Physical Device, Use of dated 4/2018 included, It is the policy of the facility to ensure a restraint is utilized for the shortest duration possible, resident is comfortable and review of devices on admission, quarterly, annually, with change in status, and when a therapeutic is being considered and trialed. NOTE: RESTRAINTS OF ANY TYPE WILL NOT BE USED AS PUNISHMENT OR AS A SUBSTITUTE FOR MORE EFFECTIVE MEDICAL AND NURSING CARE OR FOR THE CONVENIENCE OF FACILITY STAFF. The procedure directed the following: 1) if the device use is deemed necessary, the goal will be to use the least restrictive type of device for the shortest period of time possible. 3) A physician's order for a physical device restraint is required and must specify the type of device, specific reason

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2 505	Continued From page 12 (medical symptom) and duration of application. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review or revise policies regarding the use of physical/chemical restraints. The DON and /or designee could provide education for staff regarding physical restraint use. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 505		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan	21535		1/11/22

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21535	Continued From page 13 system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to document, monitor, and evaluate the effectiveness of non-pharmacological behavioral management interventions for target behaviors that were identified for antipsychotic medications for 2 of 3 residents (R2, R3) reviewed for behavioral management. Findings include R2's quarterly Minimum Data Set dated 11/10/21, indicated R2 had moderate cognitive impairment, did not have signs/symptoms of delirium, and had rejection of care behaviors. The MDS identified R2 was administered antipsychotic and antidepressant medications during the assessment period. R2's care plan dated 11/15/21, indicated R2 had diagnoses of major depressive disorder, dementia with behavioral disturbance, and anxiety disorder. R2's care plan identified R2 used psychotropic medications for the aforementioned diagnosis and identified R2's target behaviors; Target behaviors: Trazodone 1. sleeplessness Cymbalta 2. drinking poorly 3. c/o pain Seroquel 4. hollering out 5. hitting out at others 6. delirious statements. The psychotropic care plan directed staff to follow non-pharmacological interventions under the mood/behavior plan of care and administer, monitor, and evaluate medications for side effects and effectiveness. R2's care plan did not include	21535	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this timeframe should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the	

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21535	Continued From page 14 a "mood and behavior" focus and did not clearly identify non-pharmacological interventions for R2's target behaviors. R2's care plan indicated R2 had delirium or acute confusional episodes in which the care plan directed staff to redirect and provide gentle reality orientation as required. Reorient to person, place, time, situation as required. R2's depression plan of care directed staff to administer medications as ordered and encourage activities that R2 enjoyed participating in. R2's physician order report dated 12/10/21, identified R2's current medications which included: -Seroquel (antipsychotic medication) 12.5 milligrams (mg) twice per day for dementia with behavioral disturbance. -Buspirone (anxiolytic medication) 30 mg two times a day for anxiety. -Duloxetine (antidepressant medication) 30 mg two times a day for anxiety. -Trazodone (antidepressant medication) 25 mg one time a day for insomnia/depression. R2's physician orders also identified target behaviors with chart codes for staff to monitor/document for associated psychotropic medications. R2's physician note dated 11/16/21 included, "Nursing to chart on patient's mood and behaviors qshif [every shift], with specific examples of agitation, or any behaviors that may be harmful to resident, staff or other residents, or that cause interference in caring for the patient. Review with NP/PA [nurse practitioner/physician assistant] in 2 weeks." R2's behavioral record was reviewed between	21535	purpose of compliance with the rules of participation for the Medicaid and Medicare programs. R2 care plan updated to include mood and behavior, non-pharmacological interventions for target behaviors, triggers. R3 Care plan and medical record reviewed and updated to reflect care plan medication consistent with physician orders and target behaviors. EHR list of residents receiving psychotropic medication ensure resident etar includes behaviors, non –pharmacological interventions. Review of resident behavioral communication between shift to shift. Education to continue with additional all staff VA education. Additional policy “psychopharmacologic drug use.” At least quarterly comprehensive psychotropic assessments of residents receiving psychotropic medications. Lake City Care Center to monitor its corrective actions by conducting weekly “psychotropic interdisciplinary “meeting with review of identified residents which includes ensuring consents, non-pharm medications, effectiveness, behavioral documentation, prn and scheduled psychotropic medications. Findings from the meeting will be reported at the QAPI meeting for evaluation and feedback. Random audits to include POC behavioral documentation, behavioral monitoring and interventions report, behavioral nurses note up to 3x a week x 3 months. Finding from audits will be reported at the monthly QAPI meeting for additional feedback and evaluation.	

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21535	Continued From page 15 11/19/21 to 12/9/21, although the record reflected documentation of R2's behaviors, the record lacked evidence non-pharmacological interventions were consistently attempted or offered and when interventions were documented, the record lacked evaluation of effectiveness. Examples from R2's record included: -Progress note dated 11/19/21, included, "Resident is unhappy with staying here, wants to go home. Refused to eat dinner and refused to drink any ensure [dietary nutritional supplement], only water. -Progress note dated 11/21/21, included, "No observed anxiousness. Resident withdrawn. Up in w/c [wheelchair] for a short time." -Progress note dated 11/23/21, at 3:20 a.m. included, "This resident has been very resistive and hitting out when staff attempt to help her. Staff have attempted to redirect but she continued to yell at staff attempt to hit staff. Being changed required assist of 2 this shift." -Progress note dated 11/23/21 at 1:41 p.m. included, "Resident refused to eat lunch this shift." -Progress note dated 11/23/21, at 10:17 p.m. included, R2 was "listless, tired, obstinate but not anxious." -Progress note dated 11/24/21, at 2:42 a.m. included. "This resident has been very resistive to staff assist and has refused to let staff check her vitals this shift." -Progress note dated 11/25/21, at 2:31 p.m. included, "Resident has been refusing to let staff help with cares." -Progress note dated 11/26/21, at 3:22 a.m. included, "Resident hit staff during noc [night] rounds check and change." -Progress note dated 12/1/21, at 3:09 a.m. included, "Resident was combative with staff	21535	Deficiency to be corrected on January 11th, 2022 Director of nursing responsible to ensure compliance.	

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when assisting with brief change."

R2's Point of Care (POC-nursing assistant documentation) was reviewed between 12/1/21 to 12/9/21, the documentation only identified a behavior by a numerical code in a box. POC documentation lacked evidence of non-pharmacological interventions attempted or offered when there was charting of a behavior. The record also identified multiple blank boxes. Examples included:
-On 12/1/21, POC documentation for night shift identified R2 had behaviors of rejection of care, kicking/hitting and pinching/scratching/spitting.
-On 12/2/21, boxes for day/evening/night shift were blank.
-On 12/3/21, boxes for day and evening shift were blank.
-On 12/4/21, boxes for day and evening shift were blank.
-On 12/5/21, boxes for all shifts were blank.
-On 12/6/21, boxes for all shifts were blank.
-On 12/7/21, box for night shift was blank.
-On 12/8/21, POC documentation for night shift identified R2 had behaviors of kicking/hitting and pinching/scratching/spitting.

R2's record lacked evidence of a comprehensive assessment and evaluation of R2's behaviors and effectiveness of non-pharmacological behavioral interventions in combination with effectiveness of psychotropic medications to ensure necessity or lowest therapeutic dose of psychotropic medications.

During an interview on 12/9/21, at 12:14 p.m. registered nurse (RN)-B reviewed R2's behavioral documentation and confirmed the record did not identify non-pharmacological interventions offered or attempted. RN-B stated the behaviors were not

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very descriptive and should be, interventions were supposed to be documented in a progress note and if those interventions worked or not.

During an observation on 12/9/21, at 12:22 p.m. R2 sat at the dining room table in her wheelchair, R2 did not display any behaviors.

During an interview on 12/9/21, at 12:25 interim director of nursing (IDON) indicated the facility currently did not have a psychotropic interdisciplinary committee that reviewed medications and/or behaviors, however, indicated the facility worked with a pharmacist. IDON stated they encourage the least amount of psychotropic medication use. IDON indicated an expectation that nursing assess the resident and evaluate for the root cause of what is causing the behavior. IDON stated nurses should be documenting interventions that were utilized so it could be determined if the interventions were working.

R3's quarterly MDS dated 11/24/21, indicated R3 had severe cognitive impairment with no signs/symptoms of delirium, did not have hallucinations or delusions and did not have behaviors. The MDS identified R3 was administered antipsychotic and antidepressant medications during the assessment period.

R3's care plan dated 11/30/21, indicated R3 had diagnoses of major depressive disorder, anxiety disorder, and dementia with behavioral disturbance. R3's mood and behavior care plan included, "I have history of depression and anxiety for which I receive medication for these conditions." R3's care plan identified R3's target behaviors for psychotropic medications which included, Target behaviors to observe for

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Seroquel: A) Behaviors B) Hallucinations C) Delirium D) Wandering status. Bupropion: E) crying F) sad faces G) Isolating self. Buspirone: H) calling out I) verbalizations of anxiety Rivastigmine: J) Changes in cognition K) None. The mood and behavior plan of care included individualized non-pharmacological interventions associated with the target behaviors. The care plan directed staff to monitor/document side effects and effectiveness of medication

R3's physician orders dated 12/9/21, was inconsistent with the medications that were identified in the care plan. Medication orders included:
-Seroquel (antipsychotic medication) 12.5 milligrams (mg) in the morning and 25 mg at bedtime for dementia with behavioral disturbance.
-Zoloft (antidepressant medication) 100 mg once per day for depression.
-Buspirone (anxiolytic medication) 20 mg twice per day for anxiety.

R3's physician orders also identified target behaviors with chart codes for staff to monitor/document for associated antipsychotic medications. Medications associated with target behaviors were consistent with the physician orders, however, were inconsistent with care plan medications and the target behaviors. The physician order with a start date of 7/19/21, included charting codes for target behaviors to observe for Seroquel: 1) hallucinations 2) yelling 3) wandering 4) Crying Buspar 5) restlessness Zoloft 6) withdrawn 7) anxious behavior 8) sexual statements directed towards others 0) no behaviors occurred.

R3's behavioral record was reviewed between 11/28/21 to 12/9/21, although the record reflected

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documentation of R3's behaviors, the record lacked evidence that non-pharmacological interventions were consistently attempted or offered and when interventions were documented, the record lacked evaluation of effectiveness. Examples from R3's record included:
-Progress note dated 12/3/21, at 10:30 p.m. included, "Resident became agitated toward another resident in the dining room. Per "RNA [sic] resident threatened to cut the resident's throat. Resident had no sharp objects within reach. The other resident was yelling out loudly causing this resident agitation. Resident was taken back to the unit for supper meal. Charge nurse updated."

R3's Point of Care (POC-nursing assistant documentation) was reviewed between 11/28/21 to 12/9/21, the documentation only identified a behavior by a numerical code in a box. POC documentation lacked evidence of non-pharmacological interventions attempted or offered when there was charting of a behavior. The record also identified multiple blank boxes. Examples included:
-On 11/28/21, POC documentation for day shift identified R3 had behaviors of yelling/screaming and pushing.
-On 12/3/21, POC documentation for evening shift identified R3 had behaviors of pushing
-On 12/6/21, POC documentation for night shift identified R3 had behaviors of pushing.
-On 12/7/21, POC documentation for evening shift identified R3 had behaviors of yelling/screaming.

R3's progress notes did not mention and/or address or further define the behaviors that were documented in POC on 11/28/21, 12/6/21, and

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12/7/21.

R3's record lacked evidence of a comprehensive assessment and evaluation of R3's behaviors and effectiveness of non-pharmacological behavioral interventions in combination with effectiveness of psychotropic medications to ensure necessity or lowest therapeutic dose of psychotropic medications.

During an interview on 12/9/21, at 12:14 p.m. RN-B reviewed R3's behavioral documentation and confirmed the record did not identify non-pharmacological interventions offered or attempted. RN-B stated the behaviors were not very descriptive and should be, interventions were supposed to be documented in a progress note and if those interventions worked or not.

During an observation on 12/9/21, at 12:22 p.m. R3 sat at the dining room table in her wheelchair, R3 did not display any behaviors.

During an interview on 12/9/21, at 12:25 IDON, indicated the facility currently did not have a psychotropic interdisciplinary committee that reviewed medications and/or behaviors, however, indicated the facility worked with a pharmacist. DON stated they encourage the least amount of psychotropic medication use. IDON indicated an expectation that nursing assess the resident and evaluate for the root cause of what is causing the behavior. IDON stated nurses should be documenting interventions that were utilized so it could be determined if the interventions were working.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could

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21535	Continued From page 21 review policies/procedures for unnecessary medications, educate staff, and perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		