Electronically delivered

May 17, 2021

Administrator
Wabasso Restorative Care Center
660 Maple Street
Wabasso, MN 56293

RE: CCN: 245400
Cycle Start Date: December 28, 2020

Dear Administrator:

On December 31, 2020, we informed you that we may impose enforcement remedies.

On May 4, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 28, 2021, will remain in effect.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

As we notified you in our letter of December 31, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 28, 2021 since your facility didn't come into compliance by March 28, 2020. This does not apply to or affect any previously imposed NATCEP loss.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 28, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of

October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
May 17, 2021

Administrator
Wabasso Restorative Care Center
660 Maple Street
Wabasso, MN 56293

Re: State Nursing Home Licensing Orders
Event ID: M9PI11

Dear Administrator:

The above facility was surveyed on April 30, 2021 through May 4, 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00949	A. BUILDING: _____ B. WING _____	C 05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASSO RESTORATIVE CARE CENTER	660 MAPLE STREET WABASSO, MN 56293

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 4/30/21 through 5/4/21, 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	2 000		

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2 000	Continued From page 1 completed. The following complaint was found to be SUBSTANTIATED: H5400028C (MN72275, MN72322, MN72287, and MN72336) with a licensing order issued at S1540. H5400029C (MN71933), was also SUBSTANTIATED, however NO licensing order was issued. The following complaint was found to be UNSUBSTANTIATED: H5400030C (MN72023). 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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	2 000		

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2 000	Continued From page 2 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. 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		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.	21540		5/24/21

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21540	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate behavior monitoring for 1 of 1 resident (R1) receiving antipsychotic medication (Seroquel) with increased behaviors, resulting in an episode of new onset paranoid schizophrenia and inpatient psychiatric treatment. Findings include: R1's 1/4/21, admission Minimum Data Set (MDS) identified he had moderate cognitive impairment. R1 had diagnoses of Wernicke's encephalopathy (acute neurological disorder caused by a thiamine deficiency induced by alcoholism resulting in delirium, confusion, and memory disturbances), anxiety, major depression and low thyroid and alcohol dependence with withdrawal delirium. R1's Care Area Assessment identified he required supervision on the unit. R1 had expectations to discharge back to the community after completing chemical dependency treatment. R1's April 2021, physicians orders and medication administration record (MAR) identified he was administered Seroquel 25 milligrams (mg) (anti-psychotic) twice daily for major depression beginning 3/19/21, Trazodone 50 mg (anti-depressant) at bedtime for insomnia, venlafaxine 225 mg daily (anti-depressant) for depression, buspirone twice daily for anxiety, a 24 hour nicotine patch (14 micrograms), Nicorette gum hourly as needed, a multivitamin for alcohol abuse, and Melatonin 3 mg at bedtime for insomnia. R1's current, undated care plan identified he was	21540	Completed	

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21540	Continued From page 4	21540		

not always aware of physical and verbally boundaries when it comes to other residents and staff related to his Wernicke's encephalopathy. R1 had been found lurking out side of another female resident's room. He had a history of unfound accusations of staff not allowing him items or access
to certain information. R1 had a history of aggression towards male staff when boundaries were set regarding behavioral management and expectations. Staff were to:
1) Administer his medications as ordered, assist him with appropriate methods of coping and interacting, explain and reinforce why his behaviors were inappropriate and/or unacceptable, intervene as necessary, and monitor behaviors. 2) Monitor behavior episodes and attempt to determine the underlying cause and document those behaviors and potential causes. R1 also had depression due to his Wernicke's encephalopathy, depression, and anxiety. Staff were to administer medications as ordered and monitor for and document side effects and effectiveness.
3) Arrange for a psych consult and follow up as indicated.
4) Monitor, document, and report as needed any signs or symptoms of depression, including hopelessness, anxiety, sadness, insomnia, not eating, verbalizing negative statements, repetitive anxious or health-related complaints, tearfulness. There was no indication staff had followed the care plan and monitored for medication side effects or behaviors.

Interview on 4/30/21 at 11:00 a.m., with nurse aide (NA)-C identified she was familiar with R1. R1's behaviors had escalated since admission, but especially in the last few weeks. Staff were to chart behaviors in both the electronic medical

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21540	Continued From page 5 record and the paper monthly charting system. When staff charted each shift, they only charted behaviors at that moment, and not documented others they may have observed throughout their shift. There was no paper behavioral charting completed for the month of April as "no one made up the sheets". Interview on 4/30/21 at 11:30 a.m., with registered nurse (RN)-B identified she was new to the facility and had been working there about a week. RN-B was unsure what staff charted on R1. She was made aware of R1's escalating behaviors. R1 was in the ER and was on a 72 hr hold. He was very cooperative with her and the limited interaction she had with him, he showed no signs or symptoms of paranoia she was aware of. R1's progress notes identified: 1) Between 4/8/21 and 4/24/21, there were no behaviors documented in progress notes. 2) On 4/25/21 at 4:02 p.m., R1 was noted to be paranoid. R1 reported staff "were not nice to him". R1 had written down the names of all staff and was keeping a log of staff activities. Staff were encouraged to talk to him and reassure him staff were there to help him, not "after him". 3) On 4/25/21 at 8:19 p.m., R1 was noted to have been pacing several times to and from his room with a batch of papers, file, and his iPad. R1" looked distressed". He was talking to himself most of the time. Staff approached R1 to find out his concerns. He told staff that he was so stressed because of financial and other legal issues. He declined to state the specific financial and legal challenges he was facing. R1 was asked if he had any plans of self-harm which he denied. A report would be given to the social worker to address his concerns. Staff were to continue to monitor and encourage R1 to voice	21540		

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21540	Continued From page 6	21540		

his concerns so they could be addressed by the care team.
4) On 4/27/21 at 4:55 a.m., staff noted R1 went to sleep at around 10 a.m. on 4/26/21, and woke up at 0430.
5) On 4/27/21 at 12:08 p.m., R1 met with the administrator and registered nurse (RN)-A. R1 was requested to stop posting messages on company's Facebook page and his own personal page. The admin informed R1 if he had specific grievances, he should speak to himself or nursing about it and it would be addressed. R1 became upset and stated he had not been "getting any help". The administrator advised R1 any of his concerns pertaining to his stay and care related to the facility would be addressed if he voiced them to staff. R1 was reminded of specific examples of previous concerns he had and the assistance given. R1 said "I have never been given any help, even when I had issues with my bank account." Resident was informed that he was helped, however, staff were not authorized to access his private banking accounts. R1 became verbally aggressive and started yelling. Staff reinforced he was not to yell. R1 stated " I do not want to talk to you. This conversation is over. I do not want to talk to anybody. I am getting out of here. " The administrator informed R1 he was his own responsible party and could make his own decisions, and that if he felt that he wanted to leave, he was free to do so. The admin requested if he wished to leave, that R1 would provide the facility with his desired date of discharge and location where he was going to discharged to. R1 started yelling and left. A few minutes later, R1 came back to the commons area and started yelling he had been told to leave today. R1, RN-A and the interim director of nursing (IDON) informed R1 his statement was not true. RN-A reiterated what they had told R1 earlier. R1 was

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21540	Continued From page 7	21540		

asked to meet further for privacy with the administrator and RN-A. administrator and RN to the meeting room for privacy so other residents were not present. R1 left to go to his room while yelling. Staff documented they would continue to monitor.
6) On 4/28/21 at 1:31, staff documented earlier that day today while the nurse was making arrangements to discharge another resident from the facility, R1 was standing outside of that resident's room. When staff asked him what he was doing he stated he was "protecting the resident". Staff asked the female resident (R14) if she wanted him present. R14 stated "I don't know what he is doing there..." Staff asked him to move away from the door.
7) On 4/29/21 at 12:30 a.m., R1 was noted to have refused to take his evening medications. R1 stated he "wanted to stay up all night" and the medication didn't do him "any good". R1 then came out of his room and started telling staff he filed a lawsuit against the facility, the administrator and the IDON. R1 further stated, "These guys are going to jail... that is where they belong!. I have done lawsuits all my life. That is how I earned my living. This facility is going to pay me a lot of money. Me and my family...we have teamed up and we have hired a lawyer for this case. We have to shut this place down and have them go to jail". He also advised staff they better quit working for the facility since the State was going to shut down the facility following his lawsuit. He asked staff to give him the resident's phone to call the police to get him out of the facility. R1 was given the phone and called the police.
8) On 4/29/21 at 10: 02 a.m., staff advised the regional administrator of the situation regarding R1. R1 was reported to be refusing medications and threatening staff. Staff noted there was a

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concern of potential harm to others in the building. Staff then reached out to different outside resources for mental health. Those resources encouraged the facility to seek a 72 hour hold for further evaluation and possible inpatient mental health services.
9) On 4/29/21 at 1:39 p.m., staff documented R1 was seen on rounds today by the medical director (MD)-A. Nursing staff was not allowed to remain in the room during rounds. R1 had been having increased behaviors related to paranoid schizophrenia. He had been behaving with increased verbal and physical aggression. After seeing him on rounds an order was written to send R1 to the local emergency room (ER) with a recommendation for 72 hour hold. R1 was currently in the ER at that time.
There was no mention in the progress notes staff identified or documented R1's continued escalating behaviors, or were monitoring R1's behaviors related to his antipsychotic use. There was also no indication the facility attempted to obtain R1 any mental health services prior to 4/29/21.

Review of the 4/14/21, fax sent to MD-A identified the facility requested to have R1's Seroquel discontinued related to "no target behaviors" as part of a gradual dose reduction attempt (GDR). Another request was made 4/27/21. No response was ever received by the provider. There was no indication staff had ever attempted to call the provider, notifying MD-A about R1's increased behaviors and the need for a medical assessment. There was also no indication staff had actually assessed and monitored R1's behaviors since beginning his Seroquel on 3/19/21, or notified MD-A on the fax to R1's increased behaviors.

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21540	Continued From page 9 R1's physician notes and faxes identified on: 1) 1/12/21, nurse practitioner (NP)-A identified R1 was admitted to the hospital in December 2020 after a wellness check was performed after R1 missed work for 4 days. R1 was found lying in bed, delusional, weak, and confused. R1's alcohol level was negative and it was thought he was going through withdrawals. Neuropsychiatric testing was performed on 12/9/20 where it was determined R1 had no capacity to make his own decisions. Given the acute nature of his presentation to the hospital, it was recommended he have repeat testing performed after 60 to 90 days of sobriety. 2) 2/3/21 and again on 2/16/21, the order to get R1's testing was repeated by NP-A each visit. There were no notations identified in the medical record that identified staff had followed up on the order to determine why it had not been performed, or clarified if the order was needed or able to be obtained. 3) 4/7/21, NP-A saw R1 and noted R1 was oriented to person and place. He was very forgetful and had difficulty remembering conversations that occurred immediately prior. He does often repeat questions. Thought processes were coherent, speech was fluent and clear, mood was anxious, and his insight was fair. R1 was presently admitted for chemical dependency (CD) treatment. He had started classes. He continues with memory impairment. Follow-up neuropsychological testing had been requested, but was unlikely there would be much improvement. Staff were to continue medications and continue his occupational therapy for cognitive re-training. R1 had a mood disorder due to known physiological conditions with depressive features. R1 had experienced significant losses including the loss of his job recently due to alcoholism. His father was fighting cancer. R1	21540		

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reported ongoing insomnia. There was no mention NP-A was made aware of escalating behaviors of R1 leading to his diagnosis of paranoid schizophrenia 2 days later.
4) 4/8/21, MD-A discontinued the order for neurodiagnostic testing. There was no rationale provided.
There was no indication MD-A had ever assessed R1 prior to 4/29/21, after staff called to request R1 be sent to the ER for escalating behaviors.

Interview on 4/30/21 at 1:33 p.m. with the IDON identified R1 had no behaviors charted. The IDON had asked staff why no behaviors were charted, to which staff were unsure. The MD did a virtual visit on 4/29/21 and diagnosed R1 with paranoid schizophrenia. R1 was sent to the ER with a request for 72 hour hold and psych services.

Interview and document review on 5/03/21 at 11:25 a.m., with NA-A identified she knew R1 well. He was quick to "snap, flip out.... and get angry". NA-A tried to explain to R1 one time, if he wanted a haircut, he needed to pay for it. R1 stated no one was helping him and told her to get the [expletive] out of his room. R1 seemed to have "had it out" for [administrator]. Staff were to have communicated resident behaviors or needs each shift by documenting in the communication book. R1 was progressively getting worse for behaviors since his admission. Review of the communication book with NA-A identified most entries were blank for residents or marked "ok". NA-A agreed staff routinely made no mentions on the communication shift. "It was hard to know if something changed for a resident, especially if staff hadn't worked in a few days". NA-A would only chart behaviors in the electronic medical record if they happened at the moment they

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charted, during their shift. She agreed the documentation would not reflect R1's behaviors accurately and documentation lacked evidence of his increasing behaviors as staff only charted 1 x per shift. Most of the time behaviors were passed to nursing staff verbally and not documented.

Interview and document review on 5/03/21 at 11:45 a.m., with NA-B identified staff did not document behaviors. Behaviors were passed to nurses verbally. NA-B stated R1 would "write and write notes.. and then rip them into tiny pieces and throw it away". He was very paranoid and was known to be "obsessed" with R14. R1's behaviors increased since his admission and seemed to escalate once R14 was discharged on 4/28/21. NA-B identified staff documented 1 x per shift and would chart only if a resident had a behavior at that moment she charted, not for any other behaviors they may have observed throughout the shift. NA-B stated the communication book was lacking any real pertinent information. It was hard to know if residents had appointments or changes in condition by a blank section or an "ok".

R1's electronic behavior charting from 4/8/21 through 4/29/21 identified staff had continuously marked no behaviors, although R1's behaviors and paranoia had steadily increased up to his discharge on 4/29/21.

Review of the communication book identified there was to be pages for each day with sections for each resident. The communication book had pages for the dates beginning 4/25/21 through 4/27/21. No pages for the dates of 4/28/21 and 4/29/21, followed by pages for 4/30/21. If staff documented, it was commonly "ok". No definitive information was routinely documented at all.

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21540	Continued From page 12 Interview and document review on 5/3/21 with the IDON and administrator identified the IDON requested to have R1's Seroquel be discontinued as he didn't have a "justifiable diagnosis". The facility did not provide R1 with mental health visits as the facility "doesn't have one currently". The facility does have a telehealth provider who could provide psychiatric services, but they haven't used her. The IDON could not recall her name. The facility was looking at bringing on another telehealth provider. Both agreed R1's behaviors were not documented appropriately in the electronic medical record or the paper monthly versions staff were to also fill out. The IDON was unaware staff weren't filling out appropriate behavioral charting. R1's family member was aware of his mental health. She advised the facility he had been "dealing with it for years". R1 was not diagnosed with paranoid schizophrenia until he was seen by the MD the day he was sent to the ER. Both agreed the daily communication book staff used for report was incomplete, missing days, and had no behaviors or other notes to pass off in report to oncoming staff. The IDON agreed staff had not monitored R1's when increased behaviors were noted, or when he was started on and continued to receive and anti-psychotic medication Seroquel, requiring strict monitoring. Review of the current, undated Seroquel Prescribing Information identified all patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. The	21540		

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21540	Continued From page 13 following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adults being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and non-psychiatric. Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and non-psychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to healthcare providers. Such monitoring should include daily observation by families and caregivers. Review of the February 2019, Behavioral Health Services policy identified residents who exhibit signs of emotional and/or psychosocial distress receive services and support that address their individual needs and goals for care. Residents who do not display symptoms of, or have not been diagnosed with, mental, psychiatric, psychosocial adjustment, substance abuse or post-traumatic stress disorder will not develop behavioral disturbances that cannot be attributed to a specific clinical condition that makes the pattern unavoidable. Staff were to be trained in recognizing changes in behavior that indicate psychological distress, implement care plan interventions that are relevant to the resident's diagnosis and appropriate to his or her needs and monitor those interventions and report changes in their condition. There was no indication the policy had been reviewed yearly for appropriateness.	21540		

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21540	Continued From page 14 Review of the March 2018, Acute Changes in Condition policy identified the physician was to help identify individuals with a significant risk for having acute changes of condition during their stay. Direct care staff were to be trained in recognizing subtle but significant changes in the resident like increased agitation and how to communicate these changes to the nurse. The MD will help identify medications and medication combinations that are associated with adverse consequences that could cause significant changes in condition. Before contacting the MD about acute changes of condition, staff were to collect pertinent details to report to the physician. Staff were to contact the MD. The MD was to respond in a timely manner to notification of problems or changes in condition and status. Staff were to contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response. There was no indication the policy had been reviewed yearly for appropriateness. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage and potential side effects. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		

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F 000	INITIAL COMMENTS On 4/30/21 through 5/4/21, 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 were found to be SUBSTANTIATED: H5400028C (MN72275, MN72322, MN72287, and MN72336) with deficiencies cited at F689, F743, and F758. and H5400029C (MN71933) with a deficiency cited at F689. The following complaints were found to be UNSUBSTANTIATED: H5400030C (MN72023). 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 substantial compliance with the regulations has been attained.	F 000		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		5/24/21

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

Electronically Signed | 05/20/2021

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 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to appropriately monitor, assess, and immediately notify the provider for 1 of 1 resident (R3) who had new onset confusion with attempted elopement after known ingestion of cannabis oil. The facility also failed to ensure all 10 of 26 residents who smoked (R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, and R13) had their lighters and e-cigarettes secured to prevent residents from unsafely smoking indoors. Findings include: R3's 3/23/21, quarterly Minimum Data Set (MDS) identified she was admitted to the facility in September 2020 for chemical dependency treatment and long term care. R3 had diagnoses of diabetes, alcohol dependence, nicotine dependence, major depression, anxiety and a history of toxic encephalopathy (brain disease that alters brain function or structure, causing altered mental status from toxic substances). R3 had intact cognition for day to day activities and be independent in most Activities of Daily Living (ADL). R3 had no behaviors noted on her assessment. R3's 4/15/21, 7:00 p.m., incident report identified while waiting for emergency medical services (EMS) to arrive related to adverse effects from R3 vaping what was reported to be THC (cannabis), R3 elected to go outside with her roommate to have a cigarette. R3 broke the fence	F 689	1. R3 sent to ER on 4/15/21 and returned on 4/16 for confusion. Sent to Avera Marshall as in-patient on 4/22/21 to 4/28/21. A smoking assessment was completed on 4/21 which deemed her unsafe to smoke. Immediately on 5/6/21 Resident Council meeting was held and smoking policy was reviewed with resident R3, R4, R6, R7, R8, R9, R10, R11, R12, and R13. and requested smoking residents turn in their lighters per facility smoking policy. R5 was not in attendance at resident Council meeting due to recent hospitalization and no longer smoking due to use of O2. 2. All residents who smoke have the potential to be affected by this practice. The Smoking/Vaping Policy and Procedure has been updated to reflect the use of no lighters in residents□ rooms or on their person. This was reviewed at Resident Council on 5/6/21. A follow-up Resident Council meeting will be held on 5/20/21. Staff were educated on 5/6/21 regarding the smoking policy. Staff follow-up education will be completed on 5/19, 5/20, and 5/21. 3. A follow-up Resident Council meeting with residents that smoke will be held on 5/20/21. Staff were educated on 5/6/21 regarding the smoking policy. All Staff	

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F 689	Continued From page 2 and ran to the adjacent property's park. R3's roommate reported the elopement to staff. Staff retrieved R3 and taken by EMS to the local hospital. Review of the 4/16/21, report to the State Agency (SA) and the 4/21/21, facility 5 day investigation identified the facility noted staff "followed the care plan at the time the incident". Through their investigation, staff identified R3 was found in her room by the charge nurse (CN) vaping. The CN confiscated the vaping material and informed R3 she was not allowed to smoke in the facility which included vaping materials. The interim director of nursing (IDON) spoke with R3 who was noted to be "somewhat confused". Staff did a room search due to the resident having been caught with smoking materials in her room and upon the search, staff found a box containing a vape pipe and a bottle of vaping liquid marked THC. The IDON confiscated the materials and asked R3 where she got the vape pipe and THC. R3 stated she "ordered it on-line". Approximately 30-40 minutes later, nursing staff observed the resident becoming very confused and delusional. R3 was outside on the smoking patio with her roommate when her roommate informed staff R3 had broken the fence and started running to the playground, adjacent to the facility. Staff immediately caught up with the resident and asked R3 what she was doing. R3 stated "I just wanted to swing". R3 returned to the facility and completed an assessment, which was within normal limits and no injuries were noted. R3 was then sent to the emergency room (ER) for increased confusion, agitation, and delusions. Per the ER hospital notes, R3 test positive for marijuana (cannabis and/or THC) in her system. On 4/20/21, the administrator spoke with R3 and	F 689	follow-up education will be completed on 5/19, 5/20, and 5/21. The outside lighter was fixed on 5/4/21 and a replacement lighter was ordered on 5/19/21. In the case where the outside lighter is inoperable staff will light residents cigarettes. 4. Audits will be completed on resident compliance with the smoking/vaping policy 2x weekly for 4 weeks, 1x per week 1x a month and monthly for 3 months. These audits will be completed by the IDT team. Any deficient practices will be immediately identified and corrected. Results will be brought to QAPI committee for further review and recommendations	

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asked her where she got the THC. R3 was reluctant to give any information, however she stated she got the THC from her boyfriend. R3 stated her boyfriend had visited her recently and had given it to her at that time. R3 identified she had used the THC after that visit.

R3's current, undated care plan identified she used anti-anxiety medication. Staff were to monitor, document, and report any potential adverse reactions to therapy, including drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, impaired thinking and judgement, impulsive behavior, and hallucinations every shift. R3 was a smoker. The care plan noted she would not suffer injury from unsafe smoking practices and was able to smoke unsupervised. Staff were to observe clothing and skin for signs of cigarette burns and notify the nurse immediately it was suspected she had or was violating the policy. There was no mention of unsafe smoking, monitoring or side effects of medication (which had similar side effects to THC), or had been updated to reflect R3 used the THC illegally while in the building, or that staff needed to secure her cigarette lighter.

R3's progress notes identified on 4/15/21 at:
1) 5:36 a.m., staff noted R3 had episodes of confusion and agitation. She tried to push open the door of the main entrance. Staff were able to redirect R3 and her vital signs taken. There was no mention staff identified R3's new attempted elopement and confusion as concerning, monitored her closely, further assessed for her level of consciousness changes, and notified the physician of new onset behaviors.
2) 6:51 p.m., staff noted R3 was observed vaping

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in her room with THC. Then later R3 was observed by staff in her room, sitting in her window sill with the window open smoking a cigarette. There was no mention staff confiscated the lighter for safety or placed R3 on a 1 to 1 (1:1) while she awaited transport to the ER for assessment.
3) 8:07 p.m., staff documented R3 had increased confusion and erratic behavior including popping out her screen in her room and smoking in her room. Staff noted while nursing had contacted EMS, R3 was unmonitored and went outside to smoke with her room mate and eloped. Staff recovered her at the adjacent property park.
4) (an unknown actual time), a Late Entry note timed at 4:53 p.m., by R3's physician (NP-A) identified staff had asked for R3 to be assessed for "bizarre behaviors". Staff felt like R3 may be using illicit substances and reported she had increased paranoia and confusion. R3 had a history of alcohol and substance abuse. R3's exam revealed her pupils were dilated and thoughts were erratic and moving from one subject to another, and was found to have difficulty maintaining a conversation. Her responses were slow. NP-A diagnosed her with cannabis use disorder and wrote orders to complete labs. Later, while NP-A was still in the facility, staff notified her they discovered a THC vape in her room. R3 reported she had used it "a lot up" during the day. R3 tried to elope and was sent to the ER. NP-A made no mention she identified any updated interventions. like to have staff perform a search of R3's room immediately for safety and recovery of any other potential illicit materials or remove her lighter for safety. There was also no mention staff had increased supervision and monitoring for the potential negative side effects from the THC to prevent her

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elopement.

R3's 4/16/21, smoking assessment, completed 1 day after the incident identified R3 was marked "no" to having any smoking related incidents such as smoking in a non-smoking area.

R4's progress notes identified on 4/1/21, R4 was noted to be smoking in her room at 1:30 a.m.. Staff took away R4's lighter at the time and advised R4 she would not be able to keep her lighter on her person "for now". There was no indication when staff returned R4's lighter to keep on her person, or how 24 hours was determined to be a safe amount of time to determine future lighter safety.

R4's 4/11/21, smoking assessment identified R4 was marked "no" to having any smoking related incidents such as smoking in a non-smoking area.

R5's 4/29/21, smoking assessment identified R5 was documented as having no smoking related incidents, however, the section directly below marked "check all that apply" indicated staff marked R5 had been observed smoking in a non-smoking area.

R5's current, undated care plan identified she was a smoker and could smoke unsupervised, even though staff had observed unsafe behavior previously.

Interview on 5/03/21 at 10:33 a.m. with the administrator and the clinical nurse consultant identified they agreed safety was an issue with smoking. The agreed staff should have monitored R3 after it was known she had or likely had

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ingested THC and had staff monitored and appropriately supervised her, she likely would not have eloped. Smoking or vaping indoors was a safety hazard and was not to be allowed. They were aware of some residents not following the smoking policy and had been observed by staff to have smoked indoors. The IDON and admin have allowed lighters and supplies to be kept on the resident's person as they felt residents' behaviors would rise if they did not.

Interviews on 5/3/21 at 11:25 a.m. with nurse aide (NA)-A and later at 11:45 a.m., with NA-B identified R3, R4, and R5 were all known to be discovered by staff to be smoking inside the building. Lighters were not secured away form residents when not outside smoking. All residents who smoked currently possessed lighters.

Review of the 9/25/17, Smoking Safety policy identified residents who desired to smoke would be permitted to do so provided they can safely smoke independently and abide by the facilities guidelines. Additional safety measures may be taken as determined by the Standard Smoking Safety Assessment. No smoking was allowed within the building. Residents would be allowed to keep their smoking materials unless care-planned otherwise. For a first time violation, residents had a 24 Hour Restriction placed, indicating residents were not to be allowed to have any smoking materials on them. There was no mention how staff were to ensure smoking safety after a known violation occurred.

Review of the March 2019, Wandering and Elopement policy identified residents who were at risk for wandering, elopement, or other safety issues, were to have interventions to maintain the

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F 689	Continued From page 7 resident's safety. There was no mention what interventions staff were to place or when those interventions were to be in effect or for how long. Review of the above mentioned policies identified there was no indication they had been reviewed or revised as needed yearly.	F 689		
F 743 SS=D	No Behavior Difficulties Unless Unavoidable CFR(s): 483.40(b)(2) §483.40(b)(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician and provide appropriate mental health services for 1 of 1 resident (R1) who exhibited increased behaviors with no mental health intervention resulting in new onset acute paranoid schizophrenia and inpatient psychiatric treatment. Findings include: R1's 1/4/21, admission Minimum Data Set (MDS) identified he had moderate cognitive impairment. R1 had diagnoses of Wernicke's encephalopathy (acute neurological disorder caused by a thiamine deficiency induced by alcoholism resulting in delirium, confusion, and memory disturbances),	F 743	1. R1 was sent to Redwood Hospital on 4/29/21 for a 72-hour psychiatric hold. R1on 4/29/21 made the self determination to not sign a bed-hold and was discharged from the facility. 2. A review of all residents on psychotropic medications was completed on 5/19/21. All residents care plans and behavior sheets have been updated to reflect the use of psychotropic medications. Residents currently receiving psychotropic medications will be seen by the psychiatric nurse practitioner on 5/21 and 5/24/21 to review the need for any further mental health services.	5/24/21

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F 743	Continued From page 8 anxiety, major depression and low thyroid and alcohol dependence with withdrawal delirium. R1's Care Area Assessment identified he required supervision on the unit. R1 had expectations to discharge back to the community after completing chemical dependency treatment. R1's April 2021, physicians orders and medication administration record (MAR) identified he was administered Seroquel 25 milligrams (mg) (anti-psychotic) twice daily for major depression, Trazodone 50 mg (anti-depressant) at bedtime for insomnia, venlafaxine 225 mg daily (anti-depressant) for depression, buspirone twice daily for anxiety, a 24 hour nicotine patch (14 micrograms), Nicorette gum hourly as needed, a multivitamin for alcohol abuse, and Melatonin 3 mg at bedtime for insomnia. R1's 12/1/20, mental health consultation history and physical while R1 was hospitalized before his admission to the facility identified a past medical history of alcohol abuse, alcohol dependence, anxiety, and depression. No diagnosis of paranoid schizophrenia was noted. R1's 12/24/20, regional hospital discharge summary identified diagnoses of alcohol abuse, alcohol dependence, anxiety, and depression, delirium tremens (tremors caused by abrupt stoppage of alcohol), and major neurocognitive disorder. There was no mention during R1's lengthy stay that R1 exhibited signs or symptoms or paranoid schizophrenia upon discharge from the hospital to the facility. R1's current, undated care plan identified he was not always aware of physical and verbally boundaries when it comes to other residents and	F 743	3. The process of behavior committee has been reviewed and will be re-implemented on 5/24/21. This will include pharmacy recommendations involving psychotropic medications that are being administer. Education on the behavior committee process will be completed with those involved on 5/19/21. 4. Audits will be completed on appropriate behavioral documentation and notification of physician 2x weekly for 4 weeks, 1x per week 1x a month and monthly for 3 months. These audits will be completed by the IDT team. Any deficient practices will be immediately identified and corrected. Results will be brought to QAPI committee for further review and recommendations.	

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staff related to his Wernicke's encephalopathy. R1 had been found lurking out side of another female resident's room. He had a history of unfound accusations of staff not allowing him items or access to certain information. R1 had a history of aggression towards male staff when boundaries were set regarding behavioral management and expectations. Staff were to:
1) Administer his medications as ordered, assist him with appropriate methods of coping and interacting, explain and reinforce why his behaviors were inappropriate and/or unacceptable, intervene as necessary, and monitor behaviors.
2) Monitor behavior episodes and attempt to determine the underlying cause and document those behaviors and potential causes. R1 also had depression due to his Wernicke's encephalopathy, depression, and anxiety. Staff were to administer medications as ordered and monitor for and document side effects and effectiveness.
3) Arrange for a psych consult and follow up as indicated.
4) Monitor, document, and report as needed any signs or symptoms of depression, including hopelessness, anxiety, sadness, insomnia, not eating, verbalizing negative statements, repetitive anxious or health-related complaints, tearfulness.
There was no indication staff had followed the care plan and arranged for mental health services as indicated on the care plan.

Interview on 4/30/21 at 11:00 a.m., with nurse aide (NA)-C identified she was familiar with R1. R1's behaviors had escalated since admission, but especially in the last few weeks. Staff were to chart behaviors in both the electronic medical record and the paper monthly charting system.

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When staff charted each shift, they only charted behaviors at that exact moment, and not any observed throughout their shift. That was the reason his behaviors throughout their shift were not documented. There was no paper behavioral charting completed for the month of April as "no one made up the sheets".

Interview on 4/30/21 at 11:30 a.m., with registered nurse (RN)-B identified she was new to the facility and had been working there about a week. RN-B was unsure what staff charted on R1. She was made aware of R1's escalating behaviors. R1 was in the ER and was on a 72 hr hold. He was very cooperative with her and during the limited interaction she had with him, he showed no signs or symptoms of paranoia she was aware of.

Interview on 4/30/21 at 12:45 p.m., with the local sheriff's department Sergeant (S)-A identified R1 had called law enforcement (LE) on 4/28/21. He came to the facility to check on R1. S-A has had several interactions with R1 since his admission. R1 seemed to be "increasingly paranoid". R1 had a friend, [R14] and advised S-A the admin and IDON confronted her and that caused her to leave. The admin was reported to have "blew up at him". R1 talked about another staff standing there taking notes. R1's "train of thought wasn't right. He rattled on about other things. He wanted to leave." R1 wasn't on a commitment order (court order requiring a stay in a health facility), so S-A reminded him he could leave the facility at any time. R1 said he was there "for free... the state was paying for it". R1 stated he was waiting for a residential apartment. R1 stated he didn't want to leave. He told S-A he felt safe. He was choosing to stay there. S-A spoke to night staff. They didn't have any other immediate concerns. It

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was apparent to S-A "there was a mental issue going on. Had paranoid thoughts. He said his phone was being monitored. He was upset". S-A saw no issues with R1's safety. He appeared to be ok safety-wise. S-A further stated R1 would "not stay on subject and had fleeting thoughts".

R1's progress notes identified on:
1) 1/21/21, the social worker (SW) asked to see R1 related to his depression and anxiety. His initial meeting identified he reported his father was actively dying and he reported feeling angry and depressed. R1 reported to the social worker he came to be at the facility from the hospital related to his alcoholism.
2) 3/5/21, R1 sent the SW an email stating there was a female at the facility he grew to know and care about (R14). Another man who was a "known hothead" entered her room. This upset R1. He told the nurse. The nurse informed R1, the female resident could speak to whomever she wished. R1 advised the nurse "[R14] was in severe need of help and about to have a nervous breakdown. He (the other male resident) was in there making things worse. R1 noted the male resident had yelled at him in the past and "sometimes I want to stand up for myself". R1 was encouraged to be aware of his boundaries and triggers. If he was triggered, he was to leave a situation to calm down.
3) 3/10/21, the SW again received an email R1 wanted to transfer a large sum of money to his friends bank account. Staff informed him due to his poor memory, staff did not feel comfortable assisting him. R1 was also told to not ask other residents in the facility for assistance as they are vulnerable adults as well. R1 was asked if he would like to seek guardianship or a conservator, but he refused. He was "perfectly capable of

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F 743	Continued From page 12 making my own decisions." 4) 3/19/21, the SW reached out to Adult Protections Services for guardianship questions. 5) 3/22/21, the SW reached out to the Ombudsman's office for guardian/conservatorship questions. 6) Between 4/8/21 and 4/24/21, there were no behaviors documented in progress notes. 7) 4/25/21 at 4:02 p.m., R1 was noted to be paranoid. R1 reported staff "were not nice to him". R1 had written down the names of all staff and was keeping a log of staff activities. Staff were encouraged to talk to him and reassure him staff were there to help him, not "after him". 8) 4/25/21 at 8:19 p.m., R1 was noted to have been pacing several times to and from his room with a batch of papers, file, and his iPad. R1" looked distressed". He was talking to himself most of the time. Staff approached R1 to find out his concerns. He told staff that he was so stressed because of financial and other legal issues. He declined to state the specific financial and legal challenges he was facing. R1 was asked if he had any plans of self-harm which he denied. A report would be given to the social worker to address his concerns. Staff were to continue to monitor and encourage R1 to voice his concerns so they could be addressed by the care team. 9) 4/27/21 at 4:55 a.m., staff noted R1 went to sleep at around 10 p.m. on 4/26/21, and woke up at 4:30 a.m.. 10) 4/27/21 at 12:08 p.m., R1 met with the administrator and registered nurse (RN)-A. R1 was requested to stop posting messages on company's Facebook page and his own personal page. The admin informed R1 if he had specific grievances, he should speak to himself or nursing about it and it would be addressed. R1 became	F 743		

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upset and stated he had not been "getting any help". The administrator advised R1 any of his concerns pertaining to his stay and care related to the facility would be addressed if he voiced them to staff. R1 was reminded of specific examples of previous concerns he had and the assistance given. R1 said "I have never been given any help, even when I had issues with my bank account." Resident was informed that he was helped, however, staff were not authorized to access his private banking accounts. R1 became verbally aggressive and started yelling. Staff reinforced he was not to yell. R1 stated "I do not want to talk to you. This conversation is over. I do not want to talk to anybody. I am getting out of here". The administrator informed R1 he was his own responsible party and could make his own decisions, and that if he felt that he wanted to leave, he was free to do so. The admin requested if he wished to leave, that R1 would provide the facility with his desired date of discharge and location where he was going to discharged to. R1 started yelling and left. A few minutes later, R1 came back to the commons area and started yelling he had been told to leave today. R1, RN-A and the interim director of nursing (IDON) informed R1 his statement was not true. RN-A reiterated what they had told R1 earlier. R1 was asked to meet further for privacy with the administrator and RN-A administrator and RN to the meeting room for privacy so other residents were not present. R1 left to go to his room while yelling. Staff documented they would continue to monitor.

11) 4/28/21 at 1:31 p.m., staff documented earlier that day today while the nurse was making arrangements to discharge another resident from the facility, R1 was standing outside of that resident's room. When staff asked him what he

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was doing he stated he was "protecting the resident". Staff asked the female resident (R14) if she wanted him present. R14 stated "I don't know what he is doing there..." Staff asked him to move away from the door.
12) 4/29/21 at 12:30 a.m., R1 was noted to have refused to take his evening medications. R1 stated he "wanted to stay up all night" and the medication didn't do him "any good". R1 then came out of his room and started telling staff he filed a lawsuit against the facility, the administrator and the IDON. R1 further stated " These guys are going to jail... that is where they belong!. I have done lawsuits all my life. That is how I earned my living. This facility is going to pay me a lot of money. Me and my family...we have teamed up and we have hired a lawyer for this case. We have to shut this place down and have them go to jail". He also advised staff they better quit working for the facility since the State was going to shut down the facility following his lawsuit. He asked staff to give him the resident's phone to call the police to get him out of the facility. R1 was given the phone and called the police.
13) 4/29/21 at 10: 02 a.m., staff advised the regional administrator of the situation regarding R1. R1 was reported to be refusing medications and threatening staff. Staff noted there was a concern of potential harm to others in the building. Staff then reached out to different outside resources for mental health. Those resources encouraged the facility to seek a 72 hour hold for further evaluation and possible inpatient mental health services.
14) 4/29/21 at 1:39 p.m., staff documented R1 was seen on rounds today by the medical director (MD)-A. Nursing staff was not allowed to remain in the room during rounds. R1 had been having

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increased behaviors related to paranoid schizophrenia. He had been behaving with increased verbal and physical aggression. After seeing him on rounds an order was written to send R1 to the local emergency room (ER) with a recommendation for 72 hour hold. R1 was currently in the ER at that time.
There was no mention in the progress notes staff identified or documented R1's continued escalating behaviors, or were monitoring R1's behaviors related to his antipsychotic use. There was also no indication the facility attempted to obtain R1 any mental health services prior to 4/29/21.

Review of the 4/14/21, fax sent to MD-A identified the facility requested to have R1's Seroquel discontinued related to "no target behaviors" as part of a gradual dose reduction attempt (GDR). Another request was made 4/27/21. No response was ever received by the provider. There was no indication staff had ever attempted to call the MD-A, notifying MD-A about R1's increased behaviors and the need for a medical assessment. There was also no indication staff had actually assessed and monitored R1's behaviors since beginning his Seroquel on 3/19/21, or notified MD-A on the fax to R1's increased behaviors.

R1's physician notes identified on:
1) 1/12/21, nurse practitioner (NP)-A identified R1 was admitted to the hospital in December 2020 after a wellness check was performed after R1 missed work for 4 days. R1 was found lying in bed, delusional, weak, and confused. R1's alcohol level was negative and it was thought he was going through withdrawals. Neuropsychiatric testing was performed on 12/9/20 where it was

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determined R1 had no capacity to make his own decisions. Given the acute nature of his presentation to the hospital, it was recommended he have repeat testing performed after 60 to 90 days of sobriety.
2) 2/3/21 and again on 2/16/21, the order to get R1's testing was repeated by NP-A each visit. There were no notations identified in the medical record that identified staff had followed up on the order to determine why it had not been performed, or clarified if the order was needed or able to be obtained.
3) 4/7/21, NP-A saw R1 and noted R1 was oriented to person and place. He was very forgetful and had difficulty remembering conversations that occurred immediately prior. He does often repeat questions. Thought processes are coherent, speech is fluent and clear, mood is Anxious, and insight is fair. R1 was presently admitted for chemical dependency (CD) treatment. He had started classes. He continues with memory impairment. Follow-up neuropsychological testing had been requested, but was unlikely there would be much improvement. Staff were to continue medications and continue his occupational therapy for cognitive re-training. R1 had a mood disorder due to known physiological conditions with depressive features. R1 had experienced significant losses including the loss of his job recently due to alcoholism. His father was fighting cancer. R1 reported ongoing insomnia. There was no mention NP-A was made aware of escalating behaviors of R1 leading to his diagnosis of paranoid schizophrenia.
4) 4/8/21, MD-A discontinued the order for neurodiagnostic testing. There was no rationale provided.
There was no indication MD-A had ever assessed

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F 743	Continued From page 17 R1 prior to 4/29/21, after staff called to request R1 be sent to the ER for escalating behaviors. Interview on 4/30/21 at 12:42 p.m., local hospital RN-C identified R1 was admitted to the hospital on 4/29/21 on a 72 hr hold. The hospital was actively seeking inpatient psychiatric hospital admission. Interview on 4/30/21 at 1:33 p.m. with the IDON identified R1 had no behaviors charted. The IDON had asked staff why no behaviors were charted, even though R1's behaviors had increased, to which staff reported to her they were "unsure". Her expectation was staff were to document all behaviors with any resident. The MD did a virtual visit on 4/29 and diagnosed R1 with paranoid schizophrenia. R1 was sent to the ER with a request for 72 hour hold and psych services. Interview and document review on 5/03/21 at 11:25 a.m., with NA-A identified she knew R1 well. He was quick to "snap, flip out.... and get angry". NA-A tried to explain to R1 one time, if he wanted a haircut, he needed to pay for it. R1 stated no one was helping him and told her to get the [expletive] out of his room. R1 seemed to have "had it out" for [administrator]. Staff were to have communicated resident behaviors or needs each shift by documenting in the communication book. R1's behaviors had escalated in April, 2021. Review of the communication book with NA-A identified most entries were blank for residents or marked "ok". NA-A agreed staff routinely made no mentions on the communication shift. "It was hard to know if something changed for a resident, especially if staff hadn't worked in a few days". NA-A would	F 743		

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only chart behaviors in the electronic medical record if they happened at the moment they charted, during their shift. She agreed the documentation would not reflect R1's behaviors accurately and documentation lacked evidence of his increasing behaviors as staff only charted 1 x per shift. Most of the time behaviors were passed to nursing staff verbally and not documented.

Interview and document review on 5/03/21 at 11:45 a.m., with NA-B identified staff did not document behaviors. Behaviors were passed to nurses verbally. NA-B stated R1 would "write and write notes.. and then rip them into tiny pieces and throw it away". He was very paranoid and was known to be "obsessed" with R14. R1's behaviors increased since his admission and seemed to escalate once R14 was discharged on 4/28/21. NA-B identified staff documented 1 x per shift and would chart only if a resident had a behavior at the moment when she charted, and not include all behaviors seen throughout the shift. NA-B stated the communication book was lacking any real pertinent information. It was "hard to know if residents had appointments or changes in condition by a blank section or an "ok"".

R1's electronic behavior charting from 4/8/21 through 4/29/21 identified staff had continuously marked no behaviors, although R1's behaviors and paranoia had steadily increased up to his discharge on 4/29/21.

Review of the communication book identified there was to be pages for each day with sections for each resident. The communication book had pages for the dates beginning 4/25/21 through 4/27/21. No pages for the dates of 4/28/21 and

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4/29/21, followed by pages for 4/30/21, 5/1/21 and 5/2/21. If staff documented, it was commonly marked "ok". No definitive information was routinely documented.

Interview and document review on 5/3/21, with the IDON and administrator identified the IDON requested to have R1's Seroquel be discontinued as R1 didn't have a "justifiable diagnosis". The facility did not provide R1 with mental health visits as the facility "doesn't have one currently". The facility does have a telehealth provider who could provide psychiatric services, but they haven't used her and the IDON stated she could not recall her name. The facility was looking at bringing on another telehealth provider to provide mental health services. Both agreed R1's behaviors were not documented appropriately in the electronic medical record or the paper monthly versions staff were to also fill out. The IDON was unaware staff weren't filling out appropriate behavioral charting. She advised the facility he had been "dealing with it for years". R1 was not diagnosed with paranoid schizophrenia until he was seen by the MD the day he was sent to the ER. Both agreed the daily communication book staff used for report was incomplete, missing days, and had no behaviors or other notes to pass off in report to oncoming staff. The IDON agreed staff had not monitored R1's when increased behaviors were noted, or when he was started on and continued to receive and anti-psychotic medication Seroquel, requiring strict monitoring.

Review of the February 2019, Behavioral Health Services policy identified residents who exhibit signs of emotional and/or psychosocial distress receive services and support that address their

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F 743	Continued From page 20 individual needs and goals for care. Residents who do not display symptoms of, or have not been diagnosed with, mental, psychiatric, psychosocial adjustment, substance abuse or post-traumatic stress disorder will not develop behavioral disturbances that cannot be attributed to a specific clinical condition that makes the pattern unavoidable. Staff were to be trained in recognizing changes in behavior that indicate psychological distress, implement care plan interventions that are relevant to the resident's diagnosis and appropriate to his or her needs and monitor those interventions and report changes in their condition. There was no indication the policy had been reviewed yearly for appropriateness. Review of the March 2018, Acute Changes in Condition policy identified the physician was to help identify individuals with a significant risk for having acute changes of condition during their stay. Direct care staff were to be trained in recognizing subtle but significant changes in the resident like increased agitation and how to communicate these changes to the nurse. The MD will help identify medications and medication combinations that are associated with adverse consequences that could cause significant changes in condition. Before contacting the MD about acute changes of condition, staff were to collect pertinent details to report to the physician. Staff were to contact the MD. The MD was to respond in a timely manner to notification of problems or changes in condition and status. Staff were to contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response. There was no indication the policy had been reviewed yearly for appropriateness.	F 743		

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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 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	F 758		5/24/21

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F 758	Continued From page 22 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 interview and document review, the facility failed to provide appropriate behavior monitoring for 1 of 1 resident (R1) receiving antipsychotic medication (Seroquel) with increased behaviors, resulting in an episode of new onset paranoid schizophrenia and inpatient psychiatric treatment. Findings include: R1's 1/4/21, admission Minimum Data Set (MDS) identified he had moderate cognitive impairment. R1 had diagnoses of Wernicke's encephalopathy (acute neurological disorder caused by a thiamine deficiency induced by alcoholism resulting in delirium, confusion, and memory disturbances), anxiety, major depression and low thyroid and alcohol dependence with withdrawal delirium. R1's Care Area Assessment identified he required supervision on the unit. R1 had expectations to discharge back to the community after completing chemical dependency treatment. R1's April 2021, physicians orders and medication administration record (MAR) identified he was administered Seroquel 25 milligrams (mg)	F 758	1. R1 was sent to Redwood Hospital on 4/29/21 for a 72-hour psychiatric hold. R1on 4/29/21 made the self determination to not sign a bed-hold and was discharged from the facility. 2. A review of all residents on psychotropic medications was completed on 5/19/21. All residents care plans and behavior sheets have been updated to reflect the use of psychotropic medications. Residents currently receiving psychotropic medications will be seen by the psychiatric nurse practitioner on 5/21 and 5/24/21 to review the need for any further mental health services. 3. Audits will be completed on appropriate behavioral documentation and notification of physician 2x weekly for 4 weeks, 1x per week 1x a month and monthly for 3 months. These audits will be completed by the IDT team. Any deficient practices will be immediately identified and corrected. Results will be brought to QAPI committee for further review and	

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F 758	Continued From page 23 (anti-psychotic) twice daily for major depression beginning 3/19/21, Trazodone 50 mg (anti-depressant) at bedtime for insomnia, venlafaxine 225 mg daily (anti-depressant) for depression, buspirone twice daily for anxiety, a 24 hour nicotine patch (14 micrograms), Nicorette gum hourly as needed, a multivitamin for alcohol abuse, and Melatonin 3 mg at bedtime for insomnia. R1's current, undated care plan identified he was not always aware of physical and verbally boundaries when it comes to other residents and staff related to his Wernicke's encephalopathy. R1 had been found lurking out side of another female resident's room. He had a history of unfound accusations of staff not allowing him items or access to certain information. R1 had a history of aggression towards male staff when boundaries were set regarding behavioral management and expectations. Staff were to: 1) Administer his medications as ordered, assist him with appropriate methods of coping and interacting, explain and reinforce why his behaviors were inappropriate and/or unacceptable, intervene as necessary, and monitor behaviors. 2) Monitor behavior episodes and attempt to determine the underlying cause and document those behaviors and potential causes. R1 also had depression due to his Wernicke's encephalopathy, depression, and anxiety. Staff were to administer medications as ordered and monitor for and document side effects and effectiveness. 3) Arrange for a psych consult and follow up as indicated. 4) Monitor, document, and report as needed any signs or symptoms of depression, including	F 758	recommendations. 4. Audits will be completed on behavioral committee documentation and appropriate use of antipsychotic medications 2x weekly for 4 weeks, 1x per week 1x a month and monthly for 3 months. These audits will be completed by the IDT team. Any deficient practices will be immediately identified and corrected. Results will be brought to QAPI committee for further review and recommendations.	

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hopelessness, anxiety, sadness, insomnia, not eating, verbalizing negative statements, repetitive anxious or health-related complaints, tearfulness. There was no indication staff had followed the care plan and monitored for medication side effects or behaviors.

Interview on 4/30/21 at 11:00 a.m., with nurse aide (NA)-C identified she was familiar with R1. R1's behaviors had escalated since admission, but especially in the last few weeks. Staff were to chart behaviors in both the electronic medical record and the paper monthly charting system. When staff charted each shift, they only charted behaviors at that moment, and not documented others they may have observed throughout their shift. There was no paper behavioral charting completed for the month of April as "no one made up the sheets".

Interview on 4/30/21 at 11:30 a.m., with registered nurse (RN)-B identified she was new to the facility and had been working there about a week. RN-B was unsure what staff charted on R1. She was made aware of R1's escalating behaviors. R1 was in the ER and was on a 72 hr hold. He was very cooperative with her and the limited interaction she had with him, he showed no signs or symptoms of paranoia she was aware of.

R1's progress notes identified:
1) Between 4/8/21 and 4/24/21, there were no behaviors documented in progress notes.
2) On 4/25/21 at 4:02 p.m., R1 was noted to be paranoid. R1 reported staff "were not nice to him". R1 had written down the names of all staff and was keeping a log of staff activities. Staff were encouraged to talk to him and reassure him staff were there to help him, not "after him".

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F 758	Continued From page 25 3) On 4/25/21 at 8:19 p.m., R1 was noted to have been pacing several times to and from his room with a batch of papers, file, and his iPad. R1" looked distressed". He was talking to himself most of the time. Staff approached R1 to find out his concerns. He told staff that he was so stressed because of financial and other legal issues. He declined to state the specific financial and legal challenges he was facing. R1 was asked if he had any plans of self-harm which he denied. A report would be given to the social worker to address his concerns. Staff were to continue to monitor and encourage R1 to voice his concerns so they could be addressed by the care team. 4) On 4/27/21 at 4:55 a.m., staff noted R1 went to sleep at around 10 a.m. on 4/26/21, and woke up at 0430. 5) On 4/27/21 at 12:08 p.m., R1 met with the administrator and registered nurse (RN)-A. R1 was requested to stop posting messages on company's Facebook page and his own personal page. The admin informed R1 if he had specific grievances, he should speak to himself or nursing about it and it would be addressed. R1 became upset and stated he had not been "getting any help". The administrator advised R1 any of his concerns pertaining to his stay and care related to the facility would be addressed if he voiced them to staff. R1 was reminded of specific examples of previous concerns he had and the assistance given. R1 said "I have never been given any help, even when I had issues with my bank account." Resident was informed that he was helped, however, staff were not authorized to access his private banking accounts. R1 became verbally aggressive and started yelling. Staff reinforced he was not to yell. R1 stated " I do not want to talk to you. This conversation is over. I do	F 758		

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not want to talk to anybody. I am getting out of here. " The administrator informed R1 he was his own responsible party and could make his own decisions, and that if he felt that he wanted to leave, he was free to do so. The admin requested if he wished to leave, that R1 would provide the facility with his desired date of discharge and location where he was going to discharged to. R1 started yelling and left. A few minutes later, R1 came back to the commons area and started yelling he had been told to leave today. R1, RN-A and the interim director of nursing (IDON) informed R1 his statement was not true. RN-A reiterated what they had told R1 earlier. R1 was asked to meet further for privacy with the administrator and RN-A. administrator and RN to the meeting room for privacy so other residents were not present. R1 left to go to his room while yelling. Staff documented they would continue to monitor.

6) On 4/28/21 at 1:31, staff documented earlier that day today while the nurse was making arrangements to discharge another resident from the facility, R1 was standing outside of that resident's room. When staff asked him what he was doing he stated he was "protecting the resident". Staff asked the female resident (R14) if she wanted him present. R14 stated "I don't know what he is doing there..." Staff asked him to move away from the door.

7) On 4/29/21 at 12:30 a.m., R1 was noted to have refused to take his evening medications. R1 stated he "wanted to stay up all night" and the medication didn't do him "any good". R1 then came out of his room and started telling staff he filed a lawsuit against the facility, the administrator and the IDON. R1 further stated, "These guys are going to jail... that is where they belong!. I have done lawsuits all my life. That is

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F 758	Continued From page 27 how I earned my living. This facility is going to pay me a lot of money. Me and my family...we have teamed up and we have hired a lawyer for this case. We have to shut this place down and have them go to jail". He also advised staff they better quit working for the facility since the State was going to shut down the facility following his lawsuit. He asked staff to give him the resident's phone to call the police to get him out of the facility. R1 was given the phone and called the police. 8) On 4/29/21 at 10: 02 a.m., staff advised the regional administrator of the situation regarding R1. R1 was reported to be refusing medications and threatening staff. Staff noted there was a concern of potential harm to others in the building. Staff then reached out to different outside resources for mental health. Those resources encouraged the facility to seek a 72 hour hold for further evaluation and possible inpatient mental health services. 9) On 4/29/21 at 1:39 p.m., staff documented R1 was seen on rounds today by the medical director (MD)-A. Nursing staff was not allowed to remain in the room during rounds. R1 had been having increased behaviors related to paranoid schizophrenia. He had been behaving with increased verbal and physical aggression. After seeing him on rounds an order was written to send R1 to the local emergency room (ER) with a recommendation for 72 hour hold. R1 was currently in the ER at that time. There was no mention in the progress notes staff identified or documented R1's continued escalating behaviors, or were monitoring R1's behaviors related to his antipsychotic use. There was also no indication the facility attempted to obtain R1 any mental health services prior to 4/29/21.	F 758		

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Review of the 4/14/21, fax sent to MD-A identified the facility requested to have R1's Seroquel discontinued related to "no target behaviors" as part of a gradual dose reduction attempt (GDR). Another request was made 4/27/21. No response was ever received by the provider. There was no indication staff had ever attempted to call the provider, notifying MD-A about R1's increased behaviors and the need for a medical assessment. There was also no indication staff had actually assessed and monitored R1's behaviors since beginning his Seroquel on 3/19/21, or notified MD-A on the fax to R1's increased behaviors.

R1's physician notes and faxes identified on:
1) 1/12/21, nurse practitioner (NP)-A identified R1 was admitted to the hospital in December 2020 after a wellness check was performed after R1 missed work for 4 days. R1 was found lying in bed, delusional, weak, and confused. R1's alcohol level was negative and it was thought he was going through withdrawals. Neuropsychiatric testing was performed on 12/9/20 where it was determined R1 had no capacity to make his own decisions. Given the acute nature of his presentation to the hospital, it was recommended he have repeat testing performed after 60 to 90 days of sobriety.
2) 2/3/21 and again on 2/16/21, the order to get R1's testing was repeated by NP-A each visit. There were no notations identified in the medical record that identified staff had followed up on the order to determine why it had not been performed, or clarified if the order was needed or able to be obtained.
3) 4/7/21, NP-A saw R1 and noted R1 was oriented to person and place. He was very

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forgetful and had difficulty remembering conversations that occurred immediately prior. He does often repeat questions. Thought processes were coherent, speech was fluent and clear, mood was anxious, and his insight was fair. R1 was presently admitted for chemical dependency (CD) treatment. He had started classes. He continues with memory impairment. Follow-up neuropsychological testing had been requested, but was unlikely there would be much improvement. Staff were to continue medications and continue his occupational therapy for cognitive re-training. R1 had a mood disorder due to known physiological conditions with depressive features. R1 had experienced significant losses including the loss of his job recently due to alcoholism. His father was fighting cancer. R1 reported ongoing insomnia. There was no mention NP-A was made aware of escalating behaviors of R1 leading to his diagnosis of paranoid schizophrenia 2 days later.
4) 4/8/21, MD-A discontinued the order for neurodiagnostic testing. There was no rationale provided.
There was no indication MD-A had ever assessed R1 prior to 4/29/21, after staff called to request R1 be sent to the ER for escalating behaviors.

Interview on 4/30/21 at 1:33 p.m. with the IDON identified R1 had no behaviors charted. The IDON had asked staff why no behaviors were charted, to which staff were unsure. The MD did a virtual visit on 4/29/21 and diagnosed R1 with paranoid schizophrenia. R1 was sent to the ER with a request for 72 hour hold and psych services.

Interview and document review on 5/03/21 at 11:25 a.m., with NA-A identified she knew R1

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well. He was quick to "snap, flip out.... and get angry". NA-A tried to explain to R1 one time, if he wanted a haircut, he needed to pay for it. R1 stated no one was helping him and told her to get the [expletive] out of his room. R1 seemed to have "had it out" for [administrator]. Staff were to have communicated resident behaviors or needs each shift by documenting in the communication book. R1 was progressively getting worse for behaviors since his admission. Review of the communication book with NA-A identified most entries were blank for residents or marked "ok". NA-A agreed staff routinely made no mentions on the communication shift. "It was hard to know if something changed for a resident, especially if staff hadn't worked in a few days". NA-A would only chart behaviors in the electronic medical record if they happened at the moment they charted, during their shift. She agreed the documentation would not reflect R1's behaviors accurately and documentation lacked evidence of his increasing behaviors as staff only charted 1 x per shift. Most of the time behaviors were passed to nursing staff verbally and not documented.

Interview and document review on 5/03/21 at 11:45 a.m., with NA-B identified staff did not document behaviors. Behaviors were passed to nurses verbally. NA-B stated R1 would "write and write notes.. and then rip them into tiny pieces and throw it away". He was very paranoid and was known to be "obsessed" with R14. R1's behaviors increased since his admission and seemed to escalate once R14 was discharged on 4/28/21. NA-B identified staff documented 1 x per shift and would chart only if a resident had a behavior at that moment she charted, not for any other behaviors they may have observed throughout the shift. NA-B stated the

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communication book was lacking any real pertinent information. It was hard to know if residents had appointments or changes in condition by a blank section or an "ok".

R1's electronic behavior charting from 4/8/21 through 4/29/21 identified staff had continuously marked no behaviors, although R1's behaviors and paranoia had steadily increased up to his discharge on 4/29/21.

Review of the communication book identified there was to be pages for each day with sections for each resident. The communication book had pages for the dates beginning 4/25/21 through 4/27/21. No pages for the dates of 4/28/21 and 4/29/21, followed by pages for 4/30/21. If staff documented, it was commonly "ok". No definitive information was routinely documented at all.

Interview and document review on 5/3/21 with the IDON and administrator identified the IDON requested to have R1's Seroquel be discontinued as he didn't have a "justifiable diagnosis". The facility did not provide R1 with mental health visits as the facility "doesn't have one currently". The facility does have a telehealth provider who could provide psychiatric services, but they haven't used her. The IDON could not recall her name. The facility was looking at bringing on another telehealth provider. Both agreed R1's behaviors were not documented appropriately in the electronic medical record or the paper monthly versions staff were to also fill out. The IDON was unaware staff weren't filling out appropriate behavioral charting. R1's family member was aware of his mental health. She advised the facility he had been "dealing with it for years". R1 was not diagnosed with paranoid schizophrenia

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until he was seen by the MD the day he was sent to the ER. Both agreed the daily communication book staff used for report was incomplete, missing days, and had no behaviors or other notes to pass off in report to oncoming staff. The IDON agreed staff had not monitored R1's when increased behaviors were noted, or when he was started on and continued to receive and anti-psychotic medication Seroquel, requiring strict monitoring.

Review of the current, undated Seroquel Prescribing Information identified all patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adults being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and non-psychiatric. Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and non-psychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to healthcare providers. Such monitoring should include daily observation by families and caregivers.

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F 758	Continued From page 33 Review of the February 2019, Behavioral Health Services policy identified residents who exhibit signs of emotional and/or psychosocial distress receive services and support that address their individual needs and goals for care. Residents who do not display symptoms of, or have not been diagnosed with, mental, psychiatric, psychosocial adjustment, substance abuse or post-traumatic stress disorder will not develop behavioral disturbances that cannot be attributed to a specific clinical condition that makes the pattern unavoidable. Staff were to be trained in recognizing changes in behavior that indicate psychological distress, implement care plan interventions that are relevant to the resident's diagnosis and appropriate to his or her needs and monitor those interventions and report changes in their condition. There was no indication the policy had been reviewed yearly for appropriateness. Review of the March 2018, Acute Changes in Condition policy identified the physician was to help identify individuals with a significant risk for having acute changes of condition during their stay. Direct care staff were to be trained in recognizing subtle but significant changes in the resident like increased agitation and how to communicate these changes to the nurse. The MD will help identify medications and medication combinations that are associated with adverse consequences that could cause significant changes in condition. Before contacting the MD about acute changes of condition, staff were to collect pertinent details to report to the physician. Staff were to contact the MD. The MD was to respond in a timely manner to notification of problems or changes in condition and status. Staff were to contact the medical director for	F 758		

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F 758	Continued From page 34 additional guidance and consultation if they do not receive a timely or appropriate response. There was no indication the policy had been reviewed yearly for appropriateness.	F 758		