Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111356	A. BUILDING: ______ B. WING ______	R-C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL REEF SUBACUTE CARE CENTER LLC	**9869 SW 152ND STREET MIAMI, FL 33157**

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{N 000}	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2021013844 and 2021013886,was conducted on , through , at Coral Reef Subacute Care Center. The allegations for complaint number 2021013844 was substantiated without deficient practice and the allegations for complaint number 2021013886 was substantiated with deficient practice. Deficiencies were identified at Class I at the time of the survey. Class I deficiencies are those which the agency determines present an imminent danger to the residents of the facility or a substantial probability that or serious physical harm would result there from. The Class I deficiencies were identified at: N 204 - Scope and Severity (J) - Freedom from and Neglect N 201 - Scope and Severity (J) adequate and appropriate healthcare N 216 - Scope and Severity (J) Health and safety of Residents The facility's Administrator, Director of Nursing and Regional Nurse Consultant were notified of the Class I deficiencies on , at 5:54 PM. The facility census at the time of the survey was 132. The following is a description of the non-compliance:	{N 000}		
{N 201} SS=J	400.022(1)(l), FS Right to Adequate and Appropriate Health Care	{N 201}		

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{N 201}	Continued From page 1	{N 201}		

(l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

This Statute or Rule is not met as evidenced by:
Based on interview and records reviewed, the facility failed to ensure a resident's mental health care needs was adequately supervised by a psychiatrist for one (Resident #1) out of ten residents sampled as evidenced by facility failure to effectively monitor behaviors and report said behaviors related to Resident #1's diagnoses of , and , and episodes of afraid/panic to the psychiatrist. The facility failure led to Resident #1 while unsupervised in his room inflicted self-harm and suffocated himself by placing a trash bag over his , resulting in by as a result of the deficient practice. There were 17 residents receiving , medications and 47 residents receiving , medications residing in the facility at the time of this survey.

The Findings Included:

Record review of the facility's undated policies and procedures titled, , , Medication, general statement noted: medications include any drug that affects activities associated with meant process and behavior, including , , , and classes of drugs. Physicians and physician -extenders (Ex.

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{N 201}	Continued From page 2 Physician Assistant, Nurse Practitioner) will use , , , medications appropriately, working with the interdisciplinary team nurse to ensure appropriate use, evaluation, and monitoring. Standards included: C. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical and /or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of individual resident. G. Psychopharmacological medications will be used to enhance the quality of life for the resident and will never be used for the purpose of discipline or convenience. Procedures followed by the Primary Care Physician, PA [Physician's Assistant], or NP [Nurse Practitioner] Noted: 2. Documents rationale and diagnosis of the use and identifies target symptoms. 4. Evaluates with the interdisciplinary team, effects, and side effects of medications within 14 days of initiating, increasing, or decreasing dose and during routine visits thereafter. Procedures Followed by the Psychiatrist / mental health included: 1. , assist the facility in establishing appropriate guidelines for use, dosage and monitoring of , , , medications. 5. Helps develop behavior management plans. Procedures Followed by Nursing: 1. Monitors drug use daily, noting any adverse effects such as increased somnolence or functional decline. 2. Will monitor for the presence of target behaviors on a daily basis. Behaviors will be documented as warranted.	{N 201}		

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{N 201}	Continued From page 3 3. Reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behavior and or the presence of any adverse effects of the medication use. 4. [,] will be performed on any resident and on , on a quarterly basis change will be reported to the physician. 5. , develop behavioral care plans that include individualized non-pharmacological interventions. Social Services: Coordinates the interdisciplinary team resident reviews of , medications. Record review of Resident #1's behavior monitoring sheets for , , and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of 1 milligram (mg) tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as changes or danger to self. There was no behavior record to indicate that he was monitored for his diagnosis of and for the use of . Further review of the behavior monitoring sheets showed that Resident #1 had multiple episodes documented as "Afraid/Panic". The behavior monitoring sheet initiated on indicated Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred during the hours of 7:00 AM to 7:00 PM on , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between the hours of 7:00 PM to 7:00 AM, on , , , 27 and 28. The documented interventions for each episode noted "Routine." Review of the nurses' progress notes for the	{N 201}		

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{N 201}	Continued From page 4 month of , , showed no record that addressed any of the episodes of exhibited by Resident #1. Review of the behavior sheets for documented an initiated date of , but the behavior monitoring sheet showed no record (left blank) for , , and during the day shift (7:00 AM to 7:00 PM) on , indicating that Resident #1's behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records for showed that Resident #1 had 15 different episodes of Afraid/Panic during the 7:00 PM to 7:00 AM shift. The Afraid/Panic behaviors noted to have occurred on , 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29. Review of the nurses' progress notes for , showed no recorded documentation that addressed any of the afraid/panic episodes exhibited by Resident #1. Review of Resident # 1's behavior sheets for (initiated on) showed Resident #1 had a total of 17 different episodes of Afraid / Panic during the month of , . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7:00 PM on , , 3, 4,and 5. The intervention documented noted "Routine QHS [nightly at bedtime]". Further review of , 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) on , , 7, 12, 13, 14, 17, 19, 20, 21, 24, 26, 27 and 28. The documented intervention noted "Refer to Nurses Notes." Review of Nurses Notes for showed no recorded documentation that addressed the episodes of afraid/panic exhibited by Resident #1.	{N 201}		

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{N 201}	Continued From page 5	{N 201}		

Review of the behavior monitoring sheet dated , showed that Resident#1 had a total of three Afraid/Panic episodes. Resident #1 had one episode of Afraid/Panic between 7:00 PM to 7:00 AM on , . Resident #1 had two episodes of the Afraid/Panic that occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his , , . Interventions for each episode noted "Routine QHS." Review of the progress notes for , showed no recorded documentation that addressed any of the episodes exhibited by Resident #1.

On at 12:15 PM, during an interview and record review with the Director of Nursing (DON), and the Clinical Regional Nurse. The DON explained; the nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors, the CNA would report each behavior to the nurses. Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as , . The clinical records were discussed related to the Plan of care the DON explained diagnoses of , , depends on the patient. For just about anybody, the care planned interventions include provide emotional support. Activities, whatever they are interested in encouraging them to talk about their feelings. Encourage socialization, provide feedback to reinforce positive behaviors. Notify MD of changes as needed.

Review of the investigative report and interview with the Clinical Regional Nurse on at approximately 2:30 PM revealed, the Clinical

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{N 201}	Continued From page 6 regional nurse had reviewed the facility's video recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday at 2:54 PM Resident #1's CNA, [Staff A] went into the residents' room [room #] at 4:18 PM. Nurse [Staff B] was passing meds. The Clinical Regional Nurse stated: "You can see her going in and out of rooms." At 4:30 PM the friend [Resident #4] leaves Resident # 1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His door remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM [Staff C], LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area. gets the nurse and the crash cart... The Regional nurse explained that The CNA had to push the door opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . The CNA stated that he pulled the bag off Resident #1's and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs [Emergency Medical	{N 201}		

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{N 201}	Continued From page 7	{N 201}		

Technician] responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.

On , , at 10:01 AM, Staff B Registered Nurse(RN) revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. The resident was alert and oriented times three and communicated his needs well and normally slept until about 9:00 AM to 10:00 AM, participated in , and activities and liked to come out of the room. Staff B explained that on the day of the incident Resident #1 was on isolation precautions due to a , ( ). Staff B, RN stated: " I worked from Thursday, , to Saturday ... I monitored for behaviors related to his use of , , we monitored for , , fear, or , I don't remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed ...I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and , the day that he , . What I documented was that he had one behavior of ,." Staff B, RN explained that Resident #1 kept asking about the ( ) treatment. The intervention, during the , episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. Staff B stated that her documentation on the behavior monitoring sheets about the afraid/panic episode was related to the treatment, that Resident #1 received the treatment and that it was effective. Staff B stated: "I did not document

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{N 201}	Continued From page 8 in the nurses notes that the resident was having episode of , because I did my action, I did not see him to be desperate, he allowed me to administer his treatment." Staff B reported that the purpose of the behavior monitoring sheet is to follow for a prescribed , medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was to refer to nurses' notes. Staff B agreed there was no record to explain anything about the resident's or behavior. Staff B stated: " It's established that a patient can have at least three small episodes of , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month ...what the behavior monitoring sheet shows is that the medication is effective. I documented that he had , on , 3rd, and 4th. The one episode could have been something like, "I don't want to shower, I don't know the behavior." Staff B then agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know and could not recall the behavior. Staff B stated: I also documented no behavior on , 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report to anyone. I did not think that I needed to communicate it to the psychiatrist. We did not monitor him for . I did not know he had any , or diagnoses of , . With a diagnosis of " Staff B explained that she would have reacted differently and that are very dangerous, levels of in a person's can change and cause them to have a crisis. "On that day he seemed well, he did not seem depressed. He did	{N 201}		

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{N 201}	Continued From page 9 not reject care, or complaint of , . ." Upon discussion of Resident #1's Diagnoses, Staff B reported: "I am surprised that he had diagnosis of , ...when I left on that day he remained in his bed. I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." (Investigative report and interview with The Clinical Regional Nurse on at approximately 2:30 PM showed that per surveillance video, Staff B last saw the resident in his room at approximately 5:21 PM). During an interview on at 10:56 AM the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1's clinical record. The Psychiatrist explained that he met with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of the multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware and that the nurses had not communicated the behaviors to him. The Psychiatrist explained that the facility staff should have communicated , afraid/panic episodes and any other behavior exhibited by Resident#1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, I would have gone to see him, maybe change the medication ..." On at 12:13 PM attempted to interview Staff C, LPN by phone and a voicemail message was left. On at 5:04 PM Staff C was called again and Staff C answered	{N 201}		

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{N 201}	Continued From page 10 the phone and requested for the surveyor to call in 15 minutes. On 5:24 PM staff C was called, Staff C was asked if Resident #1 had any complaints of , while under her care. Staff C responded, "no! never, he never had any complaints." When asked to clarify her notes that the resident had , the call was disconnected. On at 7:20 AM a follow up telephone interview was attempted with Staff C. When asked whether or not Resident #1 ever expressed , or showed any signs /or symptoms of , or , while under her care, Staff C reported, "no!" Staff C was asked about her handwritten nurses' notes dated at 12:00 PM Staff C, revealed she remembered and stated: " oh yeah, one time, I had to call the police because he was complaining of so much , " Staff C was asked to clarify the documentation because the note indicated that the resident had called the police. Staff C then responded, "He did call the police!" Staff C, LPN then explained that the police was called to help Resident #1 calm down while she helped him transfer to the hospital. Class I	{N 201}		
{N 204} SS=J	400.022(1)(o), FS Right to be Free from , , etc (o) The right to be free from mental and , , , corporal punishment, extended involuntary , and from physical and chemical , except those authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, may be applied only by a qualified licensed nurse who shall set forth in writing the	{N 204}		

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{N 204}	Continued From page 11	{N 204}		

circumstances requiring the use of , and, in the case of use of a chemical , a physician shall be consulted immediately thereafter. may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.

This Statute or Rule is not met as evidenced by:
Based on interviews, observations and records reviewed, the facility failed to provide care, services, and supervision to prevent for one resident (Resident #1) out of 10 residents sampled. The facility failed to effectively monitor behaviors related to Resident #1's diagnoses of , and , which lead to his decline and self-inflicted harm. While unsupervised in his room, Resident #1 suffocated himself by placing a trash bag over his , resulting in by .

The Findings Included:

Record review of the Facility's policy {Review dated , } revealed; "It is the policy of the facility to protect all residents from physical or mental , involuntary , neglect or misappropriation of personal property...Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Preventive measures included: The assessment, care planning, and monitoring of residents with needs and behavior which might lead to conflict or neglect ..."

Record review of the facility's policies and procedures revealed the {undated} policy Name: Medication. The General Statement of Policy noted; , medications include

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{N 204}	Continued From page 12 any drug that affects activities associated with process and behavior, including and classes of drugs. Physicians and physician -extenders (Ex. Physician Assistant, Nurse Practitioner) will use medications appropriately, working with the interdisciplinary team nurse to ensure appropriate use, evaluation, and monitoring. Standards included: C. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical and /or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of individual resident. G. Psychopharmacological medications will be used to enhance the quality of life for the resident and will never be used for the purpose of discipline or convenience. Procedures followed by the Primary Care Physician, PA[Physician's Assistant], or NP [Nurse Practitioner] noted: 2. Documents rationale and diagnosis of the use and identifies target symptoms. 4. Evaluates with the interdisciplinary team, effects, and side effects of medications within 14 days of initiating, increasing, or decreasing dose and during routine visits thereafter. Procedures Followed by the Psychiatrist / mental health included: item 1 indicated- assist the facility in establishing appropriate guidelines for use, dosage and monitoring of medications. Item number 5 indicated- Help develop behavior management plans. Procedures Followed by Nursing: 1. Monitors drug use daily, noting any adverse effects such as increased somnolence or functional decline.	{N 204}		

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2. Will monitor for the presence of target behaviors on a daily basis. Behaviors will be documented as warranted.
3. Reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behavior and or the presence of any adverse effects of the medication use.
4. [ ] will be performed on any resident on on a quarterly basis changes and will be reported to the physician.
5. develop behavioral care plans that include individualized non-pharmacological interventions.
Social Services: Coordinates the interdisciplinary team resident reviews of medications.

Record review of Resident # 1's sheet revealed, he was admitted to the facility on . Clinical diagnoses included but were not limited too, and (blockage in the tract), and .

Record review of the Medication Administration and Treatment Record for Resident #1 revealed, medication included:
, 1 mg (milligram) tablet ordered 1 tablet to be given by at bedtime for diagnosis of
50 mg tablet ordered 1 tablet to be given by every day at bedtime for a diagnosis of .
5 milligram tablet, ordered 2 tablets to be given by twice a day for diagnoses of
.

Record review of the Comprehensive Minimum

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{N 204}	Continued From page 14 Data Set (MDS) and interview with the MDS coordinator, Staff H on , , at 9:48 AM revealed, Resident #1 was Re-admitted to the facility on . In his most recent comprehensive MDS, dated . He had a score of 15 on the ( ), which indicated that the resident was able to verbalize his needs and was not . Further review of the MDS revealed that Resident #1 had a clear speech pattern and was able to understand others as well as make self-understood. His active diagnoses included , ( ), and , but the MDS did not include the diagnosis of . Review of the care plans for Resident #1 revealed a care plan dated ; "Resident #1 exhibited behaviors of /agitation. Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, Determine cause of , Observe for changes in mental status, and behavior, Notify MD [Medical Doctor] of changes as needed. Further review of the care plans showed that Resident #1 had diagnoses of and was at risk for alterations in pattern. Approaches included, observe for changes in , encourage verbalization of feelings, administer , as ordered. There were no care plans for the diagnoses of , , or for the use of 5 mg tablet. Record review of Resident #1's Behavior Monitoring Sheets for the months of , , and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of 1 mg 1 tablet. There was no record to indicate	{N 204}		

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{N 204}	Continued From page 15 that Resident #1 was monitored for any other behavior such as changes or danger to self. Review of Resident #1's behavior monitoring records showed no records to indicate that he was monitored for his diagnosis of or for the use of the , 50 mg tablet. Further review of Behavior Monitoring Sheets showed the resident had multiple episodes documented as "Afraid/Panic": During the Month of (Initiated on) Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred between the hours of 7:00 AM to 7:00 PM, on , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between 7:00 PM to 7:00 AM, on , 27 and 28. Interventions for each episode noted "Routine", indicating that the facility's only intervention was the administration of his routine medication; , 1 mg tablet by at bedtime. For Diagnosis of . Record Review of the Nurses Progress Notes from to , showed no recorded documentation that addressed any of the episodes of exhibited by Resident #1. Review of behavior monitoring sheet for (Initiated on) showed no record and was left blank for , , and during the day shift (7:00 AM to 7:00 PM). The behavior sheet for , Indicated documented behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records for , revealed Resident #1 had 15 different episodes of Afraid/Panic during the evening shift (7:00 PM to	{N 204}		

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7:00 AM). The Afraid/Panic behaviors occurred on ,9,10,11,13, 15, 16,17,18,19, 22, 23, 24, 25 and 29.
Review of Nurses Progress Notes for showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1.

Review of behavior monitoring sheets for for Resident #1 showed the resident continued to be monitored for episodes of Afraid / Panic. Resident #1 had a total of 17 different episodes during the month of . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7 :00 PM: on ,3,4,and 5. The intervention noted Routine QHS (every night at bedtime) indicating that the facility's only intervention was the administration of his routine medication; 1 mg tablet 1 tablet by at bedtime.
Further review of 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) that occurred on ,7, 12, 13, 14, 17, 19, 20, 21, 24, 26,27 and 28. The intervention noted "Refer to Nurses Notes ."

Review of the Nurses Progress Notes for , showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1.

Review of the behavior monitoring sheet for , showed that Resident#1 had a total of three episodes of Afraid/Panic. Two episodes of Afraid/Panic occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his , . Resident #1 also had one episode of Afraid/Panic between

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{N 204}	Continued From page 17 7:00 PM to 7:00 AM on . The interventions for each episode noted "Routine QHS." indicating that the facility's only intervention was the administration of his routine medication; 1 mg tablet by at bedtime. Review of the progress notes for showed no record that addressed the afraid/panic episodes exhibited by Resident #1. Further review the nurses progress notes dated with time noted as 11:00 PM documented by LPN, Staff C revealed: "Resident assigned CNA [Certified Nursing Assistant] was observed running over to me while I was doing my med pass as he verbalized code blue, I immediately assigned a staff member to call 911 as I grabbed the defibrillator machine. I assigned another staff member to get the crash cart. I ran to his room. The residents skin color was noted as pale color, no , was noted resident was transferred from wheelchair to the bed, board was placed under the patient and [ ] was initiated. 911 arrived and EMT[Emergency Medical Technicians] pronounced his . No obvious injuries were noted at the time of . CNA assigned to this resident verbalized that he was unable to enter his room. The CNA stated he had to push very hard to open the door. CNA stated resident wheelchair was pushed against the door with patient sitting in the wheelchair. Trash bag was noted over his . CNA stated he removed the trash bag to see if patient was not breathing. Patient was not breathing per CNA statement. CNA then verbalized to me and to the police how he found the patient. Family was notified by police. Police officer spoke to [Emergency Contact]. The medical examiner arrived and	{N 204}		

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transferred residents' body out of the facility."

Review of the investigative report and interview with the Clinical Regional Nurse on at approximately 2:30 PM revealed, the regional nurse reviewed the facility's video recording as she investigated the event. She documented her observations of the video. The Clinical Regional Nurse reported that she reviewed the video recording on "Tuesday or Thursday last week." The investigative report noted that on Saturday at 2:54 PM Resident #1's Certified Nursing Assistant (CNA) (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse (Staff B), Registered Nurse (RN)was passing meds, "you can see her going in and out of rooms." At 4:30 PM the friend (Resident #4) leaves Resident #1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His Door remained open the whole time. At 5:21 PM the Nurse (Staff B) went into Resident #1's room.
At 5:43 PM the CNA [Staff A] picked up the tray. Noted that he ate 100%. At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM (Staff C, LPN) was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 until the CNA called her at around 8:15 PM. At 8:15 PM the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. (Staff A) was in the room for a few second, leaves the area gets the nurse and the crash cart... The Regional nurse explained that the CNA had to push the door open and when he entered, he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . . . . The CNA stated that he pulled the bag off Resident #1

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{N 204}	Continued From page 19 . . . and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard placed, and initiated. Law enforcement and EMT responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office. Interview on .. .. at 3:53 PM with Staff A, Certified Nursing Assistant (CNA) revealed, he worked in the facility for about one year and floated on different units every week. He took care of Resident #1 on Friday, (... ....) and Saturday ( ), when he . Staff A, CNA explained that Resident # 1 was assigned to the Bed B at the window and Bed A by the door was empty. Staff A,CNA reported that Resident #1 was alert and liked to stay in his room alone with the door closed. He required assistance to go to the bathroom and remained in his room on isolation precautions. Staff A,CNA revealed his schedule for that weekend was on Friday, ... he worked a double shift from 7:00 AM -3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday .... to again work from 7:30 AM to 11:30 PM. Staff A explained, "on the day of the incident, (........) I came . . . from my break which is from 8:00 PM to 8:30 PM, when I came . . . and was doing my rounds and noticed that the door would not open. I spoke to one of the CNAs. He recommended; I pushed the door. I thought he might have blocked the door with something. When I finally opened the door, I noticed the resident was sitting in his chair with a plastic bag over his .... The wheelchair was locked. He normally had two trash containers, one on each side of his bed, with plastic bag inside of it. Once I opened the	{N 204}		

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{N 204}	Continued From page 20 door, I notice the plastic bag on his . . . . I took the plastic bag; I threw it on the floor and cried for help. The floor nurse was on the hallway. We went to get the crash cart, She called code blue. The nurse and I transferred the resident from the wheelchair, they initiated the . They all continued until the ambulance arrived. The police arrived they interviewed me. I could not leave the facility until after the detective interviewed me." Staff A, CNA explained that sometimes Resident #1 was aggressive and had behaviors like refusing care such as he refused a haircut and refused to shave and Staff A convinced Resident #1 and allowed Staff A to shave him. Staff A added "not that long ago, maybe two weeks", [Resident #1] would sometimes get angry and yell at staff; "like one time, he took off his gown and threw at me, I told the nurse on the floor about the behavior and asked her to come to the room and help me translate. I explained to [Resident #1] that I was here to take care of him, and that there was no need to be aggressive toward me, [Resident#1] understood and even apologized." On .. .. at 12:15 PM, during an interview with the Director of Nursing (DON) and the Clinical Regional Nurse, the DON explained; The nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors, the CNA would report each behavior to the nurses. Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as . The plan of care for diagnoses of , depends on the patient. For just about anybody, the care planned interventions include provide emotional support for all staff. For	{N 204}		

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{N 204}	Continued From page 21 activities, it is whatever the residents are interested in. Encourage them to talk about their feelings. Encourage socialization. Provide feedback to reinforce positive behaviors. Notify MD (Medical Doctor) of changes as needed. Psych consult as needed and Administer as ordered. During the interview, record review of Resident #1's clinical record showed, Resident # 1's physician orders included: 1. , 1 mg tablet, 1 tablet by at bedtime for diagnosis of , and 50 mg tablet, for diagnosis of , give 1 tablet by every day at bedtime. The DON and Clinical Regional Nurse was asked about Resident #1's clinical record that showed no plan of care that specifically addressed his use of or his diagnosis of or . Both the DON and the Clinical Regional Nurse agreed there was no care plan on record specific to the use of the or , medication and explained; "For a resident on , , we would normally use same type of interventions as with a resident that has a diagnoses of . Another thing we would do is monitor for side effects, which is part of medication management. The use of requires we monitor for . We monitor depending on the resident. We have residents that are verbally able to report, we look for verbalization, we also look at signs or symptoms. We document behaviors on the behavior sheet, the specific behavior that occurs and on the daily skill nurses' notes. When it comes to the , we would monitor for side effects which could include sleepiness, fatigue, abnormal coordination, ." During the interview and continued record review of Resident #1's clinical record, the DON explained; "We have behavior monitoring sheets for the use of	{N 204}		

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{N 204}	Continued From page 22 , it shows that we monitor for behaviors "Fear/Panic, , kind of stuff." According to the nurse's documentation on the Behavior Monitoring Sheets Resident #1 had panic/ , episodes." The DON explained: "The nurses and general staff reported that the resident was showing frustration over his health. He did not like the . He did talk about it sometimes. He had , on and 2nd. The only intervention was the medication as documented on the Behavior Monitoring Sheets ...We do not have a behavior monitoring record for the use of ..." The DON and Clinical Regional Nurse both agreed to review the residents record for any notes that addressed Resident #1's behaviors, and acknowledged there were no actual written notes that addressed any of the resident's behaviors or . Both the DON and the Clinical Nurse Manager agreed such documentation was necessary. On at 12:05 PM, during an interview the Psychiatrist explained that Resident #1 gave no indication that he was depressed, and that the facility staff was "usually very good at letting us know when there is any indication, not only present, but also past history, or any indication of clinical , . They usually call me for an evaluation. I see most of the patients that are taking , , they usually generate a consult for me. If the patient had shown any signs or symptoms, indicating they had clinical or , the staff would have notified me." The Psychiatrist acknowledged that he saw Resident #1 once, on and that his diagnoses included , and . A continued interview with the Psychiatrist on at 10:56 AM revealed, the psychiatrist did not review the above-mentioned Behavior Monitoring Sheets	{N 204}		

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{N 204}	Continued From page 23 found in Resident #1's clinical record. The Psychiatrist explained that he met with facility staff and discussed residents behaviors and if any adjustments are needed. The Psychiatrist was asked about Resident #1's behaviors. The Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of multiple documented episodes of afraid/panic noted on Resident #1's clinical records the psychiatrist reported he was not aware of any of the documented behaviors and stated that the nurses did not communicate said behaviors to him. The psychiatrist stated that the facility staff should have communicated any afraid/panic episodes and other behavior exhibited by Resident #1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, would have gone to see him, maybe change the medication." On at 2:51 PM, review of Social Services assessment dated and interview with the facility's Social Services Staff; Social Services Director (SSD) and Social Services Assistant (SSA), Staff F, it was revealed that social services is responsible for assessing the residents upon admission, quarterly, and annually. The SSD revealed social services saw the residents often around the facility, assess for (Brief Interview of Mental Status) score, moods, and behaviors. The SSD stated he went to the resident's room to complete the initial assessment on . Review of the social services note dated indicated social services will be available to Resident #1 and family for support if needed ... The and assessment indicated the resident had little interest or pleasure in doing things,	{N 204}		

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{N 204}	Continued From page 24 frequency, 2 to 6 days. Feeling down depressed or hopeless, frequency, 2 to 6 days. Feeling tired or having little energy, frequency 7 to 11 days. Poor appetite or overeating, frequency 7 to 11 days. The Social Services Director explained they followed the questionnaire on the form Patient Health Questionnaire (PHQ-9) which asks about interest / pleasure in doing things, feeling down, depressed, or hopeless, trouble falling /staying asleep or sleeping too much, if tired, feeling little energy, feeling bad about yourself. [Resident #1's] assessment showed the score result for his ... was a six which indicated that the resident had a symptom of feeling tired having low energy, he had poor appetite, little interests in doing stuff and was feeling down. He was upset about the news. The SSD reported he did not address Resident #1's report that he was feeling down, "Once I learned the resident had diagnoses of , , I looked at his medications. He was already on ..., ... I saw that he was already care planned. He was a patient that we saw in the hallway often, very social, attended , . I did not do anything, I asked the resident why he was depressed, he said it was about politics, there was not much I could do about that. I was not aware of , ..." The Social Services Director reported they usually learned about residents concerning behaviors during morning meetings and never knew that he had any behaviors. When asked why there was only one social services assessment and progress note in Resident #1's clinical record, the SSD responded, "There must have been other progress notes, I don't know what happened to them." Interview on , , at 10:01 AM with Staff B Registered Nurse(RN) reported working in the facility since , this year and normally	{N 204}		

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{N 204}	Continued From page 25 worked with (Resident #1) three days a week, from 7:00 AM to 7:00 PM. The resident was alert and oriented times three. He communicated his needs well. He normally slept until about 9:00 AM/10:00 AM. He liked to participate in , and activities. He liked to come out of the room. On the day of the incident (Resident #1) was on isolation precautions due to a (,). Staff B, RN stated, " I worked from Thursday, , , to Saturday . I monitored for behaviors related to his use of , , we monitored for , , fear, or . I don't remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed." Staff B, RN reported not being present when Resident #1 had the aggressive behavior of throwing his gown at Staff A, CNA. "I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and , the day that he . What I documented was that he had one behavior of ." Staff B, RN explained, "he was asking a lot about why he remained with the treatment, about the ( ). He kept asking about it, although I had already spoken to him about it. The intervention, during the episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. What I documented on the behavior monitoring sheets about afraid/panic episode was related to the treatment, that he received the treatment and that it was effective. I did not document on the nurses notes that the resident was having an episode of because I did my action, I did not see him to be	{N 204}		

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{N 204}	Continued From page 26 desperate, he allowed me to administer his treatment. Sometimes with the elderly, they usually ask a lot about their treatment. The episode of , noted on him, was normal, expected. The purpose of the Behavior Monitoring Sheet is to follow for a prescribed , medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was 12 - Refer to nurses' notes." Staff B upon review of the records agreed there was no record to explain anything about the resident's or behavior. Staff B stated that: " It's established that a patient can have at least three small episodes of , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month. What the behavior monitoring sheet shows is that the medication is effective. I documented that he had , on , , 3rd, and 4th. The one episode could have been something like, "I don't want to shower. I don't know the behavior." Staff B agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know, could not recall. Staff B added, " I also documented no behavior on , 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report to anyone. I did not think that I needed to communicate it to the Psychiatrist. We did not monitor him for . I did not know he had any , or diagnoses of , ." Staff B then explained that with a diagnosis of , she would react differently because are very dangerous, levels of in a person's can change and cause them to have a crisis. " On that day he seemed well, he did not seem depressed, he did	{N 204}		

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{N 204}	Continued From page 27 not reject care, or complain of , . ." Upon discussion of Resident #1's Diagnoses, Staff B, RN reported, "I am surprised that he had a diagnosis of , . "When I left on that day he remained in his bed, I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." Interview with Regional Nurse and discussion of surveillance video showed that staff B last saw the resident at approximately 5:21 PM. Record review revealed Resident #1 was under the care of Staff C Licensed Practical Nurse (LPN) one of the two times it was documented that Resident #1 called the police because he was in so much , ( ) and on the night that he committed ( ). On attempted to conduct a telephone interview with Staff C, LPN on at 12:13 PM and a voice message was left. On at 5:04 PM telephone call was made again to interview Staff C. Staff C was interviewed by phone and was asked that we call in 15 minutes. On at 5:08 PM an incoming call was received from Staff C, she reported she misdialed and requested we call her in 15 minutes. On at 5:24 PM, during a telephone interview Staff C, LPN reported that Resident #1 never had any complaints and "he never had any , or , " when ask to clarify her notes that the resident had , the call was disconnected. During a follow up telephone interview on at 7:20 AM, Staff C was asked whether or not the resident ever expressed , or showed any signs or symptoms of , or , while under her care, Staff C again reported, "no", when asked about her handwritten nurses' notes dated , 12:00PM Staff C, stated: " oh yeah,	{N 204}		

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{N 204}	Continued From page 28 one time, I had to call the police because he was complaining of so much , . Staff C was asked to clarify if she had called the police or if Resident #1 had called the police, staff C stated that Resident #1 was the one who called the police. Staff C stated: "He did call the police!" Staff C LPN explained; the police was called to help Resident #1 calm down while she helped him transfer to the hospital. Class I	{N 204}		
{N 216} SS=J	400.102(1), FS Health and Safety of Resident In addition to the grounds listed in part II of chapter 408, any of the following conditions shall be grounds for action by the agency against a licensee: (1) An intentional or negligent act materially affecting the health or safety of residents of the facility; This Statute or Rule is not met as evidenced by: Based on records reviewed and interviews, the facility failed to ensure adequate behavior monitoring and supervision was provided for one resident (Resident #1) out of 10 sampled residents of the 17 Residents that received medications and 47 residents that received medications. The facility failed to effectively monitor behaviors related to Resident #1's diagnoses of and multiple episodes of panic and afraid which lead to Resident #1 self-inflicted harm. Resident #1 while unsupervised in his room, placed a plastic trash bag over his and suffocated himself resulting in by .	{N 216}		

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{N 216}	Continued From page 29	{N 216}		

The Findings Included:

Record review of the facility's policy and procedures titled, "Safety and Supervision of Residents." Revised in . . , . . . , revealed the policy statement: Our facility strives to make the environment as free from accident hazards as possible. Residents' safety and supervision and assistance to prevent accidents are facility wide commitment to safety at all levels of the organization.
Facility oriented approach to safety included: "Employees shall be trained on potential hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. Individualized, resident-centered approach to safety included: 1.Our individualized, resident centered approach to safety addresses safety and accident hazards for individual residents. 2.The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accidents hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Systems approach to safety noted: 2. Resident supervision is a core of the systems approach to safety.

Review of the care plans for Resident #1 revealed, care plan dated ; "Resident # 1 exhibited behaviors of . . . . ,/agitation. Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, determine cause of . . . , observe for changes in mental status, . , and behavior, notify MD (Medical Doctor) of changes as needed. Further review of the care plans showed that Resident #1 had diagnoses of

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{N 216}	Continued From page 30 and was at risk for alterations in pattern. Approaches included, observe for changes in , encourage verbalization of feelings, administer , as ordered. Record review of Resident #1's behavior monitoring sheets for , , and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of , 1 milligram (mg) tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as changes or danger to self. There was no behavior record to indicate that he was monitored for his diagnosis of , and for the use of , . Further review of the behavior monitoring sheets showed that Resident #1 had multiple episodes documented as "Afraid/Panic". The behavior monitoring sheet initiated on indicated Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred during the hours of 7:00 AM to 7:00 PM on , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between the hours of 7:00 PM to 7:00 AM, on , , 27 and 28. The documented interventions for each episode noted "Routine." Review of the nurses' progress notes for , , showed no record that addressed any of the episodes of , exhibited by Resident #1. Review of the behavior sheets for documented an initiated date of , but the behavior monitoring sheet showed no record (left blank) for , , and during the day shift (7:00 AM to 7:00 PM) on , indicating that Resident #1's behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records	{N 216}		

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{N 216}	Continued From page 31 for showed that Resident #1 had 15 different episodes of Afraid/Panic during the 7:00 PM to 7:00 AM shift. The Afraid/Panic behaviors noted to have occurred on , 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29. Review of the nurses' progress notes for , showed no recorded documentation that addressed any of the afraid/panic episodes exhibited by Resident #1. Review of Resident # 1's behavior sheets for , (initiated on) showed Resident #1 had a total of 17 different episodes of Afraid / Panic during the month of . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7:00 PM on , 3, 4,and 5. The intervention documented noted "Routine QHS [nightly at bedtime]". Further review of 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) on , 7, 12, 13, 14, 17, 19, 20, 21, 24, 26, 27 and 28. The documented intervention noted, "Refer to Nurses Notes." Review of Nurses Notes for , showed no recorded documentation that addressed the episodes of afraid/panic exhibited by Resident #1. Review of the behavior monitoring sheet dated , showed that Resident#1 had a total of three Afraid/Panic episodes. Resident #1 had one episode of Afraid/Panic between 7:00 PM to 7:00 AM on . Resident #1 had two episodes of the Afraid/Panic that occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his , . Interventions for each episode noted "Routine QHS[Every hour of	{N 216}		

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{N 216}	Continued From page 32	{N 216}		

sleep]." Review of the progress notes for , showed no recorded documentation that addressed any of the episodes exhibited by Resident #1.

Review of the nurses progress notes dated at 11:00 PM documented by Licensed Practical Nurse (LPN) Staff C revealed: "Resident assigned CNA [Certified Nursing Assistant] was observed running over to me while I was doing my med pass as he verbalized code blue, I immediately assigned a staff member to call 911 as I grabbed the defibrillator machine. I assigned another staff member to get the crash cart. I ran to his room. The residents skin color was noted as pale . color, no , . was noted resident was transferred from wheelchair to the bed. Board was placed under the patient and [ ] was initiated. 911 arrived and EMT[Emergency Medical Technicians] pronounced his . No obvious injuries were noted at the time of . CNA assigned to this resident verbalized that he was unable to enter his room. The CNA stated he had to push very hard to open the door. CNA stated resident wheelchair was pushed against the door with patient sitting in the wheelchair. Trash bag was noted over his . CNA stated he removed the trash bag to see if patient was not breathing. Patient was not breathing per CNA statement. CNA then verbalized to me and to the police how he found the patient. Family was notified by police. Police officer spoke to [Emergency Contact]. The medical examiner arrived and transferred residents' body out of the facility."

Review of the investigative report and interview with the Clinical Regional Nurse on at approximately 2:30 PM revealed, the Clinical regional nurse had reviewed the facility's video

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{N 216}	Continued From page 33 recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday at 2:54 PM Resident #1's CNA, (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse (Staff B) was passing meds. The Clinical Regional Nurse stated: "You can see her going in and out of rooms." At 4:30 PM the friend (Resident #4) leaves Resident # 1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His door remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA (Staff A) picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM (Staff C) LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from the time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area gets the nurse and the crash cart... The Regional nurse explained that the CNA had to push the door open and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . . . . The CNA stated that he pulled the bag off Resident #1's . . . and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The	{N 216}		

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{N 216}	Continued From page 34 Residents body was transferred to the Medical Examiner's office. During an interview on at 10:56 AM the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1's clinical record. The Psychiatrist explained that he met with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of the multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware and that the nurses had not communicated the behaviors to him. The Psychiatrist explained that the facility staff should have communicated , afraid/panic episodes and any other behavior exhibited by Resident#1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, I would have gone to see him, maybe change the medication ..." Class I	{N 216}		

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{N 000}	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2021013844 and 2021013886,was conducted on , through , at Coral Reef Subacute Care Center. The allegations for complaint number 2021013844 was substantiated without deficient practice and the allegations for complaint number 2021013886 was substantiated with deficient practice. Deficiencies were identified at Class I at the time of the survey. Class I deficiencies are those which the agency determines present an imminent danger to the residents of the facility or a substantial probability that or serious physical harm would result there from. The Class I deficiencies were identified at: N 204 - Scope and Severity (J) - Freedom from and Neglect N 201 - Scope and Severity (J) adequate and appropriate healthcare N 216 - Scope and Severity (J) Health and safety of Residents The facility's Administrator, Director of Nursing and Regional Nurse Consultant were notified of the Class I deficiencies on , at 5:54 PM. The facility census at the time of the survey was 132. The following is a description of the non-compliance:	{N 000}		
{N 201} SS=J	400.022(1)(l), FS Right to Adequate and Appropriate Health Care	{N 201}		

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{N 201}	Continued From page 1 (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on interview and records reviewed, the facility failed to ensure a resident's mental health care needs was adequately supervised by a psychiatrist for one (Resident #1) out of ten residents sampled as evidenced by facility failure to effectively monitor behaviors and report said behaviors related to Resident #1's diagnoses of , and , and episodes of afraid/panic to the psychiatrist. The facility failure led to Resident #1 while unsupervised in his room inflicted self-harm and suffocated himself by placing a trash bag over his , resulting in by as a result of the deficient practice. There were 17 residents receiving , medications and 47 residents receiving , medications residing in the facility at the time of this survey. The Findings Included: Record review of the facility's undated policies and procedures titled, , , Medication, general statement noted: medications include any drug that affects activities associated with meant process and behavior, including , , , and classes of drugs. Physicians and physician -extenders (Ex.	{N 201}	N201 Corrective action: Resident #1 no longer resides in the facility Nursing Staff involved with Resident #1's care was educated to effectively monitor behaviors related to diagnosis of and , In addition; The Administrator/designee educated facility staff including Licensed Nurses and Certified Nursing Aides on monitoring for changes in residents' behaviors and notifying the provider to obtain a Mental Health Referral as needed Identification of other residents with potential to be affected: Residents with a diagnosis of , and/or , or prescribed a , , medication have the potential to be affected. Current Residents who have a diagnosis of , and/or and are prescribed a , , medication were audited to ensure behavior sheets are in place to identify behaviors, interventions placed to intervene with the behaviors and referrals made for	

Agency for Health Care Administration

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{N 201}	Continued From page 2	{N 201}		

Physician Assistant, Nurse Practitioner) will use medications appropriately, working with the interdisciplinary team nurse to ensure appropriate use, evaluation, and monitoring. Standards included: C. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical and /or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of individual resident. G. Psychopharmacological medications will be used to enhance the quality of life for the resident and will never be used for the purpose of discipline or convenience.

Procedures followed by the Primary Care Physician, PA [Physician's Assistant], or NP [Nurse Practitioner] Noted: 2. Documents rationale and diagnosis of the use and identifies target symptoms. 4. Evaluates with the interdisciplinary team, effects, and side effects of medications within 14 days of initiating, increasing, or decreasing dose and during routine visits thereafter.

Procedures Followed by the Psychiatrist / mental health included: 1. assist the facility in establishing appropriate guidelines for use, dosage and monitoring of medications. 5. Helps develop behavior management plans.

Procedures Followed by Nursing:
1. Monitors drug use daily, noting any adverse effects such as increased somnolence or functional decline.
2. Will monitor for the presence of target behaviors on a daily basis. Behaviors will be documented as warranted.

and mental health evaluations as needed
Measures/Systematic Changes made to ensure non-reoccurrence:
Policies: Accident & Incident- investigation and Reporting and Behavioral Health services, Informed Care and -Clinical Protocol, Physician Services and Behavior Health Services were reviewed
The Administrator/designee educated Licensed Nurses, Certified Nursing Aides and Social Services regarding behavioral health with emphasis on effectively monitoring residents with and diagnosis and to ensure referrals are made for mental health evaluations.
The Administrator/designee educated the Licensed Nurses and certified nursing aides to monitor residents prescribed a medication for new or worsening behaviors, and to have those behaviors reported to the provider for a potential Mental Health referral as warranted and to ensure the resident's mental health care needs are adequately supervised by a psychiatrist/psychologist
The Administrator/designee educated Licensed Nurses and Certified Nursing Aides regarding on the Physician Services policy and Behavioral Health Policy
The Administrator/designee educated nursing staff and social services on informed care including a newly added questionnaire regarding .

Newly hired staff will be educated during orientation by the DON/designee on behavioral health with emphasis on

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CORAL REEF SUBACUTE CARE CENTER LLC	9869 SW 152ND STREET MIAMI, FL 33157

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{N 201}	Continued From page 3 3. Reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behavior and or the presence of any adverse effects of the medication use. 4. [,] will be performed on any resident and on , on a quarterly basis change will be reported to the physician. 5. , develop behavioral care plans that include individualized non-pharmacological interventions. Social Services: Coordinates the interdisciplinary team resident reviews of , , medications. Record review of Resident #1's behavior monitoring sheets for , , , and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of 1 milligram (mg) tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as changes or danger to self. There was no behavior record to indicate that he was monitored for his diagnosis of and for the use of . Further review of the behavior monitoring sheets showed that Resident #1 had multiple episodes documented as "Afraid/Panic". The behavior monitoring sheet initiated on indicated Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred during the hours of 7:00 AM to 7:00 PM on , , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between the hours of 7:00 PM to 7:00 AM, on , , , 27 and 28. The documented interventions for each episode noted "Routine." Review of the nurses' progress notes for the	{N 201}	monitoring residents with a diagnosis of , and/or , and to ensure referrals are made for mental health evaluations. Residents prescribed , , medication will be reviewed during the clinical meeting for new or worsening behaviors to ensure the behaviors are reported to the provider for a potential Mental Health referral as warranted, and to ensure the resident's mental health care needs are adequately supervised by a psychiatrist/psychologist New admissions will be reviewed during clinical meeting for Informed Care assessment and behavioral Monitoring as indicated per diagnosis of , and/or , and referrals to behavioral health will be initiated to ensure the residents Mental Health care needs are adequately supervised by a psychiatrist/psychologist Monitoring of Corrective Action: The DON/designee will audit residents with a diagnosis of and/or , and prescribed a , , medication to ensure behavior monitoring sheets accurately reflect the resident's behaviors and to ensure the provider are notified of any new or worsening behaviors for a potential mental health referral weekly X 4 then Monthly x3 Social Services/designee will audit newly admitted residents for informed screen weekly X4 monthly X 3. The DON/designee and Social Services/designee will present the results of audits to the QAPI committee for review	

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{N 201}	Continued From page 4 month of , , showed no record that addressed any of the episodes of exhibited by Resident #1. Review of the behavior sheets for documented an initiated date of , but the behavior monitoring sheet showed no record (left blank) for , , and during the day shift (7:00 AM to 7:00 PM) on , indicating that Resident #1's behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records for showed that Resident #1 had 15 different episodes of Afraid/Panic during the 7:00 PM to 7:00 AM shift. The Afraid/Panic behaviors noted to have occurred on , 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29. Review of the nurses' progress notes for , showed no recorded documentation that addressed any of the afraid/panic episodes exhibited by Resident #1. Review of Resident # 1's behavior sheets for (initiated on) showed Resident #1 had a total of 17 different episodes of Afraid / Panic during the month of , . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7:00 PM on , , 3, 4,and 5. The intervention documented noted "Routine QHS [nightly at bedtime]". Further review of , 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) on , , 7, 12, 13, 14, 17, 19, 20, 21, 24, 26, 27 and 28. The documented intervention noted "Refer to Nurses Notes." Review of Nurses Notes for showed no recorded documentation that addressed the episodes of afraid/panic exhibited by Resident #1.	{N 201}	and feedback. Responsible party: DON/Designee and Social Services/Designee	

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{N 201}	Continued From page 5 Review of the behavior monitoring sheet dated , showed that Resident#1 had a total of three Afraid/Panic episodes. Resident #1 had one episode of Afraid/Panic between 7:00 PM to 7:00 AM on , . Resident #1 had two episodes of the Afraid/Panic that occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his , , . Interventions for each episode noted "Routine QHS." Review of the progress notes for , showed no recorded documentation that addressed any of the episodes exhibited by Resident #1. On at 12:15 PM, during an interview and record review with the Director of Nursing (DON), and the Clinical Regional Nurse. The DON explained; the nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors, the CNA would report each behavior to the nurses. Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as , . The clinical records were discussed related to the Plan of care the DON explained diagnoses of , , depends on the patient. For just about anybody, the care planned interventions include provide emotional support. Activities, whatever they are interested in encouraging them to talk about their feelings. Encourage socialization, provide feedback to reinforce positive behaviors. Notify MD of changes as needed. Review of the investigative report and interview with the Clinical Regional Nurse on at approximately 2:30 PM revealed, the Clinical	{N 201}		

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{N 201}	Continued From page 6 regional nurse had reviewed the facility's video recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday at 2:54 PM Resident #1's CNA, [Staff A] went into the residents' room [room #] at 4:18 PM. Nurse [Staff B] was passing meds. The Clinical Regional Nurse stated: "You can see her going in and out of rooms." At 4:30 PM the friend [Resident #4] leaves Resident # 1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His door remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM [Staff C], LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area. gets the nurse and the crash cart... The Regional nurse explained that The CNA had to push the door opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . The CNA stated that he pulled the bag off Resident #1's . and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and . initiated. Law enforcement and EMTs [Emergency Medical	{N 201}		

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{N 201}	Continued From page 7	{N 201}		

Technician] responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.

On , , at 10:01 AM, Staff B Registered Nurse(RN) revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. The resident was alert and oriented times three and communicated his needs well and normally slept until about 9:00 AM to 10:00 AM, participated in , and activities and liked to come out of the room. Staff B explained that on the day of the incident Resident #1 was on isolation precautions due to a , ( ). Staff B, RN stated: " I worked from Thursday, , to Saturday ... I monitored for behaviors related to his use of , , we monitored for , , fear, or , I don't remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed ...I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and , the day that he , . What I documented was that he had one behavior of ,." Staff B, RN explained that Resident #1 kept asking about the ( ) treatment. The intervention, during the , episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. Staff B stated that her documentation on the behavior monitoring sheets about the afraid/panic episode was related to the treatment, that Resident #1 received the treatment and that it was effective. Staff B stated: "I did not document

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{N 201}	Continued From page 8 in the nurses notes that the resident was having episode of , because I did my action, I did not see him to be desperate, he allowed me to administer his treatment." Staff B reported that the purpose of the behavior monitoring sheet is to follow for a prescribed , medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was to refer to nurses' notes. Staff B agreed there was no record to explain anything about the resident's or behavior. Staff B stated: " It's established that a patient can have at least three small episodes of , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month ...what the behavior monitoring sheet shows is that the medication is effective. I documented that he had , on , 3rd, and 4th. The one episode could have been something like, "I don't want to shower, I don't know the behavior." Staff B then agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know and could not recall the behavior. Staff B stated: I also documented no behavior on , 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report to anyone. I did not think that I needed to communicate it to the psychiatrist. We did not monitor him for . I did not know he had any , or diagnoses of , . With a diagnosis of " Staff B explained that she would have reacted differently and that are very dangerous, levels of in a person's can change and cause them to have a crisis. "On that day he seemed well, he did not seem depressed. He did	{N 201}		

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not reject care, or complaint of , . ." Upon discussion of Resident #1's Diagnoses, Staff B reported: "I am surprised that he had diagnosis of , ...when I left on that day he remained in his bed. I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." (Investigative report and interview with The Clinical Regional Nurse on at approximately 2:30 PM showed that per surveillance video, Staff B last saw the resident in his room at approximately 5:21 PM).

During an interview on at 10:56 AM the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1's clinical record. The Psychiatrist explained that he met with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of the multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware and that the nurses had not communicated the behaviors to him. The Psychiatrist explained that the facility staff should have communicated , afraid/panic episodes and any other behavior exhibited by Resident#1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, I would have gone to see him, maybe change the medication ..."

On at 12:13 PM attempted to interview Staff C, LPN by phone and a voicemail message was left. On at 5:04 PM Staff C was called again and Staff C answered

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{N 201}	Continued From page 10 the phone and requested for the surveyor to call in 15 minutes. On 5:24 PM staff C was called, Staff C was asked if Resident #1 had any complaints of , while under her care. Staff C responded, "no! never, he never had any complaints." When asked to clarify her notes that the resident had , the call was disconnected. On at 7:20 AM a follow up telephone interview was attempted with Staff C. When asked whether or not Resident #1 ever expressed , or showed any signs /or symptoms of , or , while under her care, Staff C reported, "no!" Staff C was asked about her handwritten nurses' notes dated at 12:00 PM Staff C, revealed she remembered and stated: " oh yeah, one time, I had to call the police because he was complaining of so much , " Staff C was asked to clarify the documentation because the note indicated that the resident had called the police. Staff C then responded, "He did call the police!" Staff C, LPN then explained that the police was called to help Resident #1 calm down while she helped him transfer to the hospital. Class I	{N 201}		
{N 204} SS=J	400.022(1)(o), FS Right to be Free from , , etc (o) The right to be free from mental and , , , corporal punishment, extended involuntary , and from physical and chemical , except those authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, may be applied only by a qualified licensed nurse who shall set forth in writing the	{N 204}		

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circumstances requiring the use of , and, in the case of use of a chemical , a physician shall be consulted immediately thereafter. may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.

This Statute or Rule is not met as evidenced by:
Based on interviews, observations and records reviewed, the facility failed to provide care, services, and supervision to prevent for one resident (Resident #1) out of 10 residents sampled. The facility failed to effectively monitor behaviors related to Resident #1's diagnoses of , and , which lead to his decline and self-inflicted harm. While unsupervised in his room, Resident #1 suffocated himself by placing a trash bag over his , resulting in by .

The Findings Included:

Record review of the Facility's policy {Review dated , , } revealed; "It is the policy of the facility to protect all residents from physical or mental , involuntary , neglect or misappropriation of personal property...Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Preventive measures included: The assessment, care planning, and monitoring of residents with needs and behavior which might lead to conflict or neglect ..."

Record review of the facility's policies and procedures revealed the {undated} policy Name: , . Medication. The General Statement of Policy noted; , medications include

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Resident #1 no longer resides in the facility
Administrator/designee Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed , and , medications and identifying possible risk factors and changes in and behavior as well as side effects.
Administrator/designee in serviced all staff on and Neglect. Nurse consultant educated administrative staff on and neglect, informed care and behavioral health.
Residents with a diagnosis of , and , have the potential to be affected.
The facility has conducted an audit of all current residents with a diagnosis of , and , who are prescribed , and , medication to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in /behavior. In addition, side effects and effectiveness of , medications and behavior monitoring sheets were audited to ensure behaviors

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{N 204}	Continued From page 12 any drug that affects activities associated with process and behavior, including and classes of drugs. Physicians and physician -extenders (Ex. Physician Assistant, Nurse Practitioner) will use , , medications appropriately, working with the interdisciplinary team nurse to ensure appropriate use, evaluation, and monitoring. Standards included: C. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical and /or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of individual resident. G. Psychopharmacological medications will be used to enhance the quality of life for the resident and will never be used for the purpose of discipline or convenience. Procedures followed by the Primary Care Physician, PA[Physician's Assistant], or NP [Nurse Practitioner] noted: 2. Documents rationale and diagnosis of the use and identifies target symptoms. 4. Evaluates with the interdisciplinary team, effects, and side effects of , medications within 14 days of initiating, increasing, or decreasing dose and during routine visits thereafter. Procedures Followed by the Psychiatrist / mental health included: item 1 indicated- , assist the facility in establishing appropriate guidelines for use, dosage and monitoring of , , medications. Item number 5 indicated- Help develop behavior management plans. Procedures Followed by Nursing: 1. Monitors , , drug use daily, noting any adverse effects such as increased somnolence or functional decline.	{N 204}	are documented and side effects are monitored. Social services and nursing staff was educated by the Administrator/designee on informed care including a newly added questionnaire regarding Policies: Resident , Neglect and Policy, Informed Care, Behavioral Health Services, Medication, – Clinical Protocol, Care Plans, Comprehensive Person-Centered Administrator/designee educated Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed , and , medications and identifying possible risk factors and changes in and behavior as well as side effects and efficacy of medication Administrator/designee educated all staff on and Neglect. Nurse consultant educated administrative staff on and neglect, informed care and behavioral health. Newly hired staff will be educated during orientation by the DON/designee on monitoring residents with diagnosis of , and and to monitor for behaviors related to , and . In addition, any noted side effects and efficacy of , and , medications as well as informed care. Social Services/designee completed informed screening on all current residents. New admission will have a	

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{N 204}	Continued From page 13 2. Will monitor for the presence of target behaviors on a daily basis. Behaviors will be documented as warranted. 3. Reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behavior and or the presence of any adverse effects of the medication use. 4. [,] will be performed on any resident on , on a quarterly basis changes and will be reported to the physician. 5. , develop behavioral care plans that include individualized non-pharmacological interventions. Social Services: Coordinates the interdisciplinary team resident reviews of , medications. Record review of Resident # 1's sheet revealed, he was admitted to the facility on . Clinical diagnoses included but were not limited too, and , (blockage in the , tract), , and . Record review of the Medication Administration and Treatment Record for Resident #1 revealed, medication included: , 1 mg (milligram) tablet ordered 1 tablet to be given by at bedtime for diagnosis of ,. 50 mg tablet ordered 1 tablet to be given by every day at bedtime for a diagnosis of . 5 milligram tablet, ordered 2 tablets to be given by twice a day for diagnoses of . Record review of the Comprehensive Minimum	{N 204}	informed screening completed During the clinical meeting any changes noted in resident's and behavior, noted side effects, or any changes in the effectiveness of the resident's , or , medication will be communicated to the practitioner for potential mental health referral. During the clinical meeting, new admission will be reviewed to ensure a informed screen was completed The DON/designee will audit current residents with a diagnosis of , and , weekly x4 and monthly x3 to ensure behavior sheets reflect the resident's behaviors, that those behaviors have interventions placed to intervene with the behavior and any side effects of , and , medications are monitored. The DON/designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for review and feedback Responsible Party: DON/designee Date of Compliance	

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{N 204}	Continued From page 14 Data Set (MDS) and interview with the MDS coordinator, Staff H on , , at 9:48 AM revealed, Resident #1 was Re-admitted to the facility on . In his most recent comprehensive MDS, dated . He had a score of 15 on the ( ), which indicated that the resident was able to verbalize his needs and was not . Further review of the MDS revealed that Resident #1 had a clear speech pattern and was able to understand others as well as make self-understood. His active diagnoses included , ( ), and , but the MDS did not include the diagnosis of . Review of the care plans for Resident #1 revealed a care plan dated ; "Resident #1 exhibited behaviors of /agitation. Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, Determine cause of , Observe for changes in mental status, and behavior, Notify MD [Medical Doctor] of changes as needed. Further review of the care plans showed that Resident #1 had diagnoses of and was at risk for alterations in pattern. Approaches included, observe for changes in , encourage verbalization of feelings, administer , as ordered. There were no care plans for the diagnoses of , , or for the use of 5 mg tablet. Record review of Resident #1's Behavior Monitoring Sheets for the months of , , and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of 1 mg 1 tablet. There was no record to indicate	{N 204}		

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that Resident #1 was monitored for any other behavior such as changes or danger to self.

Review of Resident #1's behavior monitoring records showed no records to indicate that he was monitored for his diagnosis of or for the use of the , 50 mg tablet.
Further review of Behavior Monitoring Sheets showed the resident had multiple episodes documented as "Afraid/Panic": During the Month of (Initiated on) Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred between the hours of 7:00 AM to 7:00 PM, on , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between 7:00 PM to 7:00 AM, on , 27 and 28. Interventions for each episode noted "Routine", indicating that the facility's only intervention was the administration of his routine medication; , 1 mg tablet by at bedtime. For Diagnosis of

Record Review of the Nurses Progress Notes from to , showed no recorded documentation that addressed any of the episodes of exhibited by Resident #1.

Review of behavior monitoring sheet for (Initiated on) showed no record and was left blank for , , and during the day shift (7:00 AM to 7:00 PM). The behavior sheet for , Indicated documented behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records for , revealed Resident #1 had 15 different episodes of Afraid/Panic during the evening shift (7:00 PM to

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{N 204}	Continued From page 16 7:00 AM). The Afraid/Panic behaviors occurred on ,9,10,11,13, 15, 16,17,18,19, 22, 23, 24, 25 and 29. Review of Nurses Progress Notes for showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1. Review of behavior monitoring sheets for for Resident #1 showed the resident continued to be monitored for episodes of Afraid / Panic. Resident #1 had a total of 17 different episodes during the month of . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7 :00 PM: on ,3,4,and 5. The intervention noted Routine QHS (every night at bedtime) indicating that the facility's only intervention was the administration of his routine medication; 1 mg tablet 1 tablet by at bedtime. Further review of 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) that occurred on ,7, 12, 13, 14, 17, 19, 20, 21, 24, 26,27 and 28. The intervention noted "Refer to Nurses Notes ." Review of the Nurses Progress Notes for , showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1. Review of the behavior monitoring sheet for , showed that Resident#1 had a total of three episodes of Afraid/Panic. Two episodes of Afraid/Panic occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his , . Resident #1 also had one episode of Afraid/Panic between	{N 204}		

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7:00 PM to 7:00 AM on . The interventions for each episode noted "Routine QHS." indicating that the facility's only intervention was the administration of his routine medication; 1 mg tablet by at bedtime.

Review of the progress notes for showed no record that addressed the afraid/panic episodes exhibited by Resident #1.

Further review the nurses progress notes dated with time noted as 11:00 PM documented by LPN, Staff C revealed: "Resident assigned CNA [Certified Nursing Assistant] was observed running over to me while I was doing my med pass as he verbalized code blue, I immediately assigned a staff member to call 911 as I grabbed the defibrillator machine. I assigned another staff member to get the crash cart. I ran to his room. The residents skin color was noted as pale color, no , was noted resident was transferred from wheelchair to the bed, board was placed under the patient and [ ] was initiated. 911 arrived and EMT[Emergency Medical Technicians] pronounced his . No obvious injuries were noted at the time of . CNA assigned to this resident verbalized that he was unable to enter his room. The CNA stated he had to push very hard to open the door. CNA stated resident wheelchair was pushed against the door with patient sitting in the wheelchair. Trash bag was noted over his . CNA stated he removed the trash bag to see if patient was not breathing. Patient was not breathing per CNA statement. CNA then verbalized to me and to the police how he found the patient. Family was notified by police. Police officer spoke to [Emergency Contact]. The medical examiner arrived and

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{N 204}	Continued From page 18 transferred residents' body out of the facility." Review of the investigative report and interview with the Clinical Regional Nurse on at approximately 2:30 PM revealed, the regional nurse reviewed the facility's video recording as she investigated the event. She documented her observations of the video. The Clinical Regional Nurse reported that she reviewed the video recording on "Tuesday or Thursday last week." The investigative report noted that on Saturday at 2:54 PM Resident #1's Certified Nursing Assistant (CNA) (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse (Staff B), Registered Nurse (RN)was passing meds, "you can see her going in and out of rooms." At 4:30 PM the friend (Resident #4) leaves Resident #1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His Door remained open the whole time. At 5:21 PM the Nurse (Staff B) went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray. Noted that he ate 100%. At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM (Staff C, LPN) was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 until the CNA called her at around 8:15 PM. At 8:15 PM the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. (Staff A) was in the room for a few second, leaves the area gets the nurse and the crash cart... The Regional nurse explained that the CNA had to push the door open and when he entered, he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . . . . The CNA stated that he pulled the bag off Resident #1	{N 204}		

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{N 204}	Continued From page 19 . . . and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard placed, and initiated. Law enforcement and EMT responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office. Interview on .. .. at 3:53 PM with Staff A, Certified Nursing Assistant (CNA) revealed, he worked in the facility for about one year and floated on different units every week. He took care of Resident #1 on Friday, (... ....) and Saturday ( ), when he . Staff A, CNA explained that Resident # 1 was assigned to the Bed B at the window and Bed A by the door was empty. Staff A,CNA reported that Resident #1 was alert and liked to stay in his room alone with the door closed. He required assistance to go to the bathroom and remained in his room on isolation precautions. Staff A,CNA revealed his schedule for that weekend was on Friday, ... he worked a double shift from 7:00 AM -3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday .... to again work from 7:30 AM to 11:30 PM. Staff A explained, "on the day of the incident, (........) I came . . . from my break which is from 8:00 PM to 8:30 PM, when I came . . . and was doing my rounds and noticed that the door would not open. I spoke to one of the CNAs. He recommended; I pushed the door. I thought he might have blocked the door with something. When I finally opened the door, I noticed the resident was sitting in his chair with a plastic bag over his .... The wheelchair was locked. He normally had two trash containers, one on each side of his bed, with plastic bag inside of it. Once I opened the	{N 204}		

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door, I notice the plastic bag on his . . . . I took the plastic bag; I threw it on the floor and cried for help. The floor nurse was on the hallway. We went to get the crash cart, She called code blue. The nurse and I transferred the resident from the wheelchair, they initiated the . They all continued until the ambulance arrived. The police arrived they interviewed me. I could not leave the facility until after the detective interviewed me." Staff A, CNA explained that sometimes Resident #1 was aggressive and had behaviors like refusing care such as he refused a haircut and refused to shave and Staff A convinced Resident #1 and allowed Staff A to shave him. Staff A added "not that long ago, maybe two weeks", [Resident #1] would sometimes get angry and yell at staff; "like one time, he took off his gown and threw at me, I told the nurse on the floor about the behavior and asked her to come to the room and help me translate. I explained to [Resident #1] that I was here to take care of him, and that there was no need to be aggressive toward me, [Resident#1] understood and even apologized."

On .. .. at 12:15 PM, during an interview with the Director of Nursing (DON) and the Clinical Regional Nurse, the DON explained; The nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors, the CNA would report each behavior to the nurses. Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as . The plan of care for diagnoses of , depends on the patient. For just about anybody, the care planned interventions include provide emotional support for all staff. For

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{N 204}	Continued From page 21 activities, it is whatever the residents are interested in. Encourage them to talk about their feelings. Encourage socialization. Provide feedback to reinforce positive behaviors. Notify MD (Medical Doctor) of changes as needed. Psych consult as needed and Administer as ordered. During the interview, record review of Resident #1's clinical record showed, Resident # 1's physician orders included: 1. , 1 mg tablet, 1 tablet by at bedtime for diagnosis of , and 50 mg tablet, for diagnosis of , give 1 tablet by every day at bedtime. The DON and Clinical Regional Nurse was asked about Resident #1's clinical record that showed no plan of care that specifically addressed his use of or his diagnosis of , or . Both the DON and the Clinical Regional Nurse agreed there was no care plan on record specific to the use of the or , medication and explained; "For a resident on , , we would normally use same type of interventions as with a resident that has a diagnoses of . Another thing we would do is monitor for side effects, which is part of medication management. The use of requires we monitor for . We monitor depending on the resident. We have residents that are verbally able to report, we look for verbalization, we also look at signs or symptoms. We document behaviors on the behavior sheet, the specific behavior that occurs and on the daily skill nurses' notes. When it comes to the , we would monitor for side effects which could include sleepiness, fatigue, abnormal coordination, ." During the interview and continued record review of Resident #1's clinical record, the DON explained; "We have behavior monitoring sheets for the use of	{N 204}		

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{N 204}	Continued From page 22 , it shows that we monitor for behaviors "Fear/Panic, , kind of stuff." According to the nurse's documentation on the Behavior Monitoring Sheets Resident #1 had panic/ , episodes." The DON explained: "The nurses and general staff reported that the resident was showing frustration over his health. He did not like the . He did talk about it sometimes. He had , on and 2nd. The only intervention was the medication as documented on the Behavior Monitoring Sheets ...We do not have a behavior monitoring record for the use of ..." The DON and Clinical Regional Nurse both agreed to review the residents record for any notes that addressed Resident #1's behaviors, and acknowledged there were no actual written notes that addressed any of the resident's behaviors or . Both the DON and the Clinical Nurse Manager agreed such documentation was necessary. On at 12:05 PM, during an interview the Psychiatrist explained that Resident #1 gave no indication that he was depressed, and that the facility staff was "usually very good at letting us know when there is any indication, not only present, but also past history, or any indication of clinical , . They usually call me for an evaluation. I see most of the patients that are taking , , they usually generate a consult for me. If the patient had shown any signs or symptoms, indicating they had clinical or , the staff would have notified me." The Psychiatrist acknowledged that he saw Resident #1 once, on and that his diagnoses included , and . A continued interview with the Psychiatrist on at 10:56 AM revealed, the psychiatrist did not review the above-mentioned Behavior Monitoring Sheets	{N 204}		

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found in Resident #1's clinical record. The Psychiatrist explained that he met with facility staff and discussed residents behaviors and if any adjustments are needed. The Psychiatrist was asked about Resident #1's behaviors. The Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of multiple documented episodes of afraid/panic noted on Resident #1's clinical records the psychiatrist reported he was not aware of any of the documented behaviors and stated that the nurses did not communicate said behaviors to him. The psychiatrist stated that the facility staff should have communicated any afraid/panic episodes and other behavior exhibited by Resident #1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, would have gone to see him, maybe change the medication."

On at 2:51 PM, review of Social Services assessment dated and interview with the facility's Social Services Staff; Social Services Director (SSD) and Social Services Assistant (SSA), Staff F, it was revealed that social services is responsible for assessing the residents upon admission, quarterly, and annually. The SSD revealed social services saw the residents often around the facility, assess for (Brief Interview of Mental Status) score, moods, and behaviors. The SSD stated he went to the resident's room to complete the initial assessment on . Review of the social services note dated indicated social services will be available to Resident #1 and family for support if needed ... The and assessment indicated the resident had little interest or pleasure in doing things,

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{N 204}	Continued From page 24 frequency, 2 to 6 days. Feeling down depressed or hopeless, frequency, 2 to 6 days. Feeling tired or having little energy, frequency 7 to 11 days. Poor appetite or overeating, frequency 7 to 11 days. The Social Services Director explained they followed the questionnaire on the form Patient Health Questionnaire (PHQ-9) which asks about interest / pleasure in doing things, feeling down, depressed, or hopeless, trouble falling /staying asleep or sleeping too much, if tired, feeling little energy, feeling bad about yourself. [Resident #1's] assessment showed the score result for his ... was a six which indicated that the resident had a symptom of feeling tired having low energy, he had poor appetite, little interests in doing stuff and was feeling down. He was upset about the news. The SSD reported he did not address Resident #1's report that he was feeling down, "Once I learned the resident had diagnoses of , , I looked at his medications. He was already on ..., ... I saw that he was already care planned. He was a patient that we saw in the hallway often, very social, attended , . I did not do anything, I asked the resident why he was depressed, he said it was about politics, there was not much I could do about that. I was not aware of , ..." The Social Services Director reported they usually learned about residents concerning behaviors during morning meetings and never knew that he had any behaviors. When asked why there was only one social services assessment and progress note in Resident #1's clinical record, the SSD responded, "There must have been other progress notes, I don't know what happened to them." Interview on , , at 10:01 AM with Staff B Registered Nurse(RN) reported working in the facility since , this year and normally	{N 204}		

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{N 204}	Continued From page 25 worked with (Resident #1) three days a week, from 7:00 AM to 7:00 PM. The resident was alert and oriented times three. He communicated his needs well. He normally slept until about 9:00 AM/10:00 AM. He liked to participate in ., and activities. He liked to come out of the room. On the day of the incident (Resident #1) was on isolation precautions due to a (,). Staff B, RN stated, " I worked from Thursday, , , to Saturday . . I monitored for behaviors related to his use of , , we monitored for , , fear, or . I don't remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed." Staff B, RN reported not being present when Resident #1 had the aggressive behavior of throwing his gown at Staff A, CNA. "I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and , the day that he . What I documented was that he had one behavior of ." Staff B, RN explained, "he was asking a lot about why he remained with the treatment, about the ( ). He kept asking about it, although I had already spoken to him about it. The intervention, during the , episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. What I documented on the behavior monitoring sheets about afraid/panic episode was related to the treatment, that he received the treatment and that it was effective. I did not document on the nurses notes that the resident was having an episode of , because I did my action, I did not see him to be	{N 204}		

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{N 204}	Continued From page 26 desperate, he allowed me to administer his treatment. Sometimes with the elderly, they usually ask a lot about their treatment. The episode of , noted on him, was normal, expected. The purpose of the Behavior Monitoring Sheet is to follow for a prescribed , medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was 12 - Refer to nurses' notes." Staff B upon review of the records agreed there was no record to explain anything about the resident's or behavior. Staff B stated that: " It's established that a patient can have at least three small episodes of , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month. What the behavior monitoring sheet shows is that the medication is effective. I documented that he had , on , , 3rd, and 4th. The one episode could have been something like, "I don't want to shower. I don't know the behavior." Staff B agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know, could not recall. Staff B added, " I also documented no behavior on , 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report to anyone. I did not think that I needed to communicate it to the Psychiatrist. We did not monitor him for . I did not know he had any , or diagnoses of , ." Staff B then explained that with a diagnosis of , she would react differently because are very dangerous, levels of in a person's can change and cause them to have a crisis. " On that day he seemed well, he did not seem depressed, he did	{N 204}		

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{N 204}	Continued From page 27 not reject care, or complain of , . ." Upon discussion of Resident #1's Diagnoses, Staff B, RN reported, "I am surprised that he had a diagnosis of , . "When I left on that day he remained in his bed, I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." Interview with Regional Nurse and discussion of surveillance video showed that staff B last saw the resident at approximately 5:21 PM. Record review revealed Resident #1 was under the care of Staff C Licensed Practical Nurse (LPN) one of the two times it was documented that Resident #1 called the police because he was in so much , ( ) and on the night that he committed ( ). On attempted to conduct a telephone interview with Staff C, LPN on at 12:13 PM and a voice message was left. On at 5:04 PM telephone call was made again to interview Staff C. Staff C was interviewed by phone and was asked that we call in 15 minutes. On at 5:08 PM an incoming call was received from Staff C, she reported she misdialed and requested we call her in 15 minutes. On at 5:24 PM, during a telephone interview Staff C, LPN reported that Resident #1 never had any complaints and "he never had any , or " when ask to clarify her notes that the resident had , the call was disconnected. During a follow up telephone interview on at 7:20 AM, Staff C was asked whether or not the resident ever expressed , or showed any signs or symptoms of , or while under her care, Staff C again reported, "no", when asked about her handwritten nurses' notes dated , 12:00PM Staff C, stated: " oh yeah,	{N 204}		

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{N 204}	Continued From page 28 one time, I had to call the police because he was complaining of so much , . Staff C was asked to clarify if she had called the police or if Resident #1 had called the police, staff C stated that Resident #1 was the one who called the police. Staff C stated: "He did call the police!" Staff C LPN explained; the police was called to help Resident #1 calm down while she helped him transfer to the hospital. Class I	{N 204}		
{N 216} SS=J	400.102(1), FS Health and Safety of Resident In addition to the grounds listed in part II of chapter 408, any of the following conditions shall be grounds for action by the agency against a licensee: (1) An intentional or negligent act materially affecting the health or safety of residents of the facility; This Statute or Rule is not met as evidenced by: Based on records reviewed and interviews, the facility failed to ensure adequate behavior monitoring and supervision was provided for one resident (Resident #1) out of 10 sampled residents of the 17 Residents that received , medications and 47 residents that received medications. The facility failed to effectively monitor behaviors related to Resident #1's diagnoses of , , and multiple episodes of panic and afraid which lead to Resident #1 self-inflicted harm. Resident #1 while unsupervised in his room, placed a plastic trash bag over his and suffocated himself resulting in by .	{N 216}	N216 Corrective action: Resident #1 no longer resides in the facility Nursing Staff involved with Resident #1 care were educated to effectively monitor behaviors related to diagnosis of , and , Identification of other residents with potential to be affected: Residents with a diagnosis of , and have the potential to be	

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{N 216}	Continued From page 29 The Findings Included: Record review of the facility's policy and procedures titled, "Safety and Supervision of Residents." Revised in . . , . . . , revealed the policy statement: Our facility strives to make the environment as free from accident hazards as possible. Residents' safety and supervision and assistance to prevent accidents are facility wide commitment to safety at all levels of the organization. Facility oriented approach to safety included: "Employees shall be trained on potential hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. Individualized, resident-centered approach to safety included: 1.Our individualized, resident centered approach to safety addresses safety and accident hazards for individual residents. 2.The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accidents hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Systems approach to safety noted: 2. Resident supervision is a core of the systems approach to safety. Review of the care plans for Resident #1 revealed, care plan dated ; "Resident # 1 exhibited behaviors of . . . . ,/agitation. Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, determine cause of . . . ., observe for changes in mental status, . , and behavior, notify MD (Medical Doctor) of changes as needed. Further review of the care plans showed that Resident #1 had diagnoses of	{N 216}	affected. Residents who have a diagnosis of , and . . , ... were audited to ensure behavior sheets are in place to identify behaviors, interventions placed to intervene with the behaviors and referrals made for , . . , ... and mental health evaluations. Measures/Systematic Changes made to ensure non-reoccurrence: Policies titled Accident & Incident-investigation and Reporting and Behavioral Health services, . . . Informed Care and , -Clinical Protocol were reviewed The Administrator/designee educated Licensed Nurses, Certified Nursing Aides and Social Services regarding behavioral health with emphasis on effectively monitoring residents with , and . . , ... diagnosis and to ensure referrals are made for mental health evaluations. Social services and nursing staff were educated by the Administrator/designee on informed care including a newly added questionnaire regarding . . Newly hired staff will be educated by the DON/designee during orientation on behavioral health with emphasis on monitoring residents with , and . . , ... diagnosis and to ensure referrals are made for mental health evaluations. In addition, ... informed care will be educated to all new hires during orientation by the DON/designee New admissions will be reviewed during clinical meeting for . . . Informed Care assessment and behavior Monitoring	

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{N 216}	Continued From page 30 and was at risk for alterations in pattern. Approaches included, observe for changes in , encourage verbalization of feelings, administer , as ordered. Record review of Resident #1's behavior monitoring sheets for , , and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of , 1 milligram (mg) tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as changes or danger to self. There was no behavior record to indicate that he was monitored for his diagnosis of , and for the use of , . Further review of the behavior monitoring sheets showed that Resident #1 had multiple episodes documented as "Afraid/Panic". The behavior monitoring sheet initiated on indicated Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred during the hours of 7:00 AM to 7:00 PM on , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between the hours of 7:00 PM to 7:00 AM, on , , 27 and 28. The documented interventions for each episode noted "Routine." Review of the nurses' progress notes for , , showed no record that addressed any of the episodes of , exhibited by Resident #1. Review of the behavior sheets for documented an initiated date of , but the behavior monitoring sheet showed no record (left blank) for , , and during the day shift (7:00 AM to 7:00 PM) on , indicating that Resident #1's behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records	{N 216}	sheet as indicated per diagnosis of , and , and referrals to behavioral health will be initiated as required Monitoring of Corrective Action: The DON/designee will audit residents with a diagnosis of , and , to ensure behavior monitoring sheets accurately reflect resident's behaviors weekly X 4 then Monthly x3 Social Services/designee will audit newly admitted residents for informed screen weekly X4 monthly X 3. The DON/designee and Social Services/Designee will present the results of the audits to the QAPI committee for review and feedback. Responsible party: DON/Designee and Social Services/Designee	

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{N 216}	Continued From page 31 for showed that Resident #1 had 15 different episodes of Afraid/Panic during the 7:00 PM to 7:00 AM shift. The Afraid/Panic behaviors noted to have occurred on , 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29. Review of the nurses' progress notes for , showed no recorded documentation that addressed any of the afraid/panic episodes exhibited by Resident #1. Review of Resident # 1's behavior sheets for , (initiated on) showed Resident #1 had a total of 17 different episodes of Afraid / Panic during the month of . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7:00 PM on , 3, 4,and 5. The intervention documented noted "Routine QHS [nightly at bedtime]". Further review of 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) on , 7, 12, 13, 14, 17, 19, 20, 21, 24, 26, 27 and 28. The documented intervention noted, "Refer to Nurses Notes." Review of Nurses Notes for , showed no recorded documentation that addressed the episodes of afraid/panic exhibited by Resident #1. Review of the behavior monitoring sheet dated , showed that Resident#1 had a total of three Afraid/Panic episodes. Resident #1 had one episode of Afraid/Panic between 7:00 PM to 7:00 AM on . Resident #1 had two episodes of the Afraid/Panic that occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his , . Interventions for each episode noted "Routine QHS[Every hour of	{N 216}		

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{N 216}	Continued From page 32	{N 216}		

sleep]." Review of the progress notes for , showed no recorded documentation that addressed any of the episodes exhibited by Resident #1.

Review of the nurses progress notes dated at 11:00 PM documented by Licensed Practical Nurse (LPN) Staff C revealed: "Resident assigned CNA [Certified Nursing Assistant] was observed running over to me while I was doing my med pass as he verbalized code blue, I immediately assigned a staff member to call 911 as I grabbed the defibrillator machine. I assigned another staff member to get the crash cart. I ran to his room. The residents skin color was noted as pale . color, no , . was noted resident was transferred from wheelchair to the bed. Board was placed under the patient and [ ] was initiated. 911 arrived and EMT[Emergency Medical Technicians] pronounced his . No obvious injuries were noted at the time of . CNA assigned to this resident verbalized that he was unable to enter his room. The CNA stated he had to push very hard to open the door. CNA stated resident wheelchair was pushed against the door with patient sitting in the wheelchair. Trash bag was noted over his . CNA stated he removed the trash bag to see if patient was not breathing. Patient was not breathing per CNA statement. CNA then verbalized to me and to the police how he found the patient. Family was notified by police. Police officer spoke to [Emergency Contact]. The medical examiner arrived and transferred residents' body out of the facility."

Review of the investigative report and interview with the Clinical Regional Nurse on at approximately 2:30 PM revealed, the Clinical regional nurse had reviewed the facility's video

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{N 216}	Continued From page 33 recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday at 2:54 PM Resident #1's CNA, (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse (Staff B) was passing meds. The Clinical Regional Nurse stated: "You can see her going in and out of rooms." At 4:30 PM the friend (Resident #4) leaves Resident # 1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His door remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA (Staff A) picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM (Staff C) LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from the time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area gets the nurse and the crash cart... The Regional nurse explained that the CNA had to push the door open and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . . . . The CNA stated that he pulled the bag off Resident #1's . . . and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The	{N 216}		

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{N 216}	Continued From page 34 Residents body was transferred to the Medical Examiner's office. During an interview on at 10:56 AM the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1's clinical record. The Psychiatrist explained that he met with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of the multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware and that the nurses had not communicated the behaviors to him. The Psychiatrist explained that the facility staff should have communicated , afraid/panic episodes and any other behavior exhibited by Resident#1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, I would have gone to see him, maybe change the medication ..." Class I	{N 216}		

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{F 000}	INITIAL COMMENTS	{F 000}		

An unannounced survey for complaint numbers 2021013844 and 2021013886,was conducted on , through , at Coral Reef Subacute Care Center. The allegations for complaint number 2021013844 was substantiated without deficient practice. The allegations for complaint number 2021013886 was substantiated with deficient practice. The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities.

On , , it was determined the findings of the survey posed immediate jeopardy to the health and safety of the residents admitted to the facility.
Immediate Jeopardy means, a situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation or conditions of participation has caused, or is likely to cause, serious injury, harm, , , or to an individual receiving care in a facility.

The Immediate Jeopardy started on ,
.

The facility's Administrator, Director of Nursing and Regional Nurse Consultant were notified of the immediate Jeopardy on , at 5:54 PM and the Immediate Jeopardy templates were provided.

Immediate Jeopardy and Substandard Quality of Care was identified at:
F 600, Scope and Severity (J) - Freedom from and Neglect
F 656, Scope and Severity (J) - Development and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE /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 000}	Continued From page 1 Implementation of Care Plans F 689, Scope and Severity (J) - Free of Accident Hazards, Supervision, Devices The facility census at the time of the survey was 132. A partial extended survey was conducted on . The facility's Immediate Jeopardy removal plan was submitted on . The Immediate Jeopardy was ongoing at the time of the exit on . On the facility's Immediate Jeopardy Removal Plan was verified by the survey team through record reviews and interviews. It was revealed that the facility completed in-services for all staff on related to the Immediate Jeopardy deficiencies. The scope and severity was lowered as a result of the facility's corrective actions implemented. The immediate jeopardy was determined to be removed on . These corrective actions were verified by the survey team through observations,interviews and record review. The scope and severity for F 600, F 656 and F 689 were lowered to a (D) for No actual harm with a potential for more than minimal harm that is not immediate jeopardy as of . The following is a description of the non-compliance:	{F 000}		

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{F 600} SS=D	Free from and Neglect CFR(s): 483.12(a)(1)	{F 600}		

Free from and Neglect
CFR(s): 483.12(a)(1)

§483.12 Freedom from , Neglect, and

The resident has the right to be free from , neglect, misappropriation of resident property, and , as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary and any physical or chemical not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, , or , corporal punishment, or involuntary ;

This REQUIREMENT is not met as evidenced by:

Based on interviews, observations and records reviewed, the facility failed to provide care, services, and supervision to prevent for one resident (Resident #1) out of 10 residents sampled. The facility failed to effectively monitor behaviors related to Resident #1's diagnoses of and , which lead to his decline and self-inflicted harm. While unsupervised in his room, Resident #1 suffocated himself by placing a trash bag over his , resulting in by

On , it was determined the findings of the survey posed immediate jeopardy to the health and safety of all residents admitted to the facility.

On the facility's Immediate Jeopardy Removal Plan was verified by the survey team through record reviews and interviews. It was revealed that the facility completed in-services for all staff on related to the Immediate

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{F 600}	Continued From page 3	{F 600}		

Jeopardy deficiencies.
The scope and severity was lowered as a result of the facility's corrective actions implemented. The immediate jeopardy was determined to be removed on .
The scope and severity for F 600 were lowered to a (D) for No actual harm with a potential for more than minimal harm that is not immediate jeopardy as of .

The Findings Included:

Record review of the Facility's policy {Review dated , . } revealed; "It is the policy of the facility to protect all residents from physical or mental , involuntary , neglect or misappropriation of personal property...Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Preventive measures included: The assessment, care planning, and monitoring of residents with needs and behavior which might lead to conflict or neglect ..."

Record review of the facility's policies and procedures revealed the {undated} policy Name: , , Medication. The General Statement of Policy noted; medications include any drug that affects activities associated with process and behavior, including and classes of drugs. Physicians and physician -extenders (Ex. Physician Assistant, Nurse Practitioner) will use medications appropriately, working with the interdisciplinary team nurse to ensure appropriate use, evaluation, and monitoring.
Standards included:

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{F 600}	Continued From page 4 C. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical and /or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of individual resident. G. Psychopharmacological medications will be used to enhance the quality of life for the resident and will never be used for the purpose of discipline or convenience. Procedures followed by the Primary Care Physician, PA[Physician's Assistant], or NP [Nurse Practitioner] noted: 2. Documents rationale and diagnosis of the use and identifies target symptoms. 4. Evaluates with the interdisciplinary team, effects, and side effects of medications within 14 days of initiating, increasing, or decreasing dose and during routine visits thereafter. Procedures Followed by the Psychiatrist / mental health included: item 1 indicated- assist the facility in establishing appropriate guidelines for use, dosage and monitoring of medications. Item number 5 indicated- Help develop behavior management plans. Procedures Followed by Nursing: 1. Monitors drug use daily, noting any adverse effects such as increased somnolence or functional decline. 2. Will monitor for the presence of target behaviors on a daily basis. Behaviors will be documented as warranted. 3. Reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behavior and or the presence of any adverse effects of the medication use. 4. [ ]	{F 600}		

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{F 600}	Continued From page 5	{F 600}		

will be performed on any resident on
on a quarterly basis changes and
will be reported to the physician.
5. , develop behavioral care plans that include individualized non-pharmacological interventions.
Social Services: Coordinates the interdisciplinary team resident reviews of
medications.

Record review of Resident # 1's sheet revealed, he was admitted to the facility on . Clinical diagnoses included but were not limited to, and ,
(blockage in the tract), ,
and ,

Record review of the Medication Administration and Treatment Record for Resident #1 revealed, medication included:
1 mg (milligram) tablet ordered 1 tablet to be given by at bedtime for diagnosis of .
50 mg tablet ordered 1 tablet to be given by every day at bedtime for a diagnosis of .
5 milligram tablet, ordered 2 tablets to be given by twice a day for diagnoses of
.

Record review of the Comprehensive Minimum Data Set (MDS) and interview with the MDS coordinator, Staff H on , , at 9:48 AM revealed, Resident #1 was Re-admitted to the facility on . In his most recent comprehensive MDS, dated . He had a score of 15 on the
( ), which indicated that the resident was able to verbalize his needs and was not

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{F 600}	Continued From page 6 Further review of the MDS revealed that Resident #1 had a clear speech pattern and was able to understand others as well as make self-understood. His active diagnoses included , ( ), and , but the MDS did not include the diagnosis of . Review of the care plans for Resident #1 revealed a care plan dated ; "Resident #1 exhibited behaviors of /agitation. Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, determine cause of , Observe for changes in mental status, and behavior, Notify MD [Medical Doctor] of changes as needed. Further review of the care plans showed that Resident #1 had diagnoses of and was at risk for alterations in pattern. Approaches included, observe for changes in , encourage verbalization of feelings, administer , as ordered. There were no care plans for the diagnoses of , , or for the use of 5 mg tablet. Record review of Resident #1's Behavior Monitoring Sheets for the months of , , and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of 1 mg 1 tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as changes or danger to self. Review of Resident #1's behavior monitoring records showed no records to indicate that he was monitored for his diagnosis of or	{F 600}		

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{F 600}	Continued From page 7 for the use of the 50 mg tablet. Further review of Behavior Monitoring Sheets showed the resident had multiple episodes documented as "Afraid/Panic": During the Month of , (Initiated on) Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred between the hours of 7:00 AM to 7:00 PM, on , , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between 7:00 PM to 7:00 AM, on , , , 27 and 28. Interventions for each episode noted "Routine", indicating that the facility's only intervention was the administration of his routine medication; 1 mg tablet by at bedtime. For Diagnosis of Record Review of the Nurses Progress Notes from , to , , showed no recorded documentation that addressed any of the episodes of , exhibited by Resident #1. Review of behavior monitoring sheet for (Initiated on) showed no record and was left blank for , , , and during the day shift (7:00 AM to 7:00 PM). The behavior sheet for , , indicated documented behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records for , revealed Resident #1 had 15 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM). The Afraid/Panic behaviors occurred on ,9,10,11,13, 15, 16,17,18,19, 22, 23, 24, 25 and 29. Review of Nurses Progress Notes for showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1.	{F 600}		

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Review of behavior monitoring sheets for for Resident #1 showed the resident continued to be monitored for episodes of Afraid / Panic. Resident #1 had a total of 17 different episodes during the month of . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7 :00 PM: on ,3,4,and 5. The intervention noted Routine QHS (every night at bedtime) indicating that the facility's only intervention was the administration of his routine medication; 1 mg tablet 1 tablet by at bedtime.
Further review of 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) that occurred on ,7, 12, 13, 14, 17, 19, 20, 21, 24, 26,27 and 28. The intervention noted "Refer to Nurses Notes."

Review of the Nurses Progress Notes for showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1.

Review of the behavior monitoring sheet for , showed that Resident#1 had a total of three episodes of Afraid/Panic. Two episodes of Afraid/Panic occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his , . Resident #1 also had one episode of Afraid/Panic between 7:00 PM to 7:00 AM on , . The interventions for each episode noted "Routine QHS." indicating that the facility's only intervention was the administration of his routine medication; 1 mg tablet by at

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{F 600}	Continued From page 9 bedtime. Review of the progress notes for showed no record that addressed the afraid/panic episodes exhibited by Resident #1. Further review the nurses progress notes dated with time noted as 11:00 PM documented by LPN, Staff C revealed: "Resident assigned CNA [Certified Nursing Assistant] was observed running over to me while I was doing my med pass as he verbalized code blue, I immediately assigned a staff member to call 911 as I grabbed the defibrillator machine. I assigned another staff member to get the crash cart. I ran to his room. The residents skin color was noted as pale color, no was noted resident was transferred from wheelchair to the bed, board was placed under the patient and [ ] was initiated. 911 arrived and EMT[Emergency Medical Technicians] pronounced his . No obvious injuries were noted at the time of . CNA assigned to this resident verbalized that he was unable to enter his room. The CNA stated he had to push very hard to open the door. CNA stated resident wheelchair was pushed against the door with patient sitting in the wheelchair. Trash bag was noted over his . CNA stated he removed the trash bag to see if patient was not breathing. Patient was not breathing per CNA statement. CNA then verbalized to me and to the police how he found the patient. Family was notified by police. Police officer spoke to [Emergency Contact]. The medical examiner arrived and transferred residents' body out of the facility." Review of the investigative report and interview with the Clinical Regional Nurse on at	{F 600}		

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{F 600}	Continued From page 10 approximately 2:30 PM revealed, the regional nurse reviewed the facility's video recording as she investigated the event. She documented her observations of the video. The Clinical Regional Nurse reported that she reviewed the video recording on "Tuesday or Thursday last week." The investigative report noted that on Saturday at 2:54 PM Resident #1's Certified Nursing Assistant (CNA) (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse (Staff B), Registered Nurse (RN)was passing meds, "you can see her going in and out of rooms." At 4:30 PM the friend (Resident #4) leaves Resident #1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His Door remained open the whole time. At 5:21 PM the Nurse (Staff B) went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray. Noted that he ate 100%. At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM (Staff C, LPN) was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 until the CNA called her at around 8:15 PM. At 8:15 PM the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. (Staff A) was in the room for a few second, leaves the area gets the nurse and the crash cart... The Regional nurse explained that the CNA had to push the door open and when he entered, he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . The CNA stated that he pulled the bag off Resident #1 . and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard placed, and initiated. Law	{F 600}		

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{F 600}	Continued From page 11	{F 600}		

enforcement and EMT responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.

Interview on ... at 3:53 PM with Staff A, Certified Nursing Assistant (CNA) revealed, he worked in the facility for about one year and floated on different units every week. He took care of Resident #1 on Friday, (...) and Saturday ( ), when he . Staff A, CNA explained that Resident # 1 was assigned to the Bed B at the window and Bed A by the door was empty. Staff A, CNA reported that Resident #1 was alert and liked to stay in his room alone with the door closed. He required assistance to go to the bathroom and remained in his room on isolation precautions. Staff A, CNA revealed his schedule for that weekend was on Friday, ... he worked a double shift from 7:00 AM -3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday ... to again work from 7:30 AM to 11:30 PM. Staff A explained, "on the day of the incident, (...) I came ... from my break which is from 8:00 PM to 8:30 PM, when I came ... and was doing my rounds and noticed that the door would not open. I spoke to one of the CNAs. He recommended; I pushed the door. I thought he might have blocked the door with something. When I finally opened the door, I noticed the resident was sitting in his chair with a plastic bag over his .... The wheelchair was locked. He normally had two trash containers, one on each side of his bed, with plastic bag inside of it. Once I opened the door, I notice the plastic bag on his .... I took the plastic bag; I threw it on the floor and cried for help. The floor nurse was on the hallway. We went to get the

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{F 600}	Continued From page 12 crash cart, she called code blue. The nurse and I transferred the resident from the wheelchair, they initiated the . They all continued until the ambulance arrived. The police arrived they interviewed me. I could not leave the facility until after the detective interviewed me." Staff A, CNA explained that sometimes Resident #1 was aggressive and had behaviors like refusing care such as he refused a haircut and refused to shave and Staff A convinced Resident #1 and allowed Staff A to shave him. Staff A added "not that long ago, maybe two weeks", [Resident #1] would sometimes get angry and yell at staff; "like one time, he took off his gown and threw at me, I told the nurse on the floor about the behavior and asked her to come to the room and help me translate. I explained to [Resident #1] that I was here to take care of him, and that there was no need to be aggressive toward me, [Resident#1] understood and even apologized." On at 12:15 PM, during an interview with the Director of Nursing (DON) and the Clinical Regional Nurse, the DON explained; The nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors, the CNA would report each behavior to the nurses. Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as . The plan of care for diagnoses of , depends on the patient. For just about anybody, the care planned interventions include provide emotional support for all staff. For activities, it is whatever the residents are interested in. Encourage them to talk about their feelings. Encourage socialization. Provide	{F 600}		

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{F 600}	Continued From page 13 feedback to reinforce positive behaviors. Notify MD (Medical Doctor) of changes as needed. Psych consult as needed and Administer , . as ordered. During the interview, record review of Resident #1's clinical record showed, Resident # 1's physician orders included: 1. 1 mg tablet, 1 tablet by at bedtime for diagnosis of , and . 50 mg tablet, for diagnosis of , , give 1 tablet by every day at bedtime. The DON and Clinical Regional Nurse was asked about Resident #1's clinical record that showed no plan of care that specifically addressed his use of , , , or his diagnosis of , or . Both the DON and the Clinical Regional Nurse agreed there was no care plan on record specific to the use of the , or , medication and explained; "For a resident on , , we would normally use same type of interventions as with a resident that has a diagnosis of , . Another thing we would do is monitor for side effects, which is part of medication management. The use of requires we monitor for . We monitor depending on the resident. We have residents that are verbally able to report, we look for verbalization, we also look at signs or symptoms. We document behaviors on the behavior sheet, the specific behavior that occurs and on the daily skill nurses' notes. When it comes to the , we would monitor for side effects which could include sleepiness, fatigue, abnormal coordination, , ." During the interview and continued record review of Resident #1's clinical record, the DON explained; "We have behavior monitoring sheets for the use of , , it shows that we monitor for behaviors "Fear/Panic, , kind of stuff." According to	{F 600}		

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{F 600}	Continued From page 14 the nurse's documentation on the Behavior Monitoring Sheets Resident #1 had panic/ episodes." The DON explained: "The nurses and general staff reported that the resident was showing frustration over his health. He did not like the . He did talk about it sometimes. He had , on and 2nd. The only intervention was the medication as documented on the Behavior Monitoring Sheets ...We do not have a behavior monitoring record for the use of ..." The DON and Clinical Regional Nurse both agreed to review the residents record for any notes that addressed Resident #1's behaviors and acknowledged there were no actual written notes that addressed any of the resident's behaviors or . Both the DON and the Clinical Nurse Manager agreed such documentation was necessary. On at 12:05 PM, during an interview the Psychiatrist explained that Resident #1 gave no indication that he was depressed, and that the facility staff was "usually very good at letting us know when there is any indication, not only present, but also past history, or any indication of clinical , . They usually call me for an evaluation. I see most of the patients that are taking , , they usually generate a consult for me. If the patient had shown any signs or symptoms, indicating they had clinical or , the staff would have notified me." The Psychiatrist acknowledged that he saw Resident #1 once, on and that his diagnoses included , and . A continued interview with the Psychiatrist on at 10:56 AM revealed, the psychiatrist did not review the above-mentioned Behavior Monitoring Sheets found in Resident #1's clinical record. The	{F 600}		

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Psychiatrist explained that he met with facility staff and discussed resident's behaviors and if any adjustments are needed. The Psychiatrist was asked about Resident #1's behaviors. The Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of multiple documented episodes of afraid/panic noted on Resident #1's clinical records the psychiatrist reported he was not aware of any of the documented behaviors and stated that the nurses did not communicate said behaviors to him. The psychiatrist stated that the facility staff should have communicated any ......, afraid/panic episodes and other behavior exhibited by Resident #1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, would have gone to see him, maybe change the medication."

On at 2:51 PM, review of Social Services assessment dated .... and interview with the facility's Social Services Staff; Social Services Director (SSD) and Social Services Assistant (SSA), Staff F, it was revealed that social services is responsible for assessing the residents upon admission, quarterly, and annually. The SSD revealed social services saw the residents often around the facility, assess for . (Brief Interview of Mental Status) score, moods, and behaviors. The SSD stated he went to the resident's room to complete the initial assessment on . Review of the social services note dated .... indicated social services will be available to Resident #1 and family for support if needed ... The ...... and assessment indicated the resident had little interest or pleasure in doing things,

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frequency, 2 to 6 days. Feeling down depressed or hopeless, frequency, 2 to 6 days. Feeling tired or having little energy, frequency 7 to 11 days. Poor appetite or overeating, frequency 7 to 11 days. The Social Services Director explained they followed the questionnaire on the form Patient Health Questionnaire (PHQ-9) which asks about interest / pleasure in doing things, feeling down, depressed, or hopeless, trouble falling /staying asleep or sleeping too much, if tired, feeling little energy, feeling bad about yourself. [Resident #1's] assessment showed the score result for his ... was a six which indicated that the resident had a symptom of feeling tired having low energy, he had poor appetite, little interests in doing stuff and was feeling down. He was upset about the news. The SSD reported he did not address Resident #1's report that he was feeling down, "Once I learned the resident had diagnoses of , , I looked at his medications. He was already on ... , ... I saw that he was already care planned. He was a patient that we saw in the hallway often, very social, attended , . I did not do anything, I asked the resident why he was depressed, he said it was about politics, there was not much I could do about that. I was not aware of , ..." The Social Services Director reported they usually learned about residents concerning behaviors during morning meetings and never knew that he had any behaviors. When asked why there was only one social services assessment and progress note in Resident #1's clinical record, the SSD responded, "There must have been other progress notes, I don't know what happened to them."

Interview on , , at 10:01 AM with Staff B Registered Nurse (RN) reported working

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{F 600}	Continued From page 17 in the facility since , this year and normally worked with (Resident #1) three days a week, from 7:00 AM to 7:00 PM. The resident was alert and oriented times three. He communicated his needs well. He normally slept until about 9:00 AM/10:00 AM. He liked to participate in , and activities. He liked to come out of the room. On the day of the incident (Resident #1) was on isolation precautions due to a (,). Staff B, RN stated, " I worked from Thursday, , to Saturday . I monitored for behaviors related to his use of , we monitored for , fear, or . I don't remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed." Staff B, RN reported not being present when Resident #1 had the aggressive behavior of throwing his gown at Staff A, CNA. "I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and , the day that he , . What I documented was that he had one behavior of ." Staff B, RN explained, "he was asking a lot about why he remained with the treatment, about the ( ). He kept asking about it, although I had already spoken to him about it. The intervention, during the episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. What I documented on the behavior monitoring sheets about afraid/panic episode was related to the treatment, that he received the treatment and that it was effective. I did not document on the nurses notes that the	{F 600}		

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{F 600}	Continued From page 18 resident was having an episode of , because I did my action, I did not see him to be desperate, he allowed me to administer his treatment. Sometimes with the elderly, they usually ask a lot about their treatment. The episode of , noted on him, was normal, expected. The purpose of the Behavior Monitoring Sheet is to follow for a prescribed , medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was 12 - Refer to nurses' notes." Staff B upon review of the records agreed there was no record to explain anything about the resident's or behavior. Staff B stated that: " It's established that a patient can have at least three small episodes of , , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month. What the behavior monitoring sheet shows is that the medication is effective. I documented that he had , on , 3rd, and 4th. The one episode could have been something like, "I don't want to shower. I don't know the behavior." Staff B agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know, could not recall. Staff B added, " I also documented no behavior on , 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report to anyone. I did not think that I needed to communicate it to the Psychiatrist. We did not monitor him for , . I did not know he had any , or diagnoses of , ." Staff B then explained that with a diagnosis of , she would react differently because , are very dangerous, levels of in a person's	{F 600}		

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{F 600}	Continued From page 19 can change and cause them to have a crisis. " On that day he seemed well, he did not seem depressed, he did not reject care, or complain of , ." Upon discussion of Resident #1's Diagnoses, Staff B, RN reported, "I am surprised that he had a diagnosis of , . "When I left on that day he remained in his bed, I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." Interview with Regional Nurse and discussion of surveillance video showed that staff B last saw the resident at approximately 5:21 PM. Record review revealed Resident #1 was under the care of Staff C Licensed Practical Nurse (LPN) one of the two times it was documented that Resident #1 called the police because he was in so much , ( ) and on the night that he committed ( ). On attempted to conduct a telephone interview with Staff C, LPN on at 12:13 PM and a voice message was left. On at 5:04 PM telephone call was made again to interview Staff C. Staff C was interviewed by phone and was asked that we call in 15 minutes. On at 5:08 PM an incoming call was received from Staff C, she reported she misdialed and requested we call her in 15 minutes. On at 5:24 PM, during a telephone interview Staff C, LPN reported that Resident #1 never had any complaints and "he never had any , or , " when ask to clarify her notes that the resident had , the call was disconnected. During a follow up telephone interview on at 7:20 AM, Staff C was asked whether or not the resident ever expressed , or showed any signs or symptoms of , or , while under her care, Staff C again	{F 600}		

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{F 600}	Continued From page 20	{F 600}		

reported, "no", when asked about her handwritten nurses' notes dated ,
12:00PM Staff C, stated: " oh yeah, one time, I had to call the police because he was complaining of so much , . Staff C was asked to clarify if she had called the police or if Resident #1 had called the police, staff C stated that Resident #1 was the one who called the police. Staff C stated: "He did call the police!" Staff C LPN explained; the police was called to help Resident #1 calm down while she helped him transfer to the hospital.

The facility's removal plan included:
Residents who have a diagnosis of , and , were audited to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in and behavior as well as side effects and effectiveness of these medications
The Administrator/ Director of Nursing (DON) educated facility staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed , and , medications and identifying possible risk factors and changes in and behavior as well as side effects.
Administrator/DON in serviced all staff on a one-to-one basis regarding and Neglect.
The Corporate nurse consultant will in-service administrative staff on a one-to-one basis regarding , neglect. informed care and behavioral health.
Social services and nursing staff were educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding

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{F 600}	Continued From page 21 Newly hired staff will be educated during orientation by the DON/designee on monitoring residents with diagnosis of , and , and to monitor for behaviors related to , and , and any noted side effects of , and , medication as well as informed care. The facility has conducted an audit of all active residents with a diagnosis of , and , who are prescribed , and , medication to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in and behavior as well as side effects and effectiveness of these medication and to ensure behavior monitoring sheets are in place and reflect the behaviors of the resident and that side effects are monitored. The DON/designee will audit 100% of all active residents with a diagnosis of , and , weekly to ensure behavior sheets reflect the resident's behaviors, that those behaviors have interventions placed to intervene with the behavior and any side effects of , and , medications are monitored. Data will be collected weekly for a month then monthly for one quarter then monthly for the next two quarters. Social Services/designee will conduct informed screening on all active residents. Regarding the facility's failure to develop and implement a comprehensive care plan: The facility's removal plan indicated: Residents who are prescribed , and , medications were audited to ensure a care plan has been developed to effectively monitor for effectiveness and side effects of the medication.	{F 600}		

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{F 600}	Continued From page 22 Residents who are prescribed , medication were audited to ensure a care plan is developed to effectively manage the , . The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses, Certified Nursing Aides on developing and following the care plan regarding residents who are prescribed , and , medications to effectively monitor for the effectiveness of the medication and side effects. Minimum Data Set(MDS) Corporate consultant will conduct a one-to-one In service with MDS staff and will conduct an In service with nursing staff regarding developing and implementing a plan of care. The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nursing Staff, Certified Nursing Aides on developing and following the care plan for Residents who have , in order to effectively manage the Residents , symptoms. MDS Corporate consultant will conduct a one-to-one Inservice with MDS staff and will conduct an Inservice with nursing staff regarding developing and implementing a plan of care. Newly hired staff will be educated by the DON/designee during orientation on residents who are prescribed , , , , and , medication medications to effectively monitor for the effectiveness of the medication and side effects. An audit of all active residents who are on , , , and , medication was conducted to ensure a care plan has been developed to effectively monitor for effectiveness and side effects of the medication. Monitoring for Corrective Action: The DON or designee will audit 100% of all active residents who are on , , , ,	{F 600}		

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{F 600}	Continued From page 23 and ,.. medication weekly to ensure care plans have been developed to monitor the effectiveness of the medications and monitor for side effects. Data will be collected weekly for a month then twice a week for one quarter then monthly for the next two quarters. Related to: Accident Hazards, Supervision Devices failure to provide adequate supervision and accurately and effectively monitored to identify and treat changes in ... and behaviors, the facility's removal plan indicated: Residents who have a diagnosis of . .., and , were audited to ensure behavior sheets are in place to identify behaviors, interventions placed to intervene with the behaviors and referrals made for ,..,. ..... and mental health evaluations. The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses, Certified Nursing Aides and Social Services regarding behavioral health with emphasis on monitoring residents with . .., and ..,. .... diagnosis and to ensure referrals are made for mental health evaluations. Social services and nursing staff was educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding ... .. Newly hired staff will be educated during orientation on behavioral health with emphasis on monitoring residents with , and , ... diagnosis and to ensure referrals are made for mental health evaluations. The facility has conducted an audit of all active residents with a diagnosis of , and ..,. .... to ensure behavior monitoring sheets are in place and reflect the behaviors of the resident and that referrals for mental health are	{F 600}		

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{F 600}	Continued From page 24	{F 600}		

conducted as warranted from the audit. The DON or designee will audit 100% of residents with a diagnosis of . . , ... and . . . . , to ensure behavior monitoring sheets accurately reflect resident's behaviors. Data will be collected weekly for a month then twice a week for one quarter then monthly for the next two quarters. Social Services/designee will conduct the informed screening on all active residents.

The facility's removal plan was verified during an onsite visit on and telephone interviews conducted on . . . .

Observations on . . . . revealed sampled residents with diagnosis of , . or , and receiving , . medication were being provided care and services and no concerns about the safety and well-being of the residents were noted during observations.

On at 10:00 AM, the Nursing Home Administrator (NHA) stated that she provided education and one to one training session to all staff to ensure staff were fully trained and knowledgeable. The training was provided to all 160 employees to include the monitoring and documenting of any situation with residents assessed and identified for . . , ... , ... , , , and to provide the correct information on the behavior monitoring sheets.

Review of the Education/In-Services logs provided dated until topics included: . . , ... , Monitoring, Documentation. Progress Notes and behavior sheets. Monitor for . . . . Monitoring for , and , . . Monitoring residents prescribed . . . . , ... and . . . . . ,

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{F 600}	Continued From page 25 medications effectiveness. Understand Informed Care, , , behavior, and side effects. Able to identify risk factors and changes in and behavior. Able to identify side effects of , and , medications. Referral for mental health evaluation. Care Plan: , , , , , to effectively monitor for effectiveness of meds and side effects. -Documentation accuracy developing and following care plans for residents who have , in order to effectively manage their , and symptoms. Able to identify , -symptoms and effectively manage the resident's , . Review of the one to one (1:1) Education/In service dated provided by Corporate to the Administrator, Assistant, Director of Nursing. Review of the in-service logs dated to revealed education was provided to 75 nursing staff. On in-service training was provided by the three staff members of the Social Services Department. (3 staff from Social Services Department), MDS and Care Planning staff. On in-service was provided to 8 staff members. On (1 staff) and (1 staff). On in-service was provided to new hires. Interviews conducted with 21 licensed nurses and 34 Certified Nursing Assistants between and the telephone interviews on revealed that the inservices provided to the facility's staff and that the staff were able to explain understanding of the education received in the trainings provided. Review of the audit logs revealed weekly audits for residents who are on , , , and , medication and side effects	{F 600}		

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{F 600}	Continued From page 26 of the medication. Record review of the facility's Policy and Procedures: Coral Reef Subacute Resident .... Neglect and . ,. ..... Policy 1-800-96- was revised on . The facilty's Behavioral Assessment, Intervention and Monitoring last revised was reviewed with no concerns. The facility's policy for Informed Care revised was reviewed.	{F 600}		
{F 641} SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded for one resident (Resident #1) out of ten sampled residents during a complaint investigation. The Findings included: Record review of Resident #1's Comprehensive Minimum Data Set (MDS) MDS dated revealed; the assessment showed that Resident #1 returned to the facility on from "acute hospital." His Brief Interview of Mental Status ( ) score was 15 out of 15, meaning the resident was . . . . He had Clear speech, ability to understand and be understood. No indication of , . , ... and no behaviors. The resident was admitted with an . . . . . . from the hospital. He was . . . . . . of	{F 641}		

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{F 641}	Continued From page 27 He had a prior to admission within the last month and also had a two to six months prior to admission. Section N for Medications noted he used , , , and . Section I for Active Diagnoses coded; Combined , and diastolic , , , , , , , Prostatic Hyperplasia ( ), , / , and , , (blockage in the , tract), and .	{F 641}		
	Record review of the Comprehensive Minimum Data Set (MDS) and interview with MDS coordinator, Staff C on , , at 9:48 AM, revealed, Resident #1 was re-admitted to the facility on . His most recent comprehensive MDS, dated . He had a score of 15 out of 15 on the ( ), which indicated that the resident was able to verbalize his needs and was not , , . Further review of the MDS revealed that Resident #1 had clear speech pattern and was able to understand others as well as make self-understood. He had no prior to admission within the last month, also, no within two to six months prior to admissions. His active diagnoses as noted in the MDS were Medically , Conditions, , ( ), , and , . During the interview, the MDS coordinator agreed the recent MDS was incorrectly coded. It did not accurately reflect Resident #1's or active diagnoses.			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		

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F 656	Continued From page 28 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. ( )In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 29 section. This REQUIREMENT is not met as evidenced by: Based on interviews, policy and records reviewed, the facility failed to implement, develop an effective care plan for the quality of care and treatments required by one (Resident #1) out of 10 sampled residents reviewed during this complaint investigation. The facility failed to develop a care plan to address Resident #1's and did not develop a care plan that addressed the Resident's use of medications and . The facility also failed to implement the Resident's care plan for diagnoses of and by failing to effectively monitor behaviors related to Resident #1's diagnoses and failed to report episodes of Afraid/Panic to the psychiatrist. As a result of these deficient practices, Resident #1 suffocated himself by placing a plastic trash bag over his , resulting in his by On , , it was determined the findings of the survey posed immediate jeopardy to the health and safety of all residents admitted to the facility. On the facility's Immediate Jeopardy Removal Plan was verified by the survey team through record reviews and interviews. It was revealed that the facility completed in-services for all staff on related to the Immediate Jeopardy deficiencies. The scope and severity was lowered as a result of the facility's corrective actions implemented. The immediate jeopardy was determined to be removed on . The scope and severity for F656 were lowered to a (D) for No actual harm with a potential for more than minimal harm that is not immediate jeopardy	F 656		

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as of .

The Findings Included:

Record review of the Facility's policies and procedures revised titled; Care Plans, Comprehensive Person - Centered revealed the policy statement, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet resident's physical, , and functional needs is developed and implemented for each resident.

The Policy Interpretation and Implementation noted: 1. The interdisciplinary team in conjunction with the resident and his/her family or legal representative develops and implements a comprehensive, person -centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

Review of the care plans for Resident #1 revealed, a care plan dated ; "Resident #1 exhibited behaviors of /agitation. Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, determine cause of , observe for changes in mental status, , and behavior, notify MD (Medical Doctor) of changes as needed ... Further review of the care plans showed that Resident #1 had a diagnoses of and was at risk for alterations in pattern. Approaches included, observe for changes in , encourage verbalization of feelings, administer as ordered. There

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were no care plans in Resident #1's clinical records for the use of , , , diagnoses of , diagnosis of and for the use of 5 milligrams (mg) tablet (is used to treat moderate to severe related to 's).

Review of Resident #1's behavior monitoring sheets for the months of , , and , indicated that Resident # 1 was monitored for the behaviors afraid/panic related to the use of , 1 mg tablet. There was no recorded documentation to indicate that Resident #1 was monitored for any other behavior such as , , changes or danger to self. Further review of behavior monitoring sheets revealed that Resident#1 had multiple episodes documented as "Afraid/Panic":

During the Month of , (initiated on) Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred between the hours of 7:00 AM to 7:00 PM, on , , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between 7:00 PM to 7:00 AM, on , , , 27 and 28. Interventions for each episode noted "Routine", indicating that the facility's only intervention was the administration of ordered routine medication; , 1 mg tablet by at bedtime that was ordered for diagnosis of . Review of the nurses progress notes for the month of , (From , to ,) showed no record that addressed any of the episodes of exhibited by Resident #1.

During the Month of , the behavior monitoring sheet showed no documentation (left blank) for , , and during the day

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F 656	Continued From page 32 shift (7:00 AM to 7:00 PM) of ..., indicating that the behavior "Afraid/Panic" was not monitored during that time. Further review of ...'s Behavior Monitoring record for Resident #1, showed that he had 15 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) that occurred on ..., 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29, 2021. Review of nurses progress notes for the month of ... (From ... to ...), showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1. For the Month of ..., ... (Initiated on ...) Resident #1's behavior monitoring sheet showed the resident had a total of 17 different episodes during the month of ..., ... Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7:00 PM: on ..., ..., 3, 4,and 5, 2021, the intervention noted "Routine QHS" (every bedtime). indicating that the facility's only intervention was the administration of his routine medication; ..., 1 mg tablet by ... at bedtime. Further review of ...'s behavior monitoring record showed that Resident #1 had 17 episodes of Afraid/Panic. Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the 7:00 PM to 7:00 AM shift on ..., 7, 12, 13, 14, 17, 19, 20, 21, 24, 26, 27 and 28, 2021. The intervention noted "Refer to Nurses Notes." Review of nurses progress notes for ..., showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1. The Behavior Monitoring Sheet dated ...	F 656		

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2021, showed that Resident#1 had a total of three episodes. Two episodes of Afraid/Panic occurred during the day shift (7:00 AM to 7:00 PM) on and on (the day of his). He also had one episode of Afraid/Panic between 7:00 PM to 7:00 AM shift on . Interventions for each episode noted "Routine QHS." indicating that the facility's only intervention was the administration of his routine medication; , 1 mg tablet, one tablet by at bedtime. Review of the progress notes for , showed no record that addressed the afraid/panic episodes exhibited by Resident #1.

On at 12:15 P, during an interview and record review with the Director of Nursing (DON), and the Clinical Regional Nurse. The DON explained; the nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors, the CNA would report each behavior to the nurses. Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as . The clinical records were discussed related to the Plan of care the DON explained diagnoses of , depends on the patient. For just about anybody, the care planned interventions include provide emotional support. Activities, whatever they are interested in encouraging them to talk about their feelings. Encourage socialization, provide feedback to reinforce positive behaviors. Notify MD of changes as needed. Psych consult as needed and Administer as ordered. The DON and the Clinical Regional Nurse acknowledged Resident # 1's physician orders included the

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F 656	Continued From page 34 : 1. 1 mg tablet, ordered one tablet by at bedtime for diagnosis of , and 50 mg tablet for diagnosis of , one tablet by every day. The DON and the Clinical Regional Nurse were apprised that Resident #1's clinical record showed no plan of care that specifically addressed his use of , , or his diagnoses of , and . Both the DON and the Clinical Regional Nurse agreed there was no care plan on record specific to the use of the , or , medication and explained; "For a resident on , , we would normally use the same type of interventions as with a resident that has a diagnosis of , . Another thing we would do is monitor for side effects, which is part of medication management. The use of requires we monitor for . We monitor depending on the resident. We have residents that are verbally able to report, we look for verbalization, we also look at signs or symptoms. We document behaviors on the behavior sheet and documentation for the specific behavior that occurs is also on the daily skill nurses' notes. When it comes to the , ( ) we would monitor for side effects which could include sleepiness, fatigue, abnormal coordination, , ..." The DON explained; "We have behavior monitoring sheets for the use of , it shows that we monitor for behaviors "Fear/Panic, , kind of stuff." According to the nurse's documentation on the behavior monitoring sheets, Resident #1 had panic/ , episodes ..." The DON explained, "the nurses and general staff reported that the resident was showing frustration over his health. He did not like the . He did talk about it sometimes. He had , on and	F 656		

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F 656	Continued From page 35 2nd. The only intervention was the medication as documented on the behavior monitoring sheets ...We do not have a behavior monitoring record for the use of , ." The DON and Clinical Regional Nurse both agreed to review the residents record for any notes that addressed Resident #1's behaviors, "We did not notice any actual written notes that addressed any of the resident's behaviors or ..." Both the DON and the Clinical Nurse Manager agreed such documentation was necessary. Interview on at 12:05 PM, the Psychiatrist explained that Resident #1 gave no indication that he was depressed, and that facility staff was "usually very good at letting us know when there is any indication, not only present, but also past history, or any indication of clinical . They usually call me for an evaluation ... I see most of the patients that are taking , ..., they usually generate a consult for me. If the patient had shown any signs or symptoms, indicating they had clinical , or , the staff would have notified me." The Psychiatrist acknowledged that he saw Resident #1 once, on and that his diagnoses included , and , . Continued Interview with the Psychiatrist on at 10:56 AM revealed the Psychiatrist did not review the above-mentioned behavior monitoring sheets found in Resident #1's clinical record. He explained that he met with the facility staff and discussed the residents' behavior and if any adjustments are needed. When asked, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of multiple documented episodes of afraid/panic noted on Resident #1's clinical record, The	F 656		

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Psychiatrist reported he was not aware of any of the above-mentioned behaviors. The nurses did not communicate said behaviors to him. The Psychiatrist explained that the facility staff should have communicated any , afraid/panic episodes and other behavior exhibited by Resident#1. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, would have gone to see him, maybe change the medication ..."

On at 10:01 AM, Staff B Registered Nurse(RN) revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. The resident was alert and oriented times three and communicated his needs well and normally slept until about 9:00 AM to 10:00 AM, participated in , and activities and liked to come out of the room. Staff B explained that on the day of the incident Resident #1 was on isolation precautions due to a ( ). Staff B, RN stated: " I worked from Thursday, to Saturday ... I monitored for behaviors related to his use of , we monitored for , , fear, or , I don't remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed ...I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and , the day that he . What I documented was that he had one behavior of ." Staff B, RN explained that

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F 656	Continued From page 37 Resident #1 kept asking about the ( ) treatment. The intervention, during the episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. Staff B stated that her documentation on the behavior monitoring sheets about the afraid/panic episode was related to the treatment, that Resident #1 received the treatment and that it was effective. Staff B stated: "I did not document in the nurses notes that the resident was having episode of , because I did my action, I did not see him to be desperate, he allowed me to administer his treatment." Staff B reported that the purpose of the behavior monitoring sheet is to follow for a prescribed , medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was to refer to nurses' notes. Staff B agreed there was no record to explain anything about the resident's or behavior. Staff B stated: " It's established that a patient can have at least three small episodes of , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month ...what the behavior monitoring sheet shows is that the medication is effective. I documented that he had , on , 3rd, and 4th. The one episode could have been something like, "I don't want to shower, I don't know the behavior." Staff B then agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know and could not recall the behavior. Staff B stated: I also documented no behavior on , 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report	F 656		

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to anyone. I did not think that I needed to communicate it to the psychiatrist. We did not monitor him for . I did not know he had any , or diagnoses of , . With a diagnosis of " Staff B explained that she would have reacted differently and that are very dangerous, levels of in a person's can change and cause them to have a crisis. "On that day he seemed well, he did not seem depressed. He did not reject care, or complaint of ." Upon discussion of Resident #1's Diagnoses, Staff B reported: "I am surprised that he had diagnosis of , ...when I left on that day he remained in his bed. I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." (Investigative report and interview with The Clinical Regional Nurse on at approximately 2:30 PM showed that per surveillance video, staff B last saw the resident in his room at approximately 5:21 PM).

Record review of physician's orders for Resident #1 showed a Telephone Order dated for a , management consult. Further review of Resident #1's clinical record showed no documentation to indicate that Resident #1 received said , consult.
Resident #1 returned from the hospital on with a diagnosis of , .
His orders included 10 mg. for five days for a diagnosis of , . Review of Resident #1's clinical record revealed no care plans on file that addressed Resident #1s diagnosis of , .

The facility's removal plan included:
Residents who have a diagnosis of , and were audited to ensure they have an

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F 656	Continued From page 39 effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in ... and behavior as well as side effects and effectiveness of these medications The Administrator/ Director of Nursing (DON) educated facility staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed ... and ... medications and identifying possible risk factors and changes in ... and behavior as well as side effects. Administrator/DON in serviced all staff on a one-to-one basis regarding ... and Neglect. The Corporate nurse consultant will in-service administrative staff on a one-to-one basis regarding , neglect, informed care and behavioral health. Social services and nursing staff were educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding ... . Newly hired staff will be educated during orientation by the DON/designee on monitoring residents with diagnosis of , and ... and to monitor for behaviors related to , and , and any noted side effects of ... and ... medication as well as informed care. The facility has conducted an audit of all active residents with a diagnosis of , and ... who are prescribed ... and , medication to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in ... and behavior as well as side effects and effectiveness of these medication and to ensure behavior monitoring	F 656		

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F 656	Continued From page 40 sheets are in place and reflect the behaviors of the resident and that side effects are monitored. The DON/designee will audit 100% of all active residents with a diagnosis of , and weekly to ensure behavior sheets reflect the resident's behaviors, that those behaviors have interventions placed to intervene with the behavior and any side effects of and , medications are monitored. Data will be collected weekly for a month then monthly for one quarter then monthly for the next two quarters. Social Services/designee will conduct informed screening on all active residents. Regarding the facility's failure to develop and implement a comprehensive care plan: The facility's removal plan indicated: Residents who are prescribed and , medications were audited to ensure a care plan has been developed to effectively monitor for effectiveness and side effects of the medication. Residents who are prescribed , medication were audited to ensure a care plan is developed to effectively manage the , . The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses, Certified Nursing Aides on developing and following the care plan regarding residents who are prescribed and , medications to effectively monitor for the effectiveness of the medication and side effects. Minimum Data Set(MDS) Corporate consultant will conduct a one-to-one Inservice with MDS staff and will conduct an Inservice with nursing staff regarding developing and implementing a plan of care. The Administrator/DON educated facility staff on	F 656		

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a one-to-one basis including Licensed Nursing Staff, Certified Nursing Aides on developing and following the care plan for Residents who have , in order to effectively manage the Residents , symptoms. MDS Corporate consultant will conduct a one-to-one Inservice with MDS staff and will conduct an Inservice with nursing staff regarding developing and implementing a plan of care.
Newly hired staff will be educated by the DON/designee during orientation on residents who are prescribed , , , and , medication medications to effectively monitor for the effectiveness of the medication and side effects.
An audit of all active residents who are on , , , and , medication was conducted to ensure a care plan has been developed to effectively monitor for effectiveness and side effects of the medication.
Monitoring for Corrective Action:
The DON or designee will audit 100% of all active residents who are on , , , and , medication weekly to ensure care plans have been developed to monitor the effectiveness of the medications and monitor for side effects.
Data will be collected weekly for a month then twice a week for one quarter then monthly for the next two quarters.

Related to: Accident Hazards, Supervision Devices failure to provide adequate supervision and accurately and effectively monitored to identify and treat changes in and behaviors, the facility's removal plan indicated:
Residents who have a diagnosis of , and , were audited to ensure behavior sheets are in place to identify behaviors, interventions placed to intervene with the

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F 656	Continued From page 42 behaviors and referrals made for , , and mental health evaluations. The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses, Certified Nursing Aides and Social Services regarding behavioral health with emphasis on monitoring residents with , and , diagnosis and to ensure referrals are made for mental health evaluations. Social services and nursing staff was educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding . Newly hired staff will be educated during orientation on behavioral health with emphasis on monitoring residents with , and , diagnosis and to ensure referrals are made for mental health evaluations. The facility has conducted an audit of all active residents with a diagnosis of , and to ensure behavior monitoring sheets are in place and reflect the behaviors of the resident and that referrals for mental health are conducted as warranted from the audit. The DON or designee will audit 100% of residents with a diagnosis of , and , to ensure behavior monitoring sheets accurately reflect resident's behaviors. Data will be collected weekly for a month then twice a week for one quarter then monthly for the next two quarters. Social Services/designee will conduct the informed screening on all active residents. The facility's removal plan was verified during an onsite visit on and telephone interviews on . Observations on revealed sampled residents with diagnosis of , or ,	F 656		

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F 656	Continued From page 43 and receiving medication were being provided care and services and no concerns about the safety and well-being of the residents were noted during observations. On at 10:00 AM, the Nursing Home Administrator (NHA) stated that she provided education and one to one training session to all staff to ensure staff were fully trained and knowledgeable. The training was provided to all 160 employees to include the monitoring and documenting of any situation with residents assessed and identified for , and to provide the correct information on the behavior monitoring sheets. Review of the Education/In-Services logs provided dated until topics included: , Monitoring, Documentation. Progress Notes and behavior sheets. Monitor for . Monitoring for , and . Monitoring residents prescribed and medications effectiveness. Understand Informed Care, behavior, and side effects. Able to identify risk factors and changes in and behavior. Able to identify side effects of , and medications. Referral for mental health evaluation. Care Plan: to effectively monitor for effectiveness of meds and side effects. -Documentation accuracy developing and following care plans for residents who have in order to effectively manage their and symptoms. Able to identify -symptoms and effectively manage the resident's . Review of the one to one (1:1) Education/In service dated provided by Corporate to the	F 656		

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F 656	Continued From page 44	F 656		

Administrator, Assistant, Director of Nursing. Review of the in-service logs dated to revealed education was provided to 75 nursing staff. On in-service training was provided by the three staff members of the Social Services Department. (3 staff from Social Services Department), MDS and Care Planning staff. On in-service was provided to 8 staff members. On (1 staff) and (1 staff). On in-service was provided to new hires.

Review of the audit logs revealed weekly audits for residents who are on , , and medication and side effects of the medication.

Record review of the facility's Policy and Procedures for Care Plans, Comprehensive Person-Centered was revised on . The Resident Neglect and Policy 1-800-96- was revised on . The facilty's Behavioral Assessment, Intervention and Monitoring last revised was reviewed with no concerns. The facility's policy for Informed Care revised was reviewed.

On at 06:43 PM, Staff D, MDS Coordinator revealed she received in service training from DON and Corporate Regional Nurse. The training was basically to ensure that she was encoding properly the Care Plans, ensuring that if the patient has a diagnosis of , , or to make sure that everything was in place including communication with the team and if any signs of side effects and monitoring the effectiveness of the medication. Staff D stated that if she read

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F 656	Continued From page 45 anything in the chart that triggers or when talking to resident or family to communicate with direct care provider (nurse for the patient). Also, during the assessment look to see if resident has any and also when patient receiving the , , , medication to ensure the behaviors are noticed both on the care plan and to ensure that every patient has behavior sheet and make sure the behaviors sheets match the medication administration records for the medication and the Care Plan. Monitoring the behaviors is done by the nurses providing direct care and any staff in the building that observed any signs for symptoms pertaining to , , and , and for them to report it immediately to administration or supervisor. Review of the audit logs revealed weekly audits for residents who are on , , , and , medication and side effects of the medication. Record review of the facility's Policy and Procedures for Care Plans, Comprehensive Person-Centered was revised on . The Resident Neglect and , Policy 1-800-96- was revised on . The facilty's Behavioral Assessment, Intervention and Monitoring last revised was reviewed with no concerns. The facility's policy for Informed Care revised was reviewed.	F 656		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	{F 684}		

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{F 684}	Continued From page 46	{F 684}		

facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on interviews, and records reviewed, the facility failed to ensure, identify, and provide needed care and services such as the care planning, monitoring assessment and consistent response to manage diagnoses of , . experienced by one (Resident #1) out of 10 sampled residents reviewed during a complaint survey. The facility failed to effectively monitor behaviors related to Resident #1's diagnoses of , and , and , . While unsupervised in his room, Resident #1 suffocated himself by placing a trash bag over his , resulting in .... by ......

The findings included:

Record review of physician's orders for Resident #1 showed a telephone order dated for , . management consult. Further review of Resident #1's clinical record showed no documentation that Resident #1 received said , consult.

Record review of the nurse's notes dated .... for the 7:00 AM to 7:00 PM shift revealed, Resident #1 was administered two , . . 500 milligram (mg) tablets because of , in the penis, continued with , until 4 PM when he (Resident #1) called 911 at 7:00 PM to go to the hospital.

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{F 684}	Continued From page 47 Record review of the Clinical Transition of Care showed that Resident #1 arrived to the to the Hospital on at 20:12, with diagnoses of penal , and , problem. "Diagnoses during this visit" noted; ( ), Site not specified. Unspecified , Acute , problem, other specified of penis, unspecified complication of , , device, , and , initial encounter..." Record review of physician's progress dated revealed, Resident #1 transferred to the Hospital on secondary to , . He was complaining of , from his . Upon admission to the hospital, he was diagnosed with associated complicated with suspected . He was also diagnosed with mild ..." Review of clinical records revealed Resident # 1 returned to the nursing home on . Review of physician orders dated , and , showed no medication or treatment order for Resident #1 diagnoses of . Record Review of the Medication Administration Records (MAR) dated to revealed , levels of zero was documented every day of the month. Record review of nurses progress notes documented by Staff C a Licensed Practical Nurse (LPN) dated at 12:30 noted " Resident called 911- police called, resident observed banging on his bed and yelling, stating	{F 684}		

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that he had severe , and requested to be sent to the hospital. ABD [abdomen] assessed noted soft, non-tender, voiced , at the touch of lower region. Call placed to MD [Medical Doctor] to send to hospital for evaluation. Call place to 911 emergency. Paramedics arrived, assessed patient, and transferred him to the closest hospital at 11:30 PM.

Resident #1 returned from the hospital on with diagnosis of . His orders included 10 mg for five days for diagnosis of , .

Record review of , assessment again showed zero , documented during the month of , including .

Record review of physicians' progress notes dated , . , noted that Resident #1 reported he had been having some discomfort in his secondary to his .
Physician progress notes dated noted, " He reports that the , he was having on Friday was resolved." (Indicating that Resident#1 was in , on).

Record Review of the MAR for , showed staff documented , levels of zero every day of the month.

Continued record review of the MAR and nurses notes for Resident #1 showed no record to indicate the facility acknowledged Resident #1's diagnoses of , during the month of .

Interview on at 6:00 PM with Resident #4 revealed he was close friends with

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Resident #1. Resident #4 had a score of 14 out of 15 on the ( ), which indicated the resident was able to verbalize his needs and was not . Further review of the Minimum Data Set (MDS) revealed that Resident #4 had a clear speech pattern and was able to understand others as well as make self-understood. During the interview, Resident #4 reported he was friends with Resident #1 and hung out with him almost every day. Resident #4 explained that the last times he saw his friend on and "[Resident #1]was in a lot of , he was suffering. As if peeing razor blades" Resident # 4 reported that Resident #1 talked about how he just could not take it anymore and he wanted "to go home, meaning go to heaven."

Record review of Resident #1's MAR and treatment records for showed no record to indicate the facility addressed the resident's . Further review of the MAR for , and showed zero , levels documented every day the resident was in the facility, including , and on the day of his ; the day that Resident #1 suffocated himself by placing a trash bag over his , resulting in by .

Record review of the MAR for Resident #1 and Interview with Staff G, Licensed Practical Nurse (LPN) on / 2021 at 4:08 PM revealed, Staff G reported she usually cared for Resident # 1 whenever she worked on his unit from 7:00 AM to 7:00 PM on Mondays, Tuesdays, and Wednesdays. Staff G, LPN explained, "The process is that if they verbalize , we ask about location, and scale. We document location,

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and scale in the MAR. Our job is to assess for , every shift. "Staff G acknowledged that Resident #1 had conditions that could cause , , " He had , as one of his diagnoses, could be painful, sensation, discomfort ..." During the interview, clinical review of Resident #1's records showed that the resident was discharged from the community hospital with orders for diagnosis of , and for 10 mg, one tablet to be administered by every 6 hours for 5 days with start date of . Staff G acknowledged her signature on the MAR suggested she administered the , medication to Resident #1 on . Staff G stated, " It was routine, which means I have to give it to him, possibly associated with the ." Staff G insisted that Resident #1 never verbalized any ,

Interview on , at 10:01 AM with Staff B Registered Nurse(RN) revealed she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. Staff B reported that the resident was alert and oriented times three and he communicated his needs well. Staff B, RN acknowledged that Resident #1 had , at times; " I remember he did at some point take , medications, , and for about three days." Staff B was not able to explain why the MAR indicated zero (0) , for the entire month of and and insisted that the resident did not have , the last times she cared for him on Thursday, to Saturday , . Staff B stated: "Those last three days he did not have , ."

Review of clinical records revealed Staff C LPN documented that Resident #1 called the police because he was in so much , on

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{F 684}	Continued From page 51 and on the night that he committed ( ). On at 12:13 PM attempted to interview Staff C, LPN by phone and a voicemail message was left. On at 5:04 PM Staff C was called again and Staff C answered the phone and requested for the surveyor to call in 15 minutes. On 5:24 PM staff C was called, Staff C was asked if Resident #1 had any complaints of while under her care. Staff C responded, "no! never, he never had any complaints." When asked to clarify her notes that the resident had , the call was disconnected. On at 7:20 AM a follow up telephone interview was attempted with Staff C. When asked whether or not Resident #1 ever expressed , or showed any signs /or symptoms of , or while under her care, Staff C reported, "no!" Staff C was asked about her handwritten nurses' notes dated at 12:00 PM Staff C, revealed she remembered and stated: " oh yeah, one time, I had to call the police because he was complaining of so much , " Staff C was asked to clarify the documentation because the note indicated that the resident had called the police. Staff C then responded, "He did call the police!" Staff C, LPN then explained that the police was called to help Resident #1 calm down while she helped him transfer to the hospital.	{F 684}		
{F 689} SS=D	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}		

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{F 689}	Continued From page 52 §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 records reviewed and interviews, the facility failed to ensure adequate behavior monitoring and supervision was provided for one resident (Resident #1) out of 10 sampled residents of the 17 Residents that received medications and 47 residents that received medications. The facility failed to effectively monitor behaviors related to Resident #1's diagnoses of and multiple episodes of panic and afraid which lead to Resident #1 self-inflicted harm. Resident #1 while unsupervised in his room, placed a plastic trash bag over his and suffocated himself resulting in by . On , it was determined the findings of the survey posed immediate jeopardy to the health and safety of all residents admitted to the facility. On the facility's Immediate Jeopardy Removal Plan was verified by the survey team through record reviews and interviews. It was revealed that the facility completed in-services for all staff on related to the Immediate Jeopardy deficiencies. The scope and severity was lowered as a result of the facility's corrective actions implemented. The immediate jeopardy was determined to be removed on . The scope and severity for F689 were lowered to a (D) for No actual harm with a potential for more than minimal harm that is not immediate jeopardy as of .	{F 689}		

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{F 689}	Continued From page 53 The Findings Included: Record review of the Federal 1 day report revealed, on at 9:00 PM, Resident #1 was admitted to the facility on . Resident #1 was an alert and oriented resident with physical limitations, used a wheelchair and is able to transfer to the wheelchair on his own and able to go to the bathroom on his own and was independent but would ask for assistance if he needed it was found by Certified Nursing Assistant (CNA) Staff A with a plastic bag over his . The facility's staff immediately called the code and initiated ( ) and called 911 and the resident expired. Record review of the facility's policy and procedures titled, "Safety and Supervision of Residents." Revised in , revealed the policy statement: Our facility strives to make the environment as free from accident hazards as possible. Residents' safety and supervision and assistance to prevent accidents are facility wide commitment to safety at all levels of the organization. Facility oriented approach to safety included: "Employees shall be trained on potential hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. Individualized, resident-centered approach to safety included: 1.Our individualized, resident centered approach to safety addresses safety and accident hazards for individual residents. 2.The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accidents hazards or risks for individual residents. 3. The care team shall target	{F 689}		

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interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Systems approach to safety noted: 2. Resident supervision is a core of the systems approach to safety.

Review of the care plans for Resident #1 revealed, care plan dated ; "Resident # 1 exhibited behaviors of /agitation. Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, determine cause of , observe for changes in mental status, , and behavior, notify MD (Medical Doctor) of changes as needed. Further review of the care plans showed that Resident #1 had diagnoses of and was at risk for alterations in pattern. Approaches included, observe for changes in , encourage verbalization of feelings, administer , as ordered.

Record review of Resident #1's behavior monitoring sheets for and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of , 1 milligram (mg) tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as changes or danger to self. There was no behavior record to indicate that he was monitored for his diagnosis of , and for the use of , . Further review of the behavior monitoring sheets showed that Resident #1 had multiple episodes documented as "Afraid/Panic". The behavior monitoring sheet initiated on indicated Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred during the hours of 7:00 AM to 7:00 PM

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{F 689}	Continued From page 55 on , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between the hours of 7:00 PM to 7:00 AM, on , , 27 and 28. The documented interventions for each episode noted "Routine." Review of the nurses' progress notes for , , showed no record that addressed any of the episodes of , exhibited by Resident #1. Review of the behavior sheets for documented an initiated date of , but the behavior monitoring sheet showed no record (left blank) for , , and during the day shift (7:00 AM to 7:00 PM) on , indicating that Resident #1's behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records for showed that Resident #1 had 15 different episodes of Afraid/Panic during the 7:00 PM to 7:00 AM shift. The Afraid/Panic behaviors noted to have occurred on , 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29. Review of the nurses' progress notes for , showed no recorded documentation that addressed any of the afraid/panic episodes exhibited by Resident #1. Review of Resident # 1's behavior sheets for (initiated on) showed Resident #1 had a total of 17 different episodes of Afraid / Panic during the month of , . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7:00 PM on , , 3, 4,and 5. The intervention documented noted "Routine QHS [nightly at bedtime]". Further review of , 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to	{F 689}		

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CORAL REEF SUBACUTE CARE CENTER LLC	9869 SW 152ND STREET MIAMI, FL 33157

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{F 689}	Continued From page 56 7:00 AM) on , 7, 12, 13, 14, 17, 19, 20, 21, 24, 26, 27 and 28. The documented intervention noted, "Refer to Nurses Notes." Review of Nurses Notes for , showed no recorded documentation that addressed the episodes of afraid/panic exhibited by Resident #1. Review of the behavior monitoring sheet dated , showed that Resident#1 had a total of three Afraid/Panic episodes. Resident #1 had one episode of Afraid/Panic between 7:00 PM to 7:00 AM on . Resident #1 had two episodes of the Afraid/Panic that occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his , . Interventions for each episode noted "Routine QHS[Every hour of sleep]." Review of the progress notes for , showed no recorded documentation that addressed any of the episodes exhibited by Resident #1. Review of the nurses progress notes dated at 11:00 PM documented by Licensed Practical Nurse (LPN) Staff C revealed: "Resident assigned CNA [Certified Nursing Assistant] was observed running over to me while I was doing my med pass as he verbalized code blue, I immediately assigned a staff member to call 911 as I grabbed the defibrillator machine. I assigned another staff member to get the crash cart. I ran to his room. The residents skin color was noted as pale color, no , was noted resident was transferred from wheelchair to the bed. Board was placed under the patient and [,] was initiated. 911 arrived and EMT[Emergency Medical Technicians] pronounced his . No obvious	{F 689}		

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{F 689}	Continued From page 57	{F 689}		

injuries were noted at the time of .... CNA assigned to this resident verbalized that he was unable to enter his room. The CNA stated he had to push very hard to open the door. CNA stated resident wheelchair was pushed against the door with patient sitting in the wheelchair. Trash bag was noted over his .... CNA stated he removed the trash bag to see if patient was not breathing. Patient was not breathing per CNA statement. CNA then verbalized to me and to the police how he found the patient. Family was notified by police. Police officer spoke to [Emergency Contact]. The medical examiner arrived and transferred residents' body out of the facility."

Review of the investigative report and interview with the Clinical Regional Nurse on .. .. at approximately 2:30 PM revealed, the Clinical regional nurse had reviewed the facility's video recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday .... at 2:54 PM Resident #1's CNA, (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse (Staff B) was passing meds. The Clinical Regional Nurse stated: "You can see her going in and out of rooms." At 4:30 PM the friend (Resident #4) leaves Resident # 1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His door remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA (Staff A) picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM

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{F 689}	Continued From page 58 (Staff C) LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from the time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area gets the nurse and the crash cart... The Regional nurse explained that the CNA had to push the door open and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . . . . The CNA stated that he pulled the bag off Resident #1's . . . and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office. During an interview on at 10:56 AM the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1's clinical record. The Psychiatrist explained that he met with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of the multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware and that the nurses had not communicated the behaviors to him. The Psychiatrist explained that the facility staff should have communicated . . , afraid/panic episodes and any other	{F 689}		

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{F 689}	Continued From page 59 behavior exhibited by Resident#1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, I would have gone to see him, maybe change the medication ..." The facility's removal plan included: Residents who have a diagnosis of , and were audited to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in and behavior as well as side effects and effectiveness of these medications The Administrator/ Director of Nursing (DON) educated facility staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed , and , medications and identifying possible risk factors and changes in and behavior as well as side effects. Administrator/DON in serviced all staff on a one-to-one basis regarding and Neglect. The Corporate nurse consultant will in-service administrative staff on a one-to-one basis regarding , neglect. informed care and behavioral health. Social services and nursing staff were educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding . Newly hired staff will be educated during orientation by the DON/designee on monitoring residents with diagnosis of , and , and to monitor for behaviors related to and , and any noted side	{F 689}		

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{F 689}	Continued From page 60 effects of , and , medication as well as informed care. The facility has conducted an audit of all active residents with a diagnosis of , and , who are prescribed , and , medication to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in and behavior as well as side effects and effectiveness of these medication and to ensure behavior monitoring sheets are in place and reflect the behaviors of the resident and that side effects are monitored. The DON/designee will audit 100% of all active residents with a diagnosis of , and , weekly to ensure behavior sheets reflect the resident's behaviors, that those behaviors have interventions placed to intervene with the behavior and any side effects of , and , medications are monitored. Data will be collected weekly for a month then monthly for one quarter then monthly for the next two quarters. Social Services/designee will conduct informed screening on all active residents. Regarding the facility's failure to develop and implement a comprehensive care plan: The facility's removal plan indicated: Residents who are prescribed , and , medications were audited to ensure a care plan has been developed to effectively monitor for effectiveness and side effects of the medication. Residents who are prescribed , medication were audited to ensure a care plan is developed to effectively manage the , . The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses,	{F 689}		

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{F 689}	Continued From page 61	{F 689}		

Certified Nursing Aides on developing and following the care plan regarding residents who are prescribed . . . ., ... and . . . . . ., medications to effectively monitor for the effectiveness of the medication and side effects.
Minimum Data Set(MDS) Corporate consultant will conduct a one-to-one Inservice with MDS staff and will conduct an Inservice with nursing staff regarding developing and implementing a plan of care.
The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nursing Staff, Certified Nursing Aides on developing and following the care plan for Residents who have , . in order to effectively manage the Residents , symptoms. MDS Corporate consultant will conduct a one-to-one Inservice with MDS staff and will conduct an Inservice with nursing staff regarding developing and implementing a plan of care.
Newly hired staff will be educated by the DON/designee during orientation on residents who are prescribed . . . ., ..., ..., and , medication medications to effectively monitor for the effectiveness of the medication and side effects.
An audit of all active residents who are on , , , and , medication was conducted to ensure a care plan has been developed to effectively monitor for effectiveness and side effects of the medication.
Monitoring for Corrective Action:
The DON or designee will audit 100% of all active residents who are on , , ,, and , . medication weekly to ensure care plans have been developed to monitor the effectiveness of the medications and monitor for side effects.
Data will be collected weekly for a month then twice a week for one quarter then monthly for the

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{F 689}	Continued From page 62 next two quarters. Related to: Accident Hazards, Supervision Devices failure to provide adequate supervision and accurately and effectively monitored to identify and treat changes in and behaviors, the facility's removal plan indicated: Residents who have a diagnosis of , and were audited to ensure behavior sheets are in place to identify behaviors, interventions placed to intervene with the behaviors and referrals made for , , and mental health evaluations. The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses, Certified Nursing Aides and Social Services regarding behavioral health with emphasis on monitoring residents with , and diagnosis and to ensure referrals are made for mental health evaluations. Social services and nursing staff was educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding . Newly hired staff will be educated during orientation on behavioral health with emphasis on monitoring residents with , and diagnosis and to ensure referrals are made for mental health evaluations. The facility has conducted an audit of all active residents with a diagnosis of , and to ensure behavior monitoring sheets are in place and reflect the behaviors of the resident and that referrals for mental health are conducted as warranted from the audit. The DON or designee will audit 100% of residents with a diagnosis of and , to ensure behavior monitoring sheets accurately reflect resident's behaviors. Data will be collected weekly	{F 689}		

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{F 689} Continued From page 63 {F 689}

for a month then twice a week for one quarter then monthly for the next two quarters. Social Services/designee will conduct the informed screening on all active residents.

The facility's removal plan was verified during an onsite visit on and telephone interviews conducted on .

Observations on revealed sampled residents with diagnosis of or , and receiving , medication were being provided care and services and no concerns about the safety and well-being of the residents were noted during observations.

On at 10:00 AM, the Nursing Home Administrator (NHA) stated that she provided education and one to one training session to all staff to ensure staff were fully trained and knowledgeable. The training was provided to all 160 employees to include the monitoring and documenting of any situation with residents assessed and identified for , , , and to provide the correct information on the behavior monitoring sheets.

Review of the Education/In-Services logs provided dated until topics included: , , Monitoring, Documentation. Progress Notes and behavior sheets. Monitor for . Monitoring for , and . Monitoring residents prescribed , and medications effectiveness. Understand Informed Care, , , behavior, and side effects. Able to identify risk factors and changes in and behavior. Able to identify side effects of , and

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{F 689}	Continued From page 64 medications. Referral for mental health evaluation. Care Plan: , to effectively monitor for effectiveness of meds and side effects. -Documentation accuracy developing and following care plans for residents who have in order to effectively manage their and symptoms. Able to identify -symptoms and effectively manage the resident's . Review of the one to one (1:1) Education/In service dated provided by Corporate to the Administrator, Assistant, Director of Nursing. Review of the in-service logs dated to revealed education was provided to 75 nursing staff. On in-service training was provided by the three staff members of the Social Services Department. (3 staff from Social Services Department), MDS and Care Planning staff. On in-service was provided to 8 staff members. On (1 staff) and (1 staff). On in-service was provided to new hires. Review of the audit logs revealed weekly audits for residents who are on , and medication and side effects of the medication. Record review of the facility's Policy and Procedures for Care Plans, Comprehensive Person-Centered was revised on . The Resident Neglect and Policy 1-800-96- was revised on . The facilty's Behavioral Assessment, Intervention and Monitoring last revised was reviewed with no concerns. The facility's policy for Informed Care revised was reviewed.	{F 689}		

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{F 689}	Continued From page 65 Interviews conducted with 21 licensed nurses and 34 Certified Nursing Assistants between and the telephone interviews on revealed that the inservices provided to the facility's staff and that the staff were able to explain understanding of the education received in the trainings provided.	{F 689}		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of and , , which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and records reviewed, the facility failed to ensure a resident's mental health care needs was adequately supervised by a psychiatrist for one (Resident #1) out of ten residents sampled as evidenced by facility failure to effectively monitor behaviors and report said behaviors related to Resident #1's diagnoses of and , and episodes of afraid/panic to the psychiatrist. The facility failure led to Resident #1 while unsupervised in his room	F 711		

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F 711	Continued From page 66 inflicted self-harm and suffocated himself by placing a trash bag over his , resulting in by as a result of the deficient practice. There were 17 residents receiving medications and 47 residents receiving , medications residing in the facility at the time of this survey. The findings of the survey posed immediate jeopardy to the health and safety of all residents admitted to the facility. The Findings Included: Record review of the facility's undated policies and procedures titled, Medication, general statement noted: , medications include any drug that affects activities associated with meant process and behavior, including , and , classes of drugs. Physicians and physician -extenders (Ex. Physician Assistant, Nurse Practitioner) will use medications appropriately, working with the interdisciplinary team nurse to ensure appropriate use, evaluation, and monitoring. Standards included: C. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical and /or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of individual resident. G. Psychopharmacological medications will be used to enhance the quality of life for the resident and will never be used for the purpose of discipline or convenience. Procedures followed by the Primary Care Physician, PA [Physician's Assistant], or NP	F 711		

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F 711	Continued From page 67 [Nurse Practitioner] Noted: 2. Documents rationale and diagnosis of the use and identifies target symptoms. 4. Evaluates with the interdisciplinary team, effects, and side effects of , . , ... medications within 14 days of initiating, increasing, or decreasing dose and during routine visits thereafter. Procedures Followed by the Psychiatrist / mental health included: 1. , assist the facility in establishing appropriate guidelines for use, dosage and monitoring of , , , medications. 5. Helps develop behavior management plans. Procedures Followed by Nursing: 1. Monitors , . , ..., . . drug use daily, noting any adverse effects such as increased somnolence or functional decline. 2. Will monitor for the presence of target behaviors on a daily basis. Behaviors will be documented as warranted. 3. Reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behavior and or the presence of any adverse effects of the medication use. 4. [,] will be performed on any resident and on , , on a quarterly basis change will be reported to the physician. 5. , develop behavioral care plans that include individualized non-pharmacological interventions. Social Services: Coordinates the interdisciplinary team resident reviews of , . , ... medications. Record review of Resident #1's behavior	F 711		

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F 711	Continued From page 68 monitoring sheets for and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of , 1 milligram (mg) tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as changes or danger to self. There was no behavior record to indicate that he was monitored for his diagnosis of , and for the use of , . Further review of the behavior monitoring sheets showed that Resident #1 had multiple episodes documented as "Afraid/Panic". The behavior monitoring sheet initiated on indicated Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred during the hours of 7:00 AM to 7:00 PM on , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between the hours of 7:00 PM to 7:00 AM, on , , 27 and 28. The documented interventions for each episode noted "Routine." Review of the nurses' progress notes for the month of , showed no record that addressed any of the episodes of exhibited by Resident #1. Review of the behavior sheets for documented an initiated date of , but the behavior monitoring sheet showed no record (left blank) for , , and during the day shift (7:00 AM to 7:00 PM) on , indicating that Resident #1's behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records for showed that Resident #1 had 15 different episodes of Afraid/Panic during the 7:00 PM to 7:00 AM shift. The Afraid/Panic behaviors noted to have occurred on , 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29. Review	F 711		

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F 711	Continued From page 69 of the nurses' progress notes for , showed no recorded documentation that addressed any of the afraid/panic episodes exhibited by Resident #1. Review of Resident # 1's behavior sheets for (initiated on) showed Resident #1 had a total of 17 different episodes of Afraid / Panic during the month of , . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7:00 PM on , , 3, 4, and 5. The intervention documented noted "Routine QHS [nightly at bedtime]". Further review of , 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) on , , 7, 12, 13, 14, 17, 19, 20, 21, 24, 26, 27 and 28. The documented intervention noted "Refer to Nurses Notes." Review of Nurses Notes for showed no recorded documentation that addressed the episodes of afraid/panic exhibited by Resident #1. Review of the behavior monitoring sheet dated , showed that Resident#1 had a total of three Afraid/Panic episodes. Resident #1 had one episode of Afraid/Panic between 7:00 PM to 7:00 AM on . . Resident #1 had two episodes of the Afraid/Panic that occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his , . Interventions for each episode noted "Routine QHS." Review of the progress notes for , showed no recorded documentation that addressed any of the episodes exhibited by Resident #1.	F 711		

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F 711	Continued From page 70 On ... at 12:15 PM, during an interview and record review with the Director of Nursing (DON), and the Clinical Regional Nurse. The DON explained; the nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors, the CNA would report each behavior to the nurses. Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as ... . The clinical records were discussed related to the Plan of care the DON explained diagnoses of , , depends on the patient. For just about anybody, the care planned interventions include provide emotional support. Activities, whatever they are interested in encouraging them to talk about their feelings. Encourage socialization, provide feedback to reinforce positive behaviors. Notify MD of changes as needed. Review of the investigative report and interview with the Clinical Regional Nurse on at approximately 2:30 PM revealed, the Clinical regional nurse had reviewed the facility's video recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday at 2:54 PM Resident #1's CNA, [Staff A] went into the residents' room [room #] at 4:18 PM. Nurse [Staff B] was passing meds. The Clinical Regional Nurse stated: "You can see her going in and out of rooms." At 4:30 PM the friend [Resident #4] leaves Resident # 1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His door	F 711		

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F 711	Continued From page 71	F 711		

remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM [Staff C], LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area. gets the nurse and the crash cart... The Regional nurse explained that The CNA had to push the door opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . The CNA stated that he pulled the bag off Resident #1's and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs [Emergency Medical Technician] responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.

On , , at 10:01 AM, Staff B Registered Nurse (RN) revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. The resident was alert and oriented times three and communicated his needs well and normally slept until about 9:00 AM to 10:00 AM, participated in and activities and liked to come out of the room. Staff B explained that on the day of the incident Resident

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F 711	Continued From page 72 #1 was on isolation precautions due to a , ( ). Staff B, RN stated: " I worked from Thursday, to Saturday ... I monitored for behaviors related to his use of , we monitored for , , fear, or , I don't remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed ...I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and , the day that he . What I documented was that he had one behavior of ." Staff B, RN explained that Resident #1 kept asking about the ( ) treatment. The intervention, during the episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. Staff B stated that her documentation on the behavior monitoring sheets about the afraid/panic episode was related to the treatment, that Resident #1 received the treatment and that it was effective. Staff B stated: "I did not document in the nurses notes that the resident was having episode of , because I did my action, I did not see him to be desperate, he allowed me to administer his treatment." Staff B reported that the purpose of the behavior monitoring sheet is to follow for a prescribed , medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was to refer to nurses' notes. Staff B agreed there was no record to explain anything about the resident's or behavior. Staff B stated: " It's established that a	F		

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F 711	Continued From page 73 patient can have at least three small episodes of , , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month ...what the behavior monitoring sheet shows is that the medication is effective. I documented that he had , on , 3rd, and 4th. The one episode could have been something like, "I don't want to shower, I don't know the behavior." Staff B then agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know and could not recall the behavior. Staff B stated: I also documented no behavior on , 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report to anyone. I did not think that I needed to communicate it to the psychiatrist. We did not monitor him for , . I did not know he had any , or diagnoses of , . With a diagnosis of , " Staff B explained that she would have reacted differently and that , are very dangerous, levels of in a person's can change and cause them to have a crisis. "On that day he seemed well, he did not seem depressed. He did not reject care, or complaint of , ." Upon discussion of Resident #1's Diagnoses, Staff B reported: "I am surprised that he had diagnosis of , ...when I left on that day he remained in his bed. I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." (Investigative report and interview with The Clinical Regional Nurse on at approximately 2:30 PM showed that per surveillance video, Staff B last saw the resident in his room at approximately 5:21 PM).	F 711		

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F 711	Continued From page 74 During an interview on ... at 10:56 AM the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1's clinical record. The Psychiatrist explained that he met with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of the multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware and that the nurses had not communicated the behaviors to him. The Psychiatrist explained that the facility staff should have communicated ..., afraid/panic episodes and any other behavior exhibited by Resident#1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, I would have gone to see him, maybe change the medication ..."	F 711		
{F 726} SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and ... well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	{F 726}		

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{F 726}	Continued From page 75 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff were competent in providing adequate care and supervision of residents with special behavioral care needs. As evidenced by the facility's failure to ensure staff received and implemented training in informed care, accident prevention, documenting, monitoring of behaviors and communicating behavior with the Psychiatrist. Resident #1 was an English-speaking resident cared for by staff not fluent in the English language. Resident #1's diagnoses of , , , , and , as well as episodes of afraid/panic went unaddressed and/or unrecognized, leading to his decline and self-inflicted harm. As a result of the facility's deficient practice one (Resident #1) out of 10 residents sampled Resident #1 suffocated himself by placing a plastic trash bag over his , resulting in his by .	{F 726}		

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The findings included:

Record review of the facility's assessment tool dated revealed, "All potential admissions are reviewed by qualified nursing personnel to determine if needs can be met at the facility.
The assessment noted; "Our facility's resident come from different ethnic backgrounds, (ex: Hispanics, whites, blacks) ... Staff speaks Spanish, English, Creole.
Resident support /care needs included Mental Health and Behavior, with Specific Care Practices to Manage the medical conditions and medications-related issue causing , symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with , care of someone with , care of individual with , or other diagnosis, intellectual or

Staffing Plan included, "Direct care staff is given consistent assignments to promote and establish meaningful relationships with the residents and families ... All personnel training competencies related to resident care. Including staff managers, contract employees and volunteers.

Orientation is required for all newly employed personnel. Evaluations and competencies are annually completed for all direct care staff ... During orientation competencies are completed on all direct care staff.

During an interview with the Director of Nursing (DON) on at 2:00 PM, the DON

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explained, after the incident, she initiated in service training for staff on the topic of and accident prevention. "Staff have begun to have education on mental illness with emphasis on and reporting ."

During an interview and record review with the Human Resources Manager on at 3:39 PM, review of employee files showed no record to indicate staff received individualized training or competencies on behavior monitoring, mental health, care, monitoring for diagnoses of , or monitoring .

Record Review of the education calendar for the year showed monitoring and documenting for diagnoses of and/or , was not part of the facility's education plan. The education calendar did not show a training plan for informed care.

During an interview on at 1:40 PM, the DON and the Social Services Assistant reported that Resident #1 took medications for , and for because he was taking them prior to admission to the facility. The medication was routine, and he would take them whether or not he displayed signs and symptoms of . "The nurse might interpret the request for meds as an episode of ." The DON and the Social Services Assistant explained that a policy for informed care was recently added to the scope of care the facility provided and, the facility have been in the planning a new process. For new admissions Social Services started mid- or early to incorporate questions about stressful life experiences and

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{F 726}	Continued From page 78 their effect on resident's .... and behavior. At the time that Resident #1 was admitted to the facility, those questions were not asked. The DON and the Social Services Assistant revealed that the facility did not ask about Resident #1's life experiences and did not ask if the resident had any ... ... life experiences and added that the nurses that cared for him did not know about any past .... Resident # ., have experienced. Record review of Resident #1's Behavior Monitoring Sheets for the months of .., ..., , and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of , 1mg tablet. No record to indicate that Resident #1 was not monitored for any other behavior such as ... changes or danger to self. There were no behavior records to indicate that he was monitored for his diagnosis of .., ... for the use of , or for his diagnosis of .. .. Review of the behavior monitoring sheets showed the resident had multiple episodes documented as "Afraid/Panic": For of .., ... Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred between the hours of 7:00 AM to 7:00 PM, on , , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between 7:00 PM to 7:00 AM, on .., ..., ..., 27 and 28. Interventions for each episode noted "Routine." The nursing notes for .., showed no record that addressed any of the episodes of , exhibited by Resident #1. During the Month of , (Initiated on ....), The behavior monitoring sheet showed	{F 726}		

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no record (left blank) for , , and during the day shift (7AM - 7PM) of , indicating that the behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring record showed that Resident #1 had 15 different episodes of Afraid/Panic during the evening shift (7PM-7AM). The Afraid/Panic behavior occurred on , 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29. The Nurses Progress Notes for , showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1.

For , Resident #1's had a total of 17 different episodes of Afraid/Panic during the month. Four out 17 different episodes of Afraid/Panic occurred between 7 AM - 7 PM: on , 3, 4, and 5. The intervention noted Routine QHS(Every hour of sleep). Further review of 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7PM-7AM). The new intervention noted "Refer to Nurses Notes" The Afraid/Panic behavior occurred on , 7, 12, 13, 14, 17, 19, 20, 21, 24, 26, 27 and 28. Review of Nurses Progress Notes for the month of , showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1.

The behavior monitoring sheet dated , showed that Resident #1 had a total of three episodes. Two episodes of Afraid/Panic occurred during the day shift (7 AM - 7 PM) of and on the day of his , . He also had one episode of Afraid/Panic between 7PM - 7 AM on . Interventions for each episode noted "Routine

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{F 726}	Continued From page 80 QHS." Review of the progress notes for the month of , showed no record that addressed any of the episodes exhibited by Resident #1. On at 8:40 AM, Registered Nurse Supervisor, Staff I revealed: " I remember filling out the behavior monitoring, when a resident has a routine medication for diagnosis of , we check the number or episodes, whether or not the medication was effective." Staff I explained that an episode of , is if staff noticed a behavior such as trying to get out of bed, trying to get up from the wheelchair, if they show aggressive behavior with the staff, if they throw the medications and the number of times that an episode happened is recorded. Staff I stated that the intervention for when the routine medication is not working is to call the psychiatrist for evaluation of the resident and follow orders and also monitor for side effects and observe for effectiveness and side effects. Staff I, RN reported that she documented on Resident #1's Behavior Monitoring sheet on and on . Staff I stated that she documented zero to represent no episodes of during the shift. Staff I reported that she also worked on , and did not document any behavior. Interview on at 3:53 PM with Spanish speaking Certified Nursing Assistant (CNA), Staff A revealed he worked in the facility for about one year and floated to a different unit every week. Staff A reported that he provided care to Resident #1 on Friday, , and on Saturday, , the day Resident #1 . Staff A, CNA reported that Resident #1 was alert and liked to stay in his room alone with the door	{F 726}		

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{F 726}	Continued From page 81 closed and required assistance to go to bathroom and was on isolation precautions. Staff A, CNA explained his schedule for that weekend; on Friday, he worked a double shift from 7:00 AM to 3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday to again work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, ( ) he came from break which was from 8:00 PM to 8:30 PM. Staff A stated that during rounds he noticed that Resident #1's door would not open, and he pushed the door. Staff A stated that he thought the resident may have blocked the door with something. Staff A: " When I finally opened the door, I noticed the resident was sitting on his chair with a plastic bag on his . The wheelchair was locked. He normally had two trash containers, one on each side of his bed, with plastic bag inside of it. Once I opened the door, I noticed the plastic bag on his . I took the plastic bag; I threw it on the floor and cried for help. The floor nurse was on the hallway. We went to get the crash cart, she called code blue, the nurse and I transferred the resident from the chair to the wheelchair, they initiated the until the ambulance arrived ... The police arrived they interviewed me ... I could not leave the facility until after the detective interviewed me. During the interview, Staff A explained that Resident #1 Sometimes was aggressive and had behaviors like refusing care such as a haircut and refused to shave. Staff A reported that he had to convince Resident #1 and he allowed him to shave him. Staff A reported that not that long ago, maybe two weeks Resident #1 would sometimes get angry and yell at staff and one time Resident #1 took off his gown and threw it at him. Staff A reported that he reported the behavior to the floor nurse and asked the nurse to come to the room	{F 726}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 82	{F 726}		

and help him translate and explain to Resident #1 that he (Staff A) here to take care of him, and that there was no need to be aggressive and Resident #1 understood and even apologized.

Review of the investigative report and interview with the Clinical Regional Nurse on ... at approximately 2:30 PM revealed, the Clinical regional nurse had reviewed the facility's video recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday ... at 2:54 PM Resident #1's CNA, [Staff A] went into the residents' room [room #] at 4:18 PM. Nurse [Staff B] was passing meds. The Clinical Regional Nurse stated: "You can see her going in and out of rooms." At 4:30 PM the friend [Resident #4] leaves Resident # 1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His door remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM [Staff C], LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area. gets the nurse and the crash cart... The Regional nurse explained that The CNA had to push the door

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	105910	A. BUILDING ____ B. WING ____	R-C 11/02/2021

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{F 726}	Continued From page 83 opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . . . . The CNA stated that he pulled the bag off Resident #1's . . . and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office. On . . . . . . , ... , at 10:01 AM, with Spanish speaking Registered Nurse (RN), Staff B revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. The resident was alert and oriented times three and communicated his needs well. Staff B, RN was asked about Resident #1' , . . Staff B, RN acknowledged that Resident #1 had , . at times; " I remember he did at some point take , medications, , and . For about three days" Staff B, RN was not able to explain why the Medication Administration Records (MAR) indicated zero for , . level the entire month of , and . , . Staff B insisted that the resident did not have , . the last times she cared for him (Thursday, ... to Saturday . . . .); "Those last three days he did not have , ." Staff B explained that on the day of the incident Resident #1 was on isolation precautions due to a , ... (.). Staff B, RN stated: " I worked from Thursday, , . to Saturday . . . . I monitored for behaviors related to his use of , , we monitored for , ... , fear, or . . . , I don't	{F 726}		

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{F 726}	Continued From page 84 remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed ...I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and , the day that he . What I documented was that he had one behavior of ." Staff B, RN explained that Resident #1 kept asking about the ( ) treatment. The intervention, during the episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. Staff B stated that her documentation on the behavior monitoring sheets about the afraid/panic episode was related to the treatment, that Resident #1 received the treatment and that it was effective. Staff B stated: "I did not document in the nurses notes that the resident was having episode of , because I did my action, I did not see him to be desperate, he allowed me to administer his treatment." Staff B reported that the purpose of the behavior monitoring sheet is to follow for a prescribed medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was to refer to nurses' notes. Staff B agreed there was no record to explain anything about the resident's or behavior. Staff B stated: " It's established that a patient can have at least three small episodes of , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month ...what the	{F 726}		

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{F 726}	Continued From page 85 behavior monitoring sheet shows is that the medication is effective. I documented that he had , on , 3rd, and 4th. The one episode could have been something like, "I don't want to shower, I don't know the behavior." Staff B then agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know and could not recall the behavior. Staff B stated: I also documented no behavior on , , 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report to anyone. I did not think that I needed to communicate it to the psychiatrist. We did not monitor him for . I did not know he had any , or diagnoses of , . With a diagnosis of " Staff B explained that she would have reacted differently and that are very dangerous, levels of in a person's can change and cause them to have a crisis. "On that day he seemed well, he did not seem depressed. He did not reject care or complain of ." Upon discussion of Resident #1's diagnoses, Staff B reported: "I am surprised that he had diagnosis of , ...when I left on that day he remained in his bed. I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." (Note: The investigative report and interview with the Clinical Regional Nurse on at approximately 2:30PM showed that per surveillance video, Staff B last saw the resident in his room at approximately 5:21 PM). On at 10:56 AM, the Psychiatrist reported he did not review the above-mentioned behavior monitoring sheets in Resident #1's	{F 726}		

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{F 726}	Continued From page 86 clinical record. He explained that he met with facility staff and discussed residents' behavior and if any adjustments needed. When asked, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware; the nurses did not communicate the behaviors to him, and the facility's staff should have communicated . . ., afraid/panic episodes and any other behavior exhibited by Resident#1. The psychiatrist stated: "If they told me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, would have gone to see him, maybe change the medication."	{F 726}		
{F 867} SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on records reviewed and interviews, the facility failed to demonstrate an effective plans of action was implemented to correct identified quality deficiencies in problem-prone areas, related to . . . . ., accuracy of assessments, development and implementation of care plan, quality of care, accidents hazards/supervision and quality assurance and performance improvement (QAPI) as evidenced by repeated deficient	{F 867}		

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{F 867}	Continued From page 87	{F 867}		

practice found in these areas during consecutive surveys. (Cross Reference F600, F641, F656, F684, F689, F867).

The findings included:

Record review of the facility's survey history revealed, during the annual survey exit dated and during this complaint survey with the exit date repeated deficient practice was cited related to: Free from /Neglect (F600), Accuracy of Assessments (F641), failure to develop and implement a comprehensive care plan (F656), Accidents, Hazards, Supervision, Devices related to facility failure to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents (F689) and failure to ensure an effective Quality Assurance and Performance Improvement (QAPI) program, (F867).

Interview with the Nursing Home Administrator (NHA) on at 10:50 AM revealed, the NHA reported the facility had a Quality Assessment and Assurance (QAA) program that met at least once a month; on the third Thursday of every month. The participants included the Director of Nursing (DON), the Medical Director, the Assistant Director of Nursing (ADON), Medical Records participates, and Registered Nurses (RN) Supervisors. Participants included all department heads including the Maintenance Director and the Housekeeping Director. Since the last annual survey, the committee continued to meet once a month and the DON was the of the QAPI committee.

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{F 867}	Continued From page 88 During the interview, the NHA did not present a QAPI plan that met regulatory requirements. The NHA explained, "We have a system that we use to identify systemic issues in our facility, everyone in the committee brings up any issue that has been identified within their department, the Social Services Director for example, will express if any issue he addressed might require more attention. Then discuss a possible plan, the Director of Nursing (DON) documents everything that is brought to the meeting. She types up the report from the last meeting report and whatever intervention was put into place are discussed at the start of the next QAPI meeting. The last time we had a QAPI meeting was on . The NHA described the committee had identified quality deficiency related to COVID -19 and with communication / expectations from state agencies. (Referred only to deficient practices that AHCA (Agency for Health Care Administration) cited during last annual survey and subsequent complaint / control surveys). The NHA stated: "We understand that repeated deficient practice might be an indication of staff lack of adherence in following the procedures, therefore we will be doing more education." The NHA expressed understanding that repeated deficient practices, including QAA might be cited.	{F 867}		

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{F 000}	INITIAL COMMENTS	{F 000}		

An unannounced survey for complaint numbers 2021013844 and 2021013886,was conducted on , through , at Coral Reef Subacute Care Center. The allegations for complaint number 2021013844 was substantiated without deficient practice. The allegations for complaint number 2021013886 was substantiated with deficient practice. The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities.

On , , it was determined the findings of the survey posed immediate jeopardy to the health and safety of the residents admitted to the facility.
Immediate Jeopardy means, a situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation or conditions of participation has caused, or is likely to cause, serious injury, harm, , , or to an individual receiving care in a facility.

The Immediate Jeopardy started on ,

The facility's Administrator, Director of Nursing and Regional Nurse Consultant were notified of the immediate Jeopardy on , at 5:54 PM and the Immediate Jeopardy templates were provided.

Immediate Jeopardy and Substandard Quality of Care was identified at:
F 600, Scope and Severity (J) - Freedom from and Neglect
F 656, Scope and Severity (J) - Development and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: /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 000}	Continued From page 1 Implementation of Care Plans F 689, Scope and Severity (J) - Free of Accident Hazards, Supervision, Devices The facility census at the time of the survey was 132. A partial extended survey was conducted on . The facility's Immediate Jeopardy removal plan was submitted on . The Immediate Jeopardy was ongoing at the time of the exit on . On the facility's Immediate Jeopardy Removal Plan was verified by the survey team through record reviews and interviews. It was revealed that the facility completed in-services for all staff on related to the Immediate Jeopardy deficiencies. The scope and severity was lowered as a result of the facility's corrective actions implemented. The immediate jeopardy was determined to be removed on . These corrective actions were verified by the survey team through observations,interviews and record review. The scope and severity for F 600, F 656 and F 689 were lowered to a (D) for No actual harm with a potential for more than minimal harm that is not immediate jeopardy as of . The following is a description of the non-compliance:	{F 000}		

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{F 600} SS=D	Free from .... and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from , Neglect, and The resident has the right to be free from , neglect, misappropriation of resident property, and , as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary and any physical or chemical not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, , or , corporal punishment, or involuntary ; This REQUIREMENT is not met as evidenced by: Based on interviews, observations and records reviewed, the facility failed to provide care, services, and supervision to prevent for one resident (Resident #1) out of 10 residents sampled. The facility failed to effectively monitor behaviors related to Resident #1's diagnoses of and , which lead to his decline and self-inflicted harm. While unsupervised in his room, Resident #1 suffocated himself by placing a trash bag over his , resulting in by . On , it was determined the findings of the survey posed immediate jeopardy to the health and safety of all residents admitted to the facility. On the facility's Immediate Jeopardy Removal Plan was verified by the survey team through record reviews and interviews. It was revealed that the facility completed in-services for all staff on related to the Immediate	{F 600}	F600 Resident #1 no longer resides in the facility Administrator/designee educated facility staff on ... and Neglect, informed care and behavioral health with emphasis on monitoring residents prescribed , and , medications and identifying possible risk factors and changes in and behavior as well as side effects. Residents with a diagnosis of , and have the potential to be affected. The facility has conducted an audit of all current residents with a diagnosis of , and who are prescribed , and , medication to ensure they have an effective plan of care in conjunction with	

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{F 600}	Continued From page 3 Jeopardy deficiencies. The scope and severity was lowered as a result of the facility's corrective actions implemented. The immediate jeopardy was determined to be removed on . The scope and severity for F 600 were lowered to a (D) for No actual harm with a potential for more than minimal harm that is not immediate jeopardy as of . The Findings Included: Record review of the Facility's policy {Review dated , } revealed; "It is the policy of the facility to protect all residents from physical or mental , involuntary , neglect or misappropriation of personal property...Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Preventive measures included: The assessment, care planning, and monitoring of residents with needs and behavior which might lead to conflict or neglect ..." Record review of the facility's policies and procedures revealed the {undated} policy Name: , Medication. The General Statement of Policy noted; medications include any drug that affects activities associated with process and behavior, including and classes of drugs. Physicians and physician -extenders (Ex. Physician Assistant, Nurse Practitioner) will use medications appropriately, working with the interdisciplinary team nurse to ensure appropriate use, evaluation, and monitoring. Standards included:	{F 600}	implementing policies and procedures to identify risk factors and change in and behavior as well as side effects and effectiveness of these medications and to ensure behavior monitoring sheets are in place and reflect the behaviors of the resident and that side effects are monitored. Social services and nursing staff was educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding . Policies: Resident , Neglect and Policy, Informed Care, Behavioral Health Services, Medication, – Clinical Protocol, Care Plans, Comprehensive Person-Centered Administrator/designee educated facility staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed and medications and identifying possible risk factors and changes in and behavior as well as side effects and efficacy of medication Administrator/designee educated all staff on a one-to-one basis regarding and Neglect. Nurse consultant educated administrative staff on a one-to-one basis regarding , neglect. informed care and behavioral health. Newly hired staff will be educated during orientation by the DON/designee on monitoring residents with diagnosis of	

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{F 600}	Continued From page 4 C. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical and /or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of individual resident. G. Psychopharmacological medications will be used to enhance the quality of life for the resident and will never be used for the purpose of discipline or convenience. Procedures followed by the Primary Care Physician, PA[Physician's Assistant], or NP [Nurse Practitioner] noted: 2. Documents rationale and diagnosis of the use and identifies target symptoms. 4. Evaluates with the interdisciplinary team, effects, and side effects of , , medications within 14 days of initiating, increasing, or decreasing dose and during routine visits thereafter. Procedures Followed by the Psychiatrist / mental health included: item 1 indicated- , assist the facility in establishing appropriate guidelines for use, dosage and monitoring of , , , medications. Item number 5 indicated- Help develop behavior management plans. Procedures Followed by Nursing: 1. Monitors , , , drug use daily, noting any adverse effects such as increased somnolence or functional decline. 2. Will monitor for the presence of target behaviors on a daily basis. Behaviors will be documented as warranted. 3. Reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behavior and or the presence of any adverse effects of the medication use. 4. [,]	{F 600}	, and , and to monitor for behaviors related to , and , and any noted side effects and efficacy of , and , medication as well as informed care. Social Services/designee completed informed screening on all current residents. New admission will include informed screening During the clinical meeting any changes noted in resident's and behavior and noted side effects or any changes in the effectiveness of the resident's , or , medication will be communicated to the practitioner for potential mental health referral. The Administrator/designee will audit current residents with a diagnosis of , and , weekly x4 and monthly x3 to ensure behavior sheets reflect the resident's behaviors, that those behaviors have interventions placed to intervene with the behavior, and the efficacy and any side effects of the , and , medications are monitored The Administrator/designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for review and feedback Responsible Party: Administrator/designee	

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{F 600}	Continued From page 5 will be performed on any resident on on a quarterly basis changes and will be reported to the physician. 5. develop behavioral care plans that include individualized non-pharmacological interventions. Social Services: Coordinates the interdisciplinary team resident reviews of medications. Record review of Resident # 1's sheet revealed, he was admitted to the facility on . Clinical diagnoses included but were not limited to, and (blockage in the tract), and Record review of the Medication Administration and Treatment Record for Resident #1 revealed, medication included: 1 mg (milligram) tablet ordered 1 tablet to be given by at bedtime for diagnosis of 50 mg tablet ordered 1 tablet to be given by every day at bedtime for a diagnosis of 5 milligram tablet, ordered 2 tablets to be given by twice a day for diagnoses of Record review of the Comprehensive Minimum Data Set (MDS) and interview with the MDS coordinator, Staff H on , at 9:48 AM revealed, Resident #1 was Re-admitted to the facility on . In his most recent comprehensive MDS, dated . He had a score of 15 on the ( ), which indicated that the resident was able to verbalize his needs and was not	{F 600}	Date of Compliance	

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{F 600}	Continued From page 6 Further review of the MDS revealed that Resident #1 had a clear speech pattern and was able to understand others as well as make self-understood. His active diagnoses included ( ), and but the MDS did not include the diagnosis of . Review of the care plans for Resident #1 revealed a care plan dated ; "Resident #1 exhibited behaviors of /agitation. Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, determine cause of , Observe for changes in mental status, and behavior, Notify MD [Medical Doctor] of changes as needed. Further review of the care plans showed that Resident #1 had diagnoses of and was at risk for alterations in pattern. Approaches included, observe for changes in , encourage verbalization of feelings, administer as ordered. There were no care plans for the diagnoses of , or for the use of 5 mg tablet. Record review of Resident #1's Behavior Monitoring Sheets for the months of , and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of 1 mg 1 tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as changes or danger to self. Review of Resident #1's behavior monitoring records showed no records to indicate that he was monitored for his diagnosis of or	{F 600}		

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{F 600}	Continued From page 7 for the use of the 50 mg tablet. Further review of Behavior Monitoring Sheets showed the resident had multiple episodes documented as "Afraid/Panic": During the Month of , (Initiated on) Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred between the hours of 7:00 AM to 7:00 PM, on , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between 7:00 PM to 7:00 AM, on , , 27 and 28. Interventions for each episode noted "Routine", indicating that the facility's only intervention was the administration of his routine medication; 1 mg tablet by at bedtime. For Diagnosis of . Record Review of the Nurses Progress Notes from , to , , showed no recorded documentation that addressed any of the episodes of , exhibited by Resident #1. Review of behavior monitoring sheet for (Initiated on) showed no record and was left blank for , , and during the day shift (7:00 AM to 7:00 PM). The behavior sheet for , , indicated documented behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records for , revealed Resident #1 had 15 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM). The Afraid/Panic behaviors occurred on ,9,10,11,13, 15, 16,17,18,19, 22, 23, 24, 25 and 29. Review of Nurses Progress Notes for showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1.	{F 600}		

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{F 600}	Continued From page 8	{F 600}		

Review of behavior monitoring sheets for for Resident #1 showed the resident continued to be monitored for episodes of Afraid / Panic. Resident #1 had a total of 17 different episodes during the month of . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7 :00 PM: on ,3,4,and 5. The intervention noted Routine QHS (every night at bedtime) indicating that the facility's only intervention was the administration of his routine medication; 1 mg tablet 1 tablet by at bedtime.
Further review of 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) that occurred on ,7, 12, 13, 14, 17, 19, 20, 21, 24, 26,27 and 28. The intervention noted "Refer to Nurses Notes."

Review of the Nurses Progress Notes for showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1.

Review of the behavior monitoring sheet for , showed that Resident#1 had a total of three episodes of Afraid/Panic. Two episodes of Afraid/Panic occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his , . Resident #1 also had one episode of Afraid/Panic between 7:00 PM to 7:00 AM on , . The interventions for each episode noted "Routine QHS." indicating that the facility's only intervention was the administration of his routine medication; 1 mg tablet by at

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{F 600}	Continued From page 9 bedtime.	{F 600}		

Review of the progress notes for
showed no record that addressed the afraid/panic episodes exhibited by Resident #1.

Further review the nurses progress notes dated
with time noted as 11:00 PM documented by LPN, Staff C revealed: "Resident assigned CNA [Certified Nursing Assistant] was observed running over to me while I was doing my med pass as he verbalized code blue, I immediately assigned a staff member to call 911 as I grabbed the defibrillator machine. I assigned another staff member to get the crash cart. I ran to his room. The residents skin color was noted as pale color, no , was noted resident was transferred from wheelchair to the bed, board was placed under the patient and
[, ,] was initiated. 911 arrived and EMT[Emergency Medical Technicians] pronounced his . No obvious injuries were noted at the time of . CNA assigned to this resident verbalized that he was unable to enter his room. The CNA stated he had to push very hard to open the door. CNA stated resident wheelchair was pushed against the door with patient sitting in the wheelchair. Trash bag was noted over his . CNA stated he removed the trash bag to see if patient was not breathing. Patient was not breathing per CNA statement. CNA then verbalized to me and to the police how he found the patient. Family was notified by police. Police officer spoke to [Emergency Contact]. The medical examiner arrived and transferred residents' body out of the facility."

Review of the investigative report and interview with the Clinical Regional Nurse on at

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{F 600}	Continued From page 10 approximately 2:30 PM revealed, the regional nurse reviewed the facility's video recording as she investigated the event. She documented her observations of the video. The Clinical Regional Nurse reported that she reviewed the video recording on "Tuesday or Thursday last week." The investigative report noted that on Saturday at 2:54 PM Resident #1's Certified Nursing Assistant (CNA) (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse (Staff B), Registered Nurse (RN)was passing meds, "you can see her going in and out of rooms." At 4:30 PM the friend (Resident #4) leaves Resident #1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His Door remained open the whole time. At 5:21 PM the Nurse (Staff B) went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray. Noted that he ate 100%. At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM (Staff C, LPN) was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 until the CNA called her at around 8:15 PM. At 8:15 PM the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. (Staff A) was in the room for a few second, leaves the area gets the nurse and the crash cart... The Regional nurse explained that the CNA had to push the door open and when he entered, he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . The CNA stated that he pulled the bag off Resident #1 . and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard placed, and initiated. Law	{F 600}		

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{F 600}	Continued From page 11 enforcement and EMT responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office. Interview on at 3:53 PM with Staff A, Certified Nursing Assistant (CNA) revealed, he worked in the facility for about one year and floated on different units every week. He took care of Resident #1 on Friday, ( ) and Saturday ( ), when he . Staff A, CNA explained that Resident # 1 was assigned to the Bed B at the window and Bed A by the door was empty. Staff A, CNA reported that Resident #1 was alert and liked to stay in his room alone with the door closed. He required assistance to go to the bathroom and remained in his room on isolation precautions. Staff A, CNA revealed his schedule for that weekend was on Friday, he worked a double shift from 7:00 AM -3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday to again work from 7:30 AM to 11:30 PM. Staff A explained, "on the day of the incident, ( ) I came from my break which is from 8:00 PM to 8:30 PM, when I came and was doing my rounds and noticed that the door would not open. I spoke to one of the CNAs. He recommended; I pushed the door. I thought he might have blocked the door with something. When I finally opened the door, I noticed the resident was sitting in his chair with a plastic bag over his . The wheelchair was locked. He normally had two trash containers, one on each side of his bed, with plastic bag inside of it. Once I opened the door, I notice the plastic bag on his . I took the plastic bag; I threw it on the floor and cried for help. The floor nurse was on the hallway. We went to get the	{F 600}		

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{F 600}	Continued From page 12 crash cart, she called code blue. The nurse and I transferred the resident from the wheelchair, they initiated the . They all continued until the ambulance arrived. The police arrived they interviewed me. I could not leave the facility until after the detective interviewed me." Staff A, CNA explained that sometimes Resident #1 was aggressive and had behaviors like refusing care such as he refused a haircut and refused to shave and Staff A convinced Resident #1 and allowed Staff A to shave him. Staff A added "not that long ago, maybe two weeks", [Resident #1] would sometimes get angry and yell at staff; "like one time, he took off his gown and threw at me, I told the nurse on the floor about the behavior and asked her to come to the room and help me translate. I explained to [Resident #1] that I was here to take care of him, and that there was no need to be aggressive toward me, [Resident#1] understood and even apologized." On at 12:15 PM, during an interview with the Director of Nursing (DON) and the Clinical Regional Nurse, the DON explained; The nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors, the CNA would report each behavior to the nurses. Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as . The plan of care for diagnoses of , depends on the patient. For just about anybody, the care planned interventions include provide emotional support for all staff. For activities, it is whatever the residents are interested in. Encourage them to talk about their feelings. Encourage socialization. Provide	{F 600}		

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{F 600}	Continued From page 13 feedback to reinforce positive behaviors. Notify MD (Medical Doctor) of changes as needed. Psych consult as needed and Administer , . as ordered. During the interview, record review of Resident #1's clinical record showed, Resident # 1's physician orders included: 1. 1 mg tablet, 1 tablet by at bedtime for diagnosis of , and . 50 mg tablet, for diagnosis of , , give 1 tablet by every day at bedtime. The DON and Clinical Regional Nurse was asked about Resident #1's clinical record that showed no plan of care that specifically addressed his use of , , , or his diagnosis of , or . Both the DON and the Clinical Regional Nurse agreed there was no care plan on record specific to the use of the , or , medication and explained; "For a resident on , , we would normally use same type of interventions as with a resident that has a diagnosis of , . Another thing we would do is monitor for side effects, which is part of medication management. The use of requires we monitor for . We monitor depending on the resident. We have residents that are verbally able to report, we look for verbalization, we also look at signs or symptoms. We document behaviors on the behavior sheet, the specific behavior that occurs and on the daily skill nurses' notes. When it comes to the we would monitor for side effects which could include sleepiness, fatigue, abnormal coordination, , ." During the interview and continued record review of Resident #1's clinical record, the DON explained; "We have behavior monitoring sheets for the use of , , it shows that we monitor for behaviors "Fear/Panic, , kind of stuff." According to	{F 600}		

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{F 600}	Continued From page 14	{F 600}		

the nurse's documentation on the Behavior Monitoring Sheets Resident #1 had panic/ episodes." The DON explained: "The nurses and general staff reported that the resident was showing frustration over his health. He did not like the . He did talk about it sometimes. He had , on and 2nd. The only intervention was the medication as documented on the Behavior Monitoring Sheets ...We do not have a behavior monitoring record for the use of ..." The DON and Clinical Regional Nurse both agreed to review the residents record for any notes that addressed Resident #1's behaviors and acknowledged there were no actual written notes that addressed any of the resident's behaviors or . Both the DON and the Clinical Nurse Manager agreed such documentation was necessary.

On at 12:05 PM, during an interview the Psychiatrist explained that Resident #1 gave no indication that he was depressed, and that the facility staff was "usually very good at letting us know when there is any indication, not only present, but also past history, or any indication of clinical , . They usually call me for an evaluation. I see most of the patients that are taking , , they usually generate a consult for me. If the patient had shown any signs or symptoms, indicating they had clinical or , the staff would have notified me." The Psychiatrist acknowledged that he saw Resident #1 once, on and that his diagnoses included , and . A continued interview with the Psychiatrist on at 10:56 AM revealed, the psychiatrist did not review the above-mentioned Behavior Monitoring Sheets found in Resident #1's clinical record. The

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{F 600}	Continued From page 15 Psychiatrist explained that he met with facility staff and discussed resident's behaviors and if any adjustments are needed. The Psychiatrist was asked about Resident #1's behaviors. The Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of multiple documented episodes of afraid/panic noted on Resident #1's clinical records the psychiatrist reported he was not aware of any of the documented behaviors and stated that the nurses did not communicate said behaviors to him. The psychiatrist stated that the facility staff should have communicated any , afraid/panic episodes and other behavior exhibited by Resident #1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, would have gone to see him, maybe change the medication." On at 2:51 PM, review of Social Services assessment dated and interview with the facility's Social Services Staff; Social Services Director (SSD) and Social Services Assistant (SSA), Staff F, it was revealed that social services is responsible for assessing the residents upon admission, quarterly, and annually. The SSD revealed social services saw the residents often around the facility, assess for (Brief Interview of Mental Status) score, moods, and behaviors. The SSD stated he went to the resident's room to complete the initial assessment on . Review of the social services note dated indicated social services will be available to Resident #1 and family for support if needed ... The and assessment indicated the resident had little interest or pleasure in doing things,	{F 600}		

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{F 600}	Continued From page 16 frequency, 2 to 6 days. Feeling down depressed or hopeless, frequency, 2 to 6 days. Feeling tired or having little energy, frequency 7 to 11 days. Poor appetite or overeating, frequency 7 to 11 days. The Social Services Director explained they followed the questionnaire on the form Patient Health Questionnaire (PHQ-9) which asks about interest / pleasure in doing things, feeling down, depressed, or hopeless, trouble falling /staying asleep or sleeping too much, if tired, feeling little energy, feeling bad about yourself. [Resident #1's] assessment showed the score result for his ... was a six which indicated that the resident had a symptom of feeling tired having low energy, he had poor appetite, little interests in doing stuff and was feeling down. He was upset about the news. The SSD reported he did not address Resident #1's report that he was feeling down, "Once I learned the resident had diagnoses of , , I looked at his medications. He was already on ... , ... I saw that he was already care planned. He was a patient that we saw in the hallway often, very social, attended , . I did not do anything, I asked the resident why he was depressed, he said it was about politics, there was not much I could do about that. I was not aware of ... ." The Social Services Director reported they usually learned about residents concerning behaviors during morning meetings and never knew that he had any behaviors. When asked why there was only one social services assessment and progress note in Resident #1's clinical record, the SSD responded, "There must have been other progress notes, I don't know what happened to them." Interview on , , at 10:01 AM with Staff B Registered Nurse (RN) reported working	{F 600}		

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{F 600}	Continued From page 17 in the facility since , this year and normally worked with (Resident #1) three days a week, from 7:00 AM to 7:00 PM. The resident was alert and oriented times three. He communicated his needs well. He normally slept until about 9:00 AM/10:00 AM. He liked to participate in and activities. He liked to come out of the room. On the day of the incident (Resident #1) was on isolation precautions due to a ( ). Staff B, RN stated, " I worked from Thursday, , to Saturday . I monitored for behaviors related to his use of , we monitored for , fear, or . I don't remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed." Staff B, RN reported not being present when Resident #1 had the aggressive behavior of throwing his gown at Staff A, CNA. "I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and , the day that he . What I documented was that he had one behavior of ." Staff B, RN explained, "he was asking a lot about why he remained with the treatment, about the ( ). He kept asking about it, although I had already spoken to him about it. The intervention, during the episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. What I documented on the behavior monitoring sheets about afraid/panic episode was related to the treatment, that he received the treatment and that it was effective. I did not document on the nurses notes that the	{F 600}		

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{F 600}	Continued From page 18 resident was having an episode of , because I did my action, I did not see him to be desperate, he allowed me to administer his treatment. Sometimes with the elderly, they usually ask a lot about their treatment. The episode of , noted on him, was normal, expected. The purpose of the Behavior Monitoring Sheet is to follow for a prescribed , medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was 12 - Refer to nurses' notes." Staff B upon review of the records agreed there was no record to explain anything about the resident's or behavior. Staff B stated that: " It's established that a patient can have at least three small episodes of , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month. What the behavior monitoring sheet shows is that the medication is effective. I documented that he had , on , 3rd, and 4th. The one episode could have been something like, "I don't want to shower. I don't know the behavior." Staff B agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know, could not recall. Staff B added, " I also documented no behavior on , 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report to anyone. I did not think that I needed to communicate it to the Psychiatrist. We did not monitor him for , . I did not know he had any , or diagnoses of , ." Staff B then explained that with a diagnosis of , she would react differently because , are very dangerous, levels of in a person's	{F 600}		

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	105910	A. BUILDING ______ B. WING ______	R-C 11/02/2021

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{F 600}	Continued From page 19 can change and cause them to have a crisis. " On that day he seemed well, he did not seem depressed, he did not reject care, or complain of , ." Upon discussion of Resident #1's Diagnoses, Staff B, RN reported, "I am surprised that he had a diagnosis of , . "When I left on that day he remained in his bed, I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." Interview with Regional Nurse and discussion of surveillance video showed that staff B last saw the resident at approximately 5:21 PM. Record review revealed Resident #1 was under the care of Staff C Licensed Practical Nurse (LPN) one of the two times it was documented that Resident #1 called the police because he was in so much , ( ) and on the night that he committed ( ). On attempted to conduct a telephone interview with Staff C, LPN on at 12:13 PM and a voice message was left. On at 5:04 PM telephone call was made again to interview Staff C. Staff C was interviewed by phone and was asked that we call in 15 minutes. On at 5:08 PM an incoming call was received from Staff C, she reported she misdialed and requested we call her in 15 minutes. On at 5:24 PM, during a telephone interview Staff C, LPN reported that Resident #1 never had any complaints and "he never had any , or , " when ask to clarify her notes that the resident had , the call was disconnected. During a follow up telephone interview on at 7:20 AM, Staff C was asked whether or not the resident ever expressed , or showed any signs or symptoms of , or , while under her care, Staff C again	{F 600}		

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{F 600}	Continued From page 20 reported, "no", when asked about her handwritten nurses' notes dated , 12:00PM Staff C, stated: " oh yeah, one time, I had to call the police because he was complaining of so much , . Staff C was asked to clarify if she had called the police or if Resident #1 had called the police, staff C stated that Resident #1 was the one who called the police. Staff C stated: "He did call the police!" Staff C LPN explained; the police was called to help Resident #1 calm down while she helped him transfer to the hospital. The facility's removal plan included: Residents who have a diagnosis of , and , were audited to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in and behavior as well as side effects and effectiveness of these medications The Administrator/ Director of Nursing (DON) educated facility staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed , and , medications and identifying possible risk factors and changes in and behavior as well as side effects. Administrator/DON in serviced all staff on a one-to-one basis regarding and Neglect. The Corporate nurse consultant will in-service administrative staff on a one-to-one basis regarding , neglect. informed care and behavioral health. Social services and nursing staff were educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding	{F 600}		

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{F 600}	Continued From page 21 Newly hired staff will be educated during orientation by the DON/designee on monitoring residents with diagnosis of , and , and to monitor for behaviors related to , and , and any noted side effects of , and , medication as well as informed care. The facility has conducted an audit of all active residents with a diagnosis of , and , who are prescribed , and , medication to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in and behavior as well as side effects and effectiveness of these medication and to ensure behavior monitoring sheets are in place and reflect the behaviors of the resident and that side effects are monitored. The DON/designee will audit 100% of all active residents with a diagnosis of , and weekly to ensure behavior sheets reflect the resident's behaviors, that those behaviors have interventions placed to intervene with the behavior and any side effects of , and , medications are monitored. Data will be collected weekly for a month then monthly for one quarter then monthly for the next two quarters. Social Services/designee will conduct informed screening on all active residents. Regarding the facility's failure to develop and implement a comprehensive care plan: The facility's removal plan indicated: Residents who are prescribed , and , medications were audited to ensure a care plan has been developed to effectively monitor for effectiveness and side effects of the medication.	{F 600}		

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{F 600}	Continued From page 22 Residents who are prescribed , medication were audited to ensure a care plan is developed to effectively manage the , . The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses, Certified Nursing Aides on developing and following the care plan regarding residents who are prescribed , and , medications to effectively monitor for the effectiveness of the medication and side effects. Minimum Data Set(MDS) Corporate consultant will conduct a one-to-one In service with MDS staff and will conduct an In service with nursing staff regarding developing and implementing a plan of care. The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nursing Staff, Certified Nursing Aides on developing and following the care plan for Residents who have , in order to effectively manage the Residents , symptoms. MDS Corporate consultant will conduct a one-to-one Inservice with MDS staff and will conduct an Inservice with nursing staff regarding developing and implementing a plan of care. Newly hired staff will be educated by the DON/designee during orientation on residents who are prescribed , , , , and , medication medications to effectively monitor for the effectiveness of the medication and side effects. An audit of all active residents who are on , , , and , medication was conducted to ensure a care plan has been developed to effectively monitor for effectiveness and side effects of the medication. Monitoring for Corrective Action: The DON or designee will audit 100% of all active residents who are on , , ,	{F 600}		

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{F 600}	Continued From page 23 and , medication weekly to ensure care plans have been developed to monitor the effectiveness of the medications and monitor for side effects. Data will be collected weekly for a month then twice a week for one quarter then monthly for the next two quarters. Related to: Accident Hazards, Supervision Devices failure to provide adequate supervision and accurately and effectively monitored to identify and treat changes in and behaviors, the facility's removal plan indicated: Residents who have a diagnosis of , and , were audited to ensure behavior sheets are in place to identify behaviors, interventions placed to intervene with the behaviors and referrals made for , , and mental health evaluations. The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses, Certified Nursing Aides and Social Services regarding behavioral health with emphasis on monitoring residents with , and , diagnosis and to ensure referrals are made for mental health evaluations. Social services and nursing staff was educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding . Newly hired staff will be educated during orientation on behavioral health with emphasis on monitoring residents with , and , diagnosis and to ensure referrals are made for mental health evaluations. The facility has conducted an audit of all active residents with a diagnosis of , and , to ensure behavior monitoring sheets are in place and reflect the behaviors of the resident and that referrals for mental health are	{F 600}		

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{F 600}	Continued From page 24 conducted as warranted from the audit. The DON or designee will audit 100% of residents with a diagnosis of and , to ensure behavior monitoring sheets accurately reflect resident's behaviors. Data will be collected weekly for a month then twice a week for one quarter then monthly for the next two quarters. Social Services/designee will conduct the informed screening on all active residents. The facility's removal plan was verified during an onsite visit on and telephone interviews conducted on . Observations on revealed sampled residents with diagnosis of , or , and receiving , medication were being provided care and services and no concerns about the safety and well-being of the residents were noted during observations. On at 10:00 AM, the Nursing Home Administrator (NHA) stated that she provided education and one to one training session to all staff to ensure staff were fully trained and knowledgeable. The training was provided to all 160 employees to include the monitoring and documenting of any situation with residents assessed and identified for , , , , and to provide the correct information on the behavior monitoring sheets. Review of the Education/In-Services logs provided dated until topics included: , , Monitoring, Documentation. Progress Notes and behavior sheets. Monitor for . Monitoring for , and , . Monitoring residents prescribed , and ,	{F 600}		

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{F 600}	Continued From page 25 medications effectiveness. Understand Informed Care, behavior, and side effects. Able to identify risk factors and changes in and behavior. Able to identify side effects of and medications. Referral for mental health evaluation. Care Plan: to effectively monitor for effectiveness of meds and side effects. -Documentation accuracy developing and following care plans for residents who have in order to effectively manage their and symptoms. Able to identify -symptoms and effectively manage the resident's . Review of the one to one (1:1) Education/In service dated provided by Corporate to the Administrator, Assistant, Director of Nursing. Review of the in-service logs dated to revealed education was provided to 75 nursing staff. On in-service training was provided by the three staff members of the Social Services Department. (3 staff from Social Services Department), MDS and Care Planning staff. On in-service was provided to 8 staff members. On (1 staff) and (1 staff). On in-service was provided to new hires. Interviews conducted with 21 licensed nurses and 34 Certified Nursing Assistants between and the telephone interviews on revealed that the inservices provided to the facility's staff and that the staff were able to explain understanding of the education received in the trainings provided. Review of the audit logs revealed weekly audits for residents who are on , and medication and side effects	{F 600}		

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{F 600}	Continued From page 26 of the medication. Record review of the facility's Policy and Procedures: Coral Reef Subacute Resident .... Neglect and . , ... Policy 1-800-96- was revised on . The facilty's Behavioral Assessment, Intervention and Monitoring last revised was reviewed with no concerns. The facility's policy for Informed Care revised was reviewed.	{F 600}		
{F 641} SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded for one resident (Resident #1) out of ten sampled residents during a complaint investigation. The Findings included: Record review of Resident #1's Comprehensive Minimum Data Set (MDS) MDS dated revealed; the assessment showed that Resident #1 returned to the facility on from "acute hospital." His Brief Interview of Mental Status ( ) score was 15 out of 15, meaning the resident was . . , . . , ... He had Clear speech, ability to understand and be understood. No indication of , . . , ... and no behaviors. The resident was admitted with an , ... from the hospital. He was . . . . . of	{F 641}	F641 Resident #1 no longer resides in the facility The MDS Consultant educated the MDS staff on accurate coding All Residents have the potential to be affected Current Resident's recent MDS was reviewed for accurate coding of the resident's active diagnosis. Any inaccurate coding identified will be modified The MDS Consultant educated the MDS staff on accurate coding of active diagnosis Policy: Certifying Accuracy of the Resident Assessment was reviewed	

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{F 641}	Continued From page 27 . He had a prior to admission within the last month and also had a two to six months prior to admission. Section N for Medications noted he used , , , and . Section I for Active Diagnoses coded; Combined , and diastolic , , , , Prostatic Hyperplasia ( ), , / , and , (blockage in the , tract), and . Record review of the Comprehensive Minimum Data Set (MDS) and interview with MDS coordinator, Staff C on , at 9:48 AM, revealed, Resident #1 was re-admitted to the facility on . His most recent comprehensive MDS, dated . He had a score of 15 out of 15 on the ( ), which indicated that the resident was able to verbalize his needs and was not , , . Further review of the MDS revealed that Resident #1 had clear speech pattern and was able to understand others as well as make self-understood. He had no prior to admission within the last month, also, no within two to six months prior to admissions. His active diagnoses as noted in the MDS were Medically , Conditions, , ( ), , and , . During the interview, the MDS coordinator agreed the recent MDS was incorrectly coded. It did not accurately reflect Resident #1's or active diagnoses.	{F 641}	The MDS Consultant educated the MDS staff on accurately coding the resident's active diagnosis The Interdisciplinary Team will review the MDS coding for accuracy during the resident's care plan review The MDS Nurse/designee will conduct an audit of residents MDS coding for active diagnosis with each submission for 3 months to ensure the Resident's MDS is coded accurately for active diagnosis The MDS Nurse/designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for review and feedback Responsible Party: DON/designee Date of Compliance:	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		

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F 656	Continued From page 28 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and ,. ., ... needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and ,. ., ... well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. ( )In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 29 section. This REQUIREMENT is not met as evidenced by: Based on interviews, policy and records reviewed, the facility failed to implement, develop an effective care plan for the quality of care and treatments required by one (Resident #1) out of 10 sampled residents reviewed during this complaint investigation. The facility failed to develop a care plan to address Resident #1's and did not develop a care plan that addressed the Resident's use of , , , medications and . The facility also failed to implement the Resident's care plan for diagnoses of and , by failing to effectively monitor behaviors related to Resident #1's diagnoses and failed to report episodes of Afraid/Panic to the psychiatrist. As a result of these deficient practices, Resident #1 suffocated himself by placing a plastic trash bag over his , resulting in his by . On , , it was determined the findings of the survey posed immediate jeopardy to the health and safety of all residents admitted to the facility. On the facility's Immediate Jeopardy Removal Plan was verified by the survey team through record reviews and interviews. It was revealed that the facility completed in-services for all staff on related to the Immediate Jeopardy deficiencies. The scope and severity was lowered as a result of the facility's corrective actions implemented. The immediate jeopardy was determined to be removed on . The scope and severity for F656 were lowered to a (D) for No actual harm with a potential for more than minimal harm that is not immediate jeopardy	F 656	F656 Resident #1 no longer resides in the facility The Administrator/designee educated Licensed Nurses on Developing and following the care plan regarding residents who are prescribed , , , and medication to effectively monitor for the effectiveness and side effects of the medication MDS consultant educated MDS staff regarding developing and implementing a plan of care for diagnosis of , and , and management Residents that have a diagnosis of and , and that are prescribed , , , and/or medications have the potential to be affected. Residents who are prescribed and , medications were audited to ensure a care plan has been developed to monitor for effectiveness and side effects of the medication. Residents that have a diagnosis of , and , were audited to ensure a care plan has been developed for behaviors related to their diagnosis of and . Residents who are prescribed medication were audited to ensure a care plan is developed to manage their	

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F 656	Continued From page 30 as of . The Findings Included: Record review of the Facility's policies and procedures revised titled; Care Plans, Comprehensive Person - Centered revealed the policy statement, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet resident's physical, , and functional needs is developed and implemented for each resident. The Policy Interpretation and Implementation noted: 1. The interdisciplinary team in conjunction with the resident and his/her family or legal representative develops and implements a comprehensive, person -centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Review of the care plans for Resident #1 revealed, a care plan dated ; "Resident #1 exhibited behaviors of /agitation. Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, determine cause of , observe for changes in mental status, , and behavior, notify MD (Medical Doctor) of changes as needed ... Further review of the care plans showed that Resident #1 had a diagnoses of and was at risk for alterations in pattern. Approaches included, observe for changes in , encourage verbalization of feelings, administer as ordered. There	F 656	and to monitor the effectiveness and side effects of the medication Policies: -Clinical Protocol, Care Plans, Comprehensive Person-Centered, Medication, -Clinical Protocol The Administrator/designee educated Licensed Nurses on Developing and following the care plan regarding residents who are prescribed , and medications to monitor the effectiveness and side effects of the medication MDS consultant educated MDS staff regarding developing and implementing a plan of care for diagnosis of , and The Administrator/designee educated Licensed Nursing Staff on Developing and following the care plan for Residents who have in order to manage the Residents , and monitor the effectiveness and side effects of the medication MDS consultant educated MDS staff regarding developing and implementing a plan of care for . Newly hired staff will be educated by the DON/designee during orientation on residents who are prescribed , and medication to monitor for the effectiveness and side effects of the medication New admissions with a diagnosis of , or , and that are prescribed an or , medication will be reviewed in the clinical meeting to ensure a	

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F 656	Continued From page 31 were no care plans in Resident #1's clinical records for the use of , , , diagnoses of , diagnosis of and for the use of 5 milligrams (mg) tablet (is used to treat moderate to severe related to 's). Review of Resident #1's behavior monitoring sheets for the months of , , , and , indicated that Resident # 1 was monitored for the behaviors afraid/panic related to the use of , 1 mg tablet. There was no recorded documentation to indicate that Resident #1 was monitored for any other behavior such as , , changes or danger to self. Further review of behavior monitoring sheets revealed that Resident#1 had multiple episodes documented as "Afraid/Panic": During the Month of , (initiated on) Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred between the hours of 7:00 AM to 7:00 PM, on , , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between 7:00 PM to 7:00 AM, on , , , 27 and 28. Interventions for each episode noted "Routine", indicating that the facility's only intervention was the administration of ordered routine medication; , 1 mg tablet by at bedtime that was ordered for diagnosis of . Review of the nurses progress notes for the month of , (From , to ,) showed no record that addressed any of the episodes of , exhibited by Resident #1. During the Month of , the behavior monitoring sheet showed no documentation (left blank) for , , and during the day	F 656	comprehensive plan of care will be developed and the medications will be monitored for effectiveness and side effects The DON/designee will audit current residents who are on , , , and , medication weekly x 4 and monthly x 3 to ensure care plans have been developed to monitor the effectiveness of the medications and monitor for side effects. The DON/designee will report the results of the audits to the QAPI Committee for review and feedback Responsible Party: DON/designee Date of Compliance	

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F 656	Continued From page 32	F 656		

shift (7:00 AM to 7:00 PM) of ,
indicating that the behavior "Afraid/Panic" was not monitored during that time. Further review of 's Behavior Monitoring record for Resident #1, showed that he had 15 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) that occurred on , 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29, 2021. Review of nurses progress notes for the month of (From to), showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1.

For the Month of , (Initiated on) Resident #1's behavior monitoring sheet showed the resident had a total of 17 different episodes during the month of , . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7:00 PM: on , , 3, 4,and 5, 2021, the intervention noted "Routine QHS" (every bedtime). indicating that the facility's only intervention was the administration of his routine medication; , 1 mg tablet by at bedtime.

Further review of 's behavior monitoring record showed that Resident #1 had 17 episodes of Afraid/Panic. Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the 7:00 PM to 7:00 AM shift on , 7, 12, 13, 14, 17, 19, 20, 21, 24, 26, 27 and 28, 2021. The intervention noted "Refer to Nurses Notes." Review of nurses progress notes for , showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1.

The Behavior Monitoring Sheet dated

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F 656	Continued From page 33 2021, showed that Resident#1 had a total of three episodes. Two episodes of Afraid/Panic occurred during the day shift (7:00 AM to 7:00 PM) on and on (the day of his). He also had one episode of Afraid/Panic between 7:00 PM to 7:00 AM shift on . Interventions for each episode noted "Routine QHS." indicating that the facility's only intervention was the administration of his routine medication; , 1 mg tablet, one tablet by at bedtime. Review of the progress notes for , showed no record that addressed the afraid/panic episodes exhibited by Resident #1. On at 12:15 P, during an interview and record review with the Director of Nursing (DON), and the Clinical Regional Nurse. The DON explained; the nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors, the CNA would report each behavior to the nurses. Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as . The clinical records were discussed related to the Plan of care the DON explained diagnoses of , depends on the patient. For just about anybody, the care planned interventions include provide emotional support. Activities, whatever they are interested in encouraging them to talk about their feelings. Encourage socialization, provide feedback to reinforce positive behaviors. Notify MD of changes as needed. Psych consult as needed and Administer as ordered. The DON and the Clinical Regional Nurse acknowledged Resident # 1's physician orders included the	F 656		

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F 656	Continued From page 34 : 1. 1 mg tablet, ordered one tablet by at bedtime for diagnosis of , and 50 mg tablet for diagnosis of , one tablet by every day. The DON and the Clinical Regional Nurse were apprised that Resident #1's clinical record showed no plan of care that specifically addressed his use of , , or his diagnoses of , and . Both the DON and the Clinical Regional Nurse agreed there was no care plan on record specific to the use of the , or , medication and explained; "For a resident on , , we would normally use the same type of interventions as with a resident that has a diagnosis of , . Another thing we would do is monitor for side effects, which is part of medication management. The use of requires we monitor for . We monitor depending on the resident. We have residents that are verbally able to report, we look for verbalization, we also look at signs or symptoms. We document behaviors on the behavior sheet and documentation for the specific behavior that occurs is also on the daily skill nurses' notes. When it comes to the , ( ) we would monitor for side effects which could include sleepiness, fatigue, abnormal coordination, , ..." The DON explained; "We have behavior monitoring sheets for the use of , it shows that we monitor for behaviors "Fear/Panic, , kind of stuff." According to the nurse's documentation on the behavior monitoring sheets, Resident #1 had panic/ , episodes ..." The DON explained, "the nurses and general staff reported that the resident was showing frustration over his health. He did not like the . He did talk about it sometimes. He had , on and	F 656		

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2nd. The only intervention was the medication as documented on the behavior monitoring sheets ...We do not have a behavior monitoring record for the use of , ." The DON and Clinical Regional Nurse both agreed to review the residents record for any notes that addressed Resident #1's behaviors, "We did not notice any actual written notes that addressed any of the resident's behaviors or ..." Both the DON and the Clinical Nurse Manager agreed such documentation was necessary.

Interview on at 12:05 PM, the Psychiatrist explained that Resident #1 gave no indication that he was depressed, and that facility staff was "usually very good at letting us know when there is any indication, not only present, but also past history, or any indication of clinical . They usually call me for an evaluation ... I see most of the patients that are taking ..., they usually generate a consult for me. If the patient had shown any signs or symptoms, indicating they had clinical , or , the staff would have notified me." The Psychiatrist acknowledged that he saw Resident #1 once, on and that his diagnoses included , and , . Continued Interview with the Psychiatrist on at 10:56 AM revealed the Psychiatrist did not review the above-mentioned behavior monitoring sheets found in Resident #1's clinical record. He explained that he met with the facility staff and discussed the residents' behavior and if any adjustments are needed. When asked, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of multiple documented episodes of afraid/panic noted on Resident #1's clinical record, The

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F 656	Continued From page 36 Psychiatrist reported he was not aware of any of the above-mentioned behaviors. The nurses did not communicate said behaviors to him. The Psychiatrist explained that the facility staff should have communicated any , afraid/panic episodes and other behavior exhibited by Resident#1. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, would have gone to see him, maybe change the medication ..." On at 10:01 AM, Staff B Registered Nurse(RN) revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. The resident was alert and oriented times three and communicated his needs well and normally slept until about 9:00 AM to 10:00 AM, participated in , and activities and liked to come out of the room. Staff B explained that on the day of the incident Resident #1 was on isolation precautions due to a ( ). Staff B, RN stated: " I worked from Thursday, to Saturday ... I monitored for behaviors related to his use of , we monitored for , , fear, or , I don't remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed ...I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and , the day that he . What I documented was that he had one behavior of ." Staff B, RN explained that	F 656		

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F 656	Continued From page 37 Resident #1 kept asking about the ( ) treatment. The intervention, during the episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. Staff B stated that her documentation on the behavior monitoring sheets about the afraid/panic episode was related to the treatment, that Resident #1 received the treatment and that it was effective. Staff B stated: "I did not document in the nurses notes that the resident was having episode of , because I did my action, I did not see him to be desperate, he allowed me to administer his treatment." Staff B reported that the purpose of the behavior monitoring sheet is to follow for a prescribed , medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was to refer to nurses' notes. Staff B agreed there was no record to explain anything about the resident's or behavior. Staff B stated: " It's established that a patient can have at least three small episodes of , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month ...what the behavior monitoring sheet shows is that the medication is effective. I documented that he had , on , 3rd, and 4th. The one episode could have been something like, "I don't want to shower, I don't know the behavior." Staff B then agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know and could not recall the behavior. Staff B stated: I also documented no behavior on , 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report	F 656		

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F 656	Continued From page 38 to anyone. I did not think that I needed to communicate it to the psychiatrist. We did not monitor him for . I did not know he had any , or diagnoses of , . With a diagnosis of . " Staff B explained that she would have reacted differently and that are very dangerous, levels of in a person's can change and cause them to have a crisis. "On that day he seemed well, he did not seem depressed. He did not reject care, or complaint of ." Upon discussion of Resident #1's Diagnoses, Staff B reported: "I am surprised that he had diagnosis of , ...when I left on that day he remained in his bed. I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." (Investigative report and interview with The Clinical Regional Nurse on at approximately 2:30 PM showed that per surveillance video, staff B last saw the resident in his room at approximately 5:21 PM). Record review of physician's orders for Resident #1 showed a Telephone Order dated for a , management consult. Further review of Resident #1's clinical record showed no documentation to indicate that Resident #1 received said , consult. Resident #1 returned from the hospital on with a diagnosis of , . His orders included 10 mg. for five days for a diagnosis of , . Review of Resident #1's clinical record revealed no care plans on file that addressed Resident #1s diagnosis of , . The facility's removal plan included: Residents who have a diagnosis of , and were audited to ensure they have an	F 656		

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F 656	Continued From page 39 effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in ... and behavior as well as side effects and effectiveness of these medications The Administrator/ Director of Nursing (DON) educated facility staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed ... and ... medications and identifying possible risk factors and changes in ... and behavior as well as side effects. Administrator/DON in serviced all staff on a one-to-one basis regarding ... and Neglect. The Corporate nurse consultant will in-service administrative staff on a one-to-one basis regarding , neglect, informed care and behavioral health. Social services and nursing staff were educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding ... . Newly hired staff will be educated during orientation by the DON/designee on monitoring residents with diagnosis of , and ... and to monitor for behaviors related to , and , and any noted side effects of ... and ... medication as well as informed care. The facility has conducted an audit of all active residents with a diagnosis of , and ... who are prescribed ... and , medication to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in ... and behavior as well as side effects and effectiveness of these medication and to ensure behavior monitoring	F 656		

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F 656	Continued From page 40 sheets are in place and reflect the behaviors of the resident and that side effects are monitored. The DON/designee will audit 100% of all active residents with a diagnosis of , and weekly to ensure behavior sheets reflect the resident's behaviors, that those behaviors have interventions placed to intervene with the behavior and any side effects of and , medications are monitored. Data will be collected weekly for a month then monthly for one quarter then monthly for the next two quarters. Social Services/designee will conduct informed screening on all active residents. Regarding the facility's failure to develop and implement a comprehensive care plan: The facility's removal plan indicated: Residents who are prescribed and , medications were audited to ensure a care plan has been developed to effectively monitor for effectiveness and side effects of the medication. Residents who are prescribed , medication were audited to ensure a care plan is developed to effectively manage the , . The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses, Certified Nursing Aides on developing and following the care plan regarding residents who are prescribed and , medications to effectively monitor for the effectiveness of the medication and side effects. Minimum Data Set(MDS) Corporate consultant will conduct a one-to-one Inservice with MDS staff and will conduct an Inservice with nursing staff regarding developing and implementing a plan of care. The Administrator/DON educated facility staff on	F 656		

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F 656	Continued From page 41 a one-to-one basis including Licensed Nursing Staff, Certified Nursing Aides on developing and following the care plan for Residents who have , in order to effectively manage the Residents , symptoms. MDS Corporate consultant will conduct a one-to-one Inservice with MDS staff and will conduct an Inservice with nursing staff regarding developing and implementing a plan of care. Newly hired staff will be educated by the DON/designee during orientation on residents who are prescribed , , , , and , medication medications to effectively monitor for the effectiveness of the medication and side effects. An audit of all active residents who are on , , , and , medication was conducted to ensure a care plan has been developed to effectively monitor for effectiveness and side effects of the medication. Monitoring for Corrective Action: The DON or designee will audit 100% of all active residents who are on , , , and , medication weekly to ensure care plans have been developed to monitor the effectiveness of the medications and monitor for side effects. Data will be collected weekly for a month then twice a week for one quarter then monthly for the next two quarters. Related to: Accident Hazards, Supervision Devices failure to provide adequate supervision and accurately and effectively monitored to identify and treat changes in and behaviors, the facility's removal plan indicated: Residents who have a diagnosis of , and , were audited to ensure behavior sheets are in place to identify behaviors, interventions placed to intervene with the	F 656		

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F 656	Continued From page 42 behaviors and referrals made for , , and mental health evaluations. The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses, Certified Nursing Aides and Social Services regarding behavioral health with emphasis on monitoring residents with , and diagnosis and to ensure referrals are made for mental health evaluations. Social services and nursing staff was educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding . Newly hired staff will be educated during orientation on behavioral health with emphasis on monitoring residents with , and , diagnosis and to ensure referrals are made for mental health evaluations. The facility has conducted an audit of all active residents with a diagnosis of , and to ensure behavior monitoring sheets are in place and reflect the behaviors of the resident and that referrals for mental health are conducted as warranted from the audit. The DON or designee will audit 100% of residents with a diagnosis of , and , to ensure behavior monitoring sheets accurately reflect resident's behaviors. Data will be collected weekly for a month then twice a week for one quarter then monthly for the next two quarters. Social Services/designee will conduct the informed screening on all active residents. The facility's removal plan was verified during an onsite visit on and telephone interviews on . Observations on revealed sampled residents with diagnosis of or ,	F 656		

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F 656	Continued From page 43 and receiving , medication were being provided care and services and no concerns about the safety and well-being of the residents were noted during observations. On at 10:00 AM, the Nursing Home Administrator (NHA) stated that she provided education and one to one training session to all staff to ensure staff were fully trained and knowledgeable. The training was provided to all 160 employees to include the monitoring and documenting of any situation with residents assessed and identified for , , , , and to provide the correct information on the behavior monitoring sheets. Review of the Education/In-Services logs provided dated until topics included: , , Monitoring, Documentation. Progress Notes and behavior sheets. Monitor for . Monitoring for , and , . Monitoring residents prescribed , and , medications effectiveness. Understand Informed Care, , , , behavior, and side effects. Able to identify risk factors and changes in and behavior. Able to identify side effects of , and , medications. Referral for mental health evaluation. Care Plan: , , , , , to effectively monitor for effectiveness of meds and side effects. -Documentation accuracy developing and following care plans for residents who have in order to effectively manage their , and symptoms. Able to identify , -symptoms and effectively manage the resident's , . Review of the one to one (1:1) Education/In service dated provided by Corporate to the	F 656		

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F 656	Continued From page 44 Administrator, Assistant, Director of Nursing. Review of the in-service logs dated to revealed education was provided to 75 nursing staff. On in-service training was provided by the three staff members of the Social Services Department. (3 staff from Social Services Department), MDS and Care Planning staff. On in-service was provided to 8 staff members. On (1 staff) and (1 staff). On in-service was provided to new hires. Review of the audit logs revealed weekly audits for residents who are on , , and medication and side effects of the medication. Record review of the facility's Policy and Procedures for Care Plans, Comprehensive Person-Centered was revised on . The Resident Neglect and Policy 1-800-96- was revised on . The facilty's Behavioral Assessment, Intervention and Monitoring last revised was reviewed with no concerns. The facility's policy for Informed Care revised was reviewed. On at 06:43 PM, Staff D, MDS Coordinator revealed she received in service training from DON and Corporate Regional Nurse. The training was basically to ensure that she was encoding properly the Care Plans, ensuring that if the patient has a diagnosis of , , or to make sure that everything was in place including communication with the team and if any signs of side effects and monitoring the effectiveness of the medication. Staff D stated that if she read	F 656		

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F 656	Continued From page 45 anything in the chart that triggers or when talking to resident or family to communicate with direct care provider (nurse for the patient). Also, during the assessment look to see if resident has any and also when patient receiving the , , , medication to ensure the behaviors are noticed both on the care plan and to ensure that every patient has behavior sheet and make sure the behaviors sheets match the medication administration records for the medication and the Care Plan. Monitoring the behaviors is done by the nurses providing direct care and any staff in the building that observed any signs for symptoms pertaining to , , and , and for them to report it immediately to administration or supervisor. Review of the audit logs revealed weekly audits for residents who are on , , , and , medication and side effects of the medication. Record review of the facility's Policy and Procedures for Care Plans, Comprehensive Person-Centered was revised on . The Resident Neglect and , Policy 1-800-96- was revised on . The facilty's Behavioral Assessment, Intervention and Monitoring last revised was reviewed with no concerns. The facility's policy for Informed Care revised was reviewed.	F 656		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	{F 684}		

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{F 684}	Continued From page 46 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews, and records reviewed, the facility failed to ensure, identify, and provide needed care and services such as the care planning, monitoring assessment and consistent response to manage diagnoses of , . experienced by one (Resident #1) out of 10 sampled residents reviewed during a complaint survey. The facility failed to effectively monitor behaviors related to Resident #1's diagnoses of , and , and , . While unsupervised in his room, Resident #1 suffocated himself by placing a trash bag over his , resulting in .... by ...... The findings included: Record review of physician's orders for Resident #1 showed a telephone order dated for , . management consult. Further review of Resident #1's clinical record showed no documentation that Resident #1 received said , consult. Record review of the nurse's notes dated .... for the 7:00 AM to 7:00 PM shift revealed, Resident #1 was administered two , . . 500 milligram (mg) tablets because of , in the penis, continued with , until 4 PM when he (Resident #1) called 911 at 7:00 PM to go to the hospital.	{F 684}	F684 Corrective action: Resident #1 no longer resides in the facility The Administrator/designee educated Licensed Nurses and Certified Nursing Aides regarding , . management with developing a plan of care, and monitoring the resident's , . for effectiveness Identification of other residents with potential to be affected: All Residents who experience , have the potential to be affected. Residents Medication Administration Record was reviewed for , . monitoring. In addition, Residents who are prescribed a , . medication were reviewed to ensure residents that are experiencing , . noted is being addressed. Any Resident who experienced , or has a , . medication prescribed had their care plan reviewed, revised, or developed as warranted from the audit. Measures/Systematic Changes made to ensure non-reoccurrence: Policy: - clinical protocol was reviewed. The Administrator/designee educated Licensed Nurses and Certified Nursing	

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{F 684}	Continued From page 47 Record review of the Clinical Transition of Care showed that Resident #1 arrived to the to the Hospital on at 20:12, with diagnoses of penal , and , problem. "Diagnoses during this visit" noted; , ( ), Site not specified. Unspecified , Acute , , , problem, other specified of penis, unspecified complication of , , device, , and , initial encounter..." Record review of physician's progress dated revealed, Resident #1 transferred to the Hospital on secondary to , . He was complaining of , from his . Upon admission to the hospital, he was diagnosed with associated complicated , with suspected , . He was also diagnosed with mild , ..." Review of clinical records revealed Resident # 1 returned to the nursing home on . Review of physician orders dated , and , showed no medication or treatment order for Resident #1 diagnoses of , . Record Review of the Medication Administration Records (MAR) dated to revealed , levels of zero was documented every day of the month. Record review of nurses progress notes documented by Staff C a Licensed Practical Nurse (LPN) dated at 12:30 noted " Resident called 911- police called, resident observed banging on his bed and yelling, stating	{F 684}	Aides regarding , assessment, documentation and monitoring for , relief after interventions are placed. Newly hired staff will be educated during orientation regarding , assessment, documentation and monitoring for , relief after interventions are placed Current residents who experience , will be reviewed in the clinical meeting to ensure effective , management. New admissions will be reviewed in the clinical meeting to ensure effective , management Monitoring of Corrective Action: The DON/designee will audit Residents Medication Administration Record weekly X4 then monthly X3 to ensure Resident's , management is effective. The DON/designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for review and feedback Responsible Party: DON/designee	

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{F 684}	Continued From page 48 that he had severe , and requested to be sent to the hospital. ABD [abdomen] assessed noted soft, non-tender, voiced , at the touch of lower region. Call placed to MD [Medical Doctor] to send to hospital for evaluation. Call place to 911 emergency. Paramedics arrived, assessed patient, and transferred him to the closest hospital at 11:30 PM. Resident #1 returned from the hospital on with diagnosis of . His orders included 10 mg for five days for diagnosis of , . Record review of , assessment again showed zero , documented during the month of , including . Record review of physicians' progress notes dated , , noted that Resident #1 reported he had been having some discomfort in his secondary to his . Physician progress notes dated noted, " He reports that the , he was having on Friday was resolved." (Indicating that Resident#1 was in , on). Record Review of the MAR for , showed staff documented , levels of zero every day of the month. Continued record review of the MAR and nurses notes for Resident #1 showed no record to indicate the facility acknowledged Resident #1's diagnoses of , during the month of . Interview on at 6:00 PM with Resident #4 revealed he was close friends with	{F 684}		

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{F 684}	Continued From page 49	{F 684}		

Resident #1. Resident #4 had a score of 14 out of 15 on the
( ), which indicated the resident was able to verbalize his needs and was not
. Further review of the Minimum Data Set (MDS) revealed that Resident #4 had a clear speech pattern and was able to understand others as well as make self-understood. During the interview, Resident #4 reported he was friends with Resident #1 and hung out with him almost every day. Resident #4 explained that the last times he saw his friend on and
"[Resident #1]was in a lot of , he was suffering. As if peeing razor blades" Resident # 4 reported that Resident #1 talked about how he just could not take it anymore and he wanted "to go home, meaning go to heaven."

Record review of Resident #1's MAR and treatment records for showed no record to indicate the facility addressed the resident's . Further review of the MAR for
, and showed zero , levels documented every day the resident was in the facility, including ,
and on the day of his , ; the day that Resident #1 suffocated himself by placing a trash bag over his , resulting in by
.

Record review of the MAR for Resident #1 and Interview with Staff G, Licensed Practical Nurse (LPN) on /2021 at 4:08 PM revealed, Staff G reported she usually cared for Resident # 1 whenever she worked on his unit from 7:00 AM to 7:00 PM on Mondays, Tuesdays, and Wednesdays. Staff G, LPN explained, "The process is that if they verbalize , , we ask about location, and scale. We document location,

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{F 684}	Continued From page 50 and scale in the MAR. Our job is to assess for , every shift. "Staff G acknowledged that Resident #1 had conditions that could cause , , " He had , as one of his diagnoses, could be painful, , sensation, discomfort ..." During the interview, clinical review of Resident #1's records showed that the resident was discharged from the community hospital with orders for diagnosis of , and for 10 mg, one tablet to be administered by every 6 hours for 5 days with start date of . Staff G acknowledged her signature on the MAR suggested she administered the , medication to Resident #1 on . Staff G stated, " It was routine, which means I have to give it to him, possibly associated with the ." Staff G insisted that Resident #1 never verbalized any ,	{F 684}		
	Interview on , at 10:01 AM with Staff B Registered Nurse(RN) revealed she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. Staff B reported that the resident was alert and oriented times three and he communicated his needs well. Staff B, RN acknowledged that Resident #1 had , at times; " I remember he did at some point take , medications, , and for about three days." Staff B was not able to explain why the MAR indicated zero (0) , for the entire month of and and insisted that the resident did not have , the last times she cared for him on Thursday, to Saturday , . Staff B stated: "Those last three days he did not have , ."			
	Review of clinical records revealed Staff C LPN documented that Resident #1 called the police because he was in so much , on			

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{F 684}	Continued From page 51 and on the night that he committed ( ). On at 12:13 PM attempted to interview Staff C, LPN by phone and a voicemail message was left. On at 5:04 PM Staff C was called again and Staff C answered the phone and requested for the surveyor to call in 15 minutes. On 5:24 PM staff C was called, Staff C was asked if Resident #1 had any complaints of while under her care. Staff C responded, "no! never, he never had any complaints." When asked to clarify her notes that the resident had , the call was disconnected. On at 7:20 AM a follow up telephone interview was attempted with Staff C. When asked whether or not Resident #1 ever expressed , or showed any signs /or symptoms of , or while under her care, Staff C reported, "no!" Staff C was asked about her handwritten nurses' notes dated at 12:00 PM Staff C, revealed she remembered and stated: " oh yeah, one time, I had to call the police because he was complaining of so much , " Staff C was asked to clarify the documentation because the note indicated that the resident had called the police. Staff C then responded, "He did call the police!" Staff C, LPN then explained that the police was called to help Resident #1 calm down while she helped him transfer to the hospital.	{F 684}		
{F 689} SS=D	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}		

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{F 689}	Continued From page 52 §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 records reviewed and interviews, the facility failed to ensure adequate behavior monitoring and supervision was provided for one resident (Resident #1) out of 10 sampled residents of the 17 Residents that received , medications and 47 residents that received medications. The facility failed to effectively monitor behaviors related to Resident #1's diagnoses of and multiple episodes of panic and afraid which lead to Resident #1 self-inflicted harm. Resident #1 while unsupervised in his room, placed a plastic trash bag over his and suffocated himself resulting in by . On , it was determined the findings of the survey posed immediate jeopardy to the health and safety of all residents admitted to the facility. On the facility's Immediate Jeopardy Removal Plan was verified by the survey team through record reviews and interviews. It was revealed that the facility completed in-services for all staff on related to the Immediate Jeopardy deficiencies. The scope and severity was lowered as a result of the facility's corrective actions implemented. The immediate jeopardy was determined to be removed on . The scope and severity for F689 were lowered to a (D) for No actual harm with a potential for more than minimal harm that is not immediate jeopardy as of .	{F 689}	F689 Resident # 1 no longer resides in the facility Nursing Staff involved with Resident #1 care were educated to effectively monitor behaviors related to diagnosis of and Residents with a diagnosis of , and have the potential to be affected. Current residents who have a diagnosis of , and were audited to ensure behavior sheets are in place to identify behaviors, interventions placed to intervene with the behaviors and referrals made for and mental health evaluations Policies titled Accident & Incident-investigation and Reporting and Behavioral Health services, Informed Care and -Clinical Protocol were reviewed The Administrator/designee educated Licensed Nurses, Certified Nursing Aides and Social Services regarding behavioral health with emphasis on effectively monitoring residents with , and diagnosis and to ensure referrals are made for mental health evaluations.	

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{F 689}	Continued From page 53 The Findings Included: Record review of the Federal 1 day report revealed, on at 9:00 PM, Resident #1 was admitted to the facility on . Resident #1 was an alert and oriented resident with physical limitations, used a wheelchair and is able to transfer to the wheelchair on his own and able to go to the bathroom on his own and was independent but would ask for assistance if he needed it was found by Certified Nursing Assistant (CNA) Staff A with a plastic bag over his . The facility's staff immediately called the code and initiated ( ) and called 911 and the resident expired. Record review of the facility's policy and procedures titled, "Safety and Supervision of Residents." Revised in , revealed the policy statement: Our facility strives to make the environment as free from accident hazards as possible. Residents' safety and supervision and assistance to prevent accidents are facility wide commitment to safety at all levels of the organization. Facility oriented approach to safety included: "Employees shall be trained on potential hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. Individualized, resident-centered approach to safety included: 1.Our individualized, resident centered approach to safety addresses safety and accident hazards for individual residents. 2.The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accidents hazards or risks for individual residents. 3. The care team shall target	{F 689}	Social services and nursing staff were educated by Administrator/designee on informed care including a newly added questionnaire regarding . Newly hired staff will be educated during orientation on behavioral health with emphasis on monitoring residents with , and , diagnosis and to ensure referrals are made for mental health evaluations. New admissions will be reviewed during clinical meeting for Informed Care assessment and behavioral Monitoring sheet as indicated per diagnosis of , and and referrals to behavioral health will be initiated as needed The DON/designee will audit residents with a diagnosis of and weekly x4 and monthly x3 to ensure behavior monitoring sheets accurately reflect resident's behaviors and referrals are made for and mental health evaluations as needed Social Services/designee will audit newly admitted residents weekly X4 and monthly X 3 to ensure they have been screened for informed care The DON/designee and Social Services/designee will present the results of audits to QAPI committee for review and feedback. Responsible parties: DON/Designee and Social Services/Designee Date of Compliance	

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{F 689} Continued From page 54

{F 689}

interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Systems approach to safety noted: 2. Resident supervision is a core of the systems approach to safety.

Review of the care plans for Resident #1 revealed, care plan dated ; "Resident # 1 exhibited behaviors of /agitation. Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, determine cause of , observe for changes in mental status, , and behavior, notify MD (Medical Doctor) of changes as needed. Further review of the care plans showed that Resident #1 had diagnoses of and was at risk for alterations in pattern. Approaches included, observe for changes in , encourage verbalization of feelings, administer , as ordered.

Record review of Resident #1's behavior monitoring sheets for and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of , 1 milligram (mg) tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as changes or danger to self. There was no behavior record to indicate that he was monitored for his diagnosis of , and for the use of , . Further review of the behavior monitoring sheets showed that Resident #1 had multiple episodes documented as "Afraid/Panic". The behavior monitoring sheet initiated on indicated Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred during the hours of 7:00 AM to 7:00 PM

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{F 689}	Continued From page 55 on , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between the hours of 7:00 PM to 7:00 AM, on , , 27 and 28. The documented interventions for each episode noted "Routine." Review of the nurses' progress notes for , , showed no record that addressed any of the episodes of , exhibited by Resident #1. Review of the behavior sheets for documented an initiated date of , but the behavior monitoring sheet showed no record (left blank) for , , and during the day shift (7:00 AM to 7:00 PM) on , indicating that Resident #1's behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records for showed that Resident #1 had 15 different episodes of Afraid/Panic during the 7:00 PM to 7:00 AM shift. The Afraid/Panic behaviors noted to have occurred on , 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29. Review of the nurses' progress notes for , showed no recorded documentation that addressed any of the afraid/panic episodes exhibited by Resident #1. Review of Resident # 1's behavior sheets for (initiated on) showed Resident #1 had a total of 17 different episodes of Afraid / Panic during the month of , . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7:00 PM on , , 3, 4,and 5. The intervention documented noted "Routine QHS [nightly at bedtime]". Further review of , 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to	{F 689}		

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{F 689}	Continued From page 56 7:00 AM) on , , 7, 12, 13, 14, 17, 19, 20, 21, 24, 26, 27 and 28. The documented intervention noted, "Refer to Nurses Notes." Review of Nurses Notes for , showed no recorded documentation that addressed the episodes of afraid/panic exhibited by Resident #1. Review of the behavior monitoring sheet dated , showed that Resident#1 had a total of three Afraid/Panic episodes. Resident #1 had one episode of Afraid/Panic between 7:00 PM to 7:00 AM on , . Resident #1 had two episodes of the Afraid/Panic that occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his , , . Interventions for each episode noted "Routine QHS[Every hour of sleep]." Review of the progress notes for , showed no recorded documentation that addressed any of the episodes exhibited by Resident #1. Review of the nurses progress notes dated at 11:00 PM documented by Licensed Practical Nurse (LPN) Staff C revealed: "Resident assigned CNA [Certified Nursing Assistant] was observed running over to me while I was doing my med pass as he verbalized code blue, I immediately assigned a staff member to call 911 as I grabbed the defibrillator machine. I assigned another staff member to get the crash cart. I ran to his room. The residents skin color was noted as pale color, no , was noted resident was transferred from wheelchair to the bed. Board was placed under the patient and [,] was initiated. 911 arrived and EMT[Emergency Medical Technicians] pronounced his . No obvious	{F 689}		

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{F 689}	Continued From page 57	{F 689}		

injuries were noted at the time of .... CNA assigned to this resident verbalized that he was unable to enter his room. The CNA stated he had to push very hard to open the door. CNA stated resident wheelchair was pushed against the door with patient sitting in the wheelchair. Trash bag was noted over his .... CNA stated he removed the trash bag to see if patient was not breathing. Patient was not breathing per CNA statement. CNA then verbalized to me and to the police how he found the patient. Family was notified by police. Police officer spoke to [Emergency Contact]. The medical examiner arrived and transferred residents' body out of the facility."

Review of the investigative report and interview with the Clinical Regional Nurse on .... at approximately 2:30 PM revealed, the Clinical regional nurse had reviewed the facility's video recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday .... at 2:54 PM Resident #1's CNA, (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse (Staff B) was passing meds. The Clinical Regional Nurse stated: "You can see her going in and out of rooms." At 4:30 PM the friend (Resident #4) leaves Resident # 1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His door remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA (Staff A) picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM

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{F 689}	Continued From page 58 (Staff C) LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from the time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area gets the nurse and the crash cart... The Regional nurse explained that the CNA had to push the door open and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . . . . The CNA stated that he pulled the bag off Resident #1's . . . and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office. During an interview on at 10:56 AM the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1's clinical record. The Psychiatrist explained that he met with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of the multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware and that the nurses had not communicated the behaviors to him. The Psychiatrist explained that the facility staff should have communicated . . , afraid/panic episodes and any other	{F 689}		

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{F 689}	Continued From page 59 behavior exhibited by Resident#1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, I would have gone to see him, maybe change the medication ..." The facility's removal plan included: Residents who have a diagnosis of , and were audited to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in and behavior as well as side effects and effectiveness of these medications The Administrator/ Director of Nursing (DON) educated facility staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed , and , medications and identifying possible risk factors and changes in and behavior as well as side effects. Administrator/DON in serviced all staff on a one-to-one basis regarding and Neglect. The Corporate nurse consultant will in-service administrative staff on a one-to-one basis regarding , neglect. informed care and behavioral health. Social services and nursing staff were educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding . Newly hired staff will be educated during orientation by the DON/designee on monitoring residents with diagnosis of , and , and to monitor for behaviors related to and , and any noted side	{F 689}		

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{F 689}	Continued From page 60 effects of , and , medication as well as informed care. The facility has conducted an audit of all active residents with a diagnosis of , and who are prescribed and , medication to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in and behavior as well as side effects and effectiveness of these medication and to ensure behavior monitoring sheets are in place and reflect the behaviors of the resident and that side effects are monitored. The DON/designee will audit 100% of all active residents with a diagnosis of , and , weekly to ensure behavior sheets reflect the resident's behaviors, that those behaviors have interventions placed to intervene with the behavior and any side effects of , and , medications are monitored. Data will be collected weekly for a month then monthly for one quarter then monthly for the next two quarters. Social Services/designee will conduct informed screening on all active residents. Regarding the facility's failure to develop and implement a comprehensive care plan: The facility's removal plan indicated: Residents who are prescribed , and , medications were audited to ensure a care plan has been developed to effectively monitor for effectiveness and side effects of the medication. Residents who are prescribed , medication were audited to ensure a care plan is developed to effectively manage the , . The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses,	{F 689}		

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{F 689}	Continued From page 61 Certified Nursing Aides on developing and following the care plan regarding residents who are prescribed , and , medications to effectively monitor for the effectiveness of the medication and side effects. Minimum Data Set(MDS) Corporate consultant will conduct a one-to-one Inservice with MDS staff and will conduct an Inservice with nursing staff regarding developing and implementing a plan of care. The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nursing Staff, Certified Nursing Aides on developing and following the care plan for Residents who have in order to effectively manage the Residents , symptoms. MDS Corporate consultant will conduct a one-to-one Inservice with MDS staff and will conduct an Inservice with nursing staff regarding developing and implementing a plan of care. Newly hired staff will be educated by the DON/designee during orientation on residents who are prescribed , , , and , medication medications to effectively monitor for the effectiveness of the medication and side effects. An audit of all active residents who are on , , , and , medication was conducted to ensure a care plan has been developed to effectively monitor for effectiveness and side effects of the medication. Monitoring for Corrective Action: The DON or designee will audit 100% of all active residents who are on , , , and , medication weekly to ensure care plans have been developed to monitor the effectiveness of the medications and monitor for side effects. Data will be collected weekly for a month then twice a week for one quarter then monthly for the	{F 689}		

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{F 689}	Continued From page 62 next two quarters. Related to: Accident Hazards, Supervision Devices failure to provide adequate supervision and accurately and effectively monitored to identify and treat changes in and behaviors, the facility's removal plan indicated: Residents who have a diagnosis of , and were audited to ensure behavior sheets are in place to identify behaviors, interventions placed to intervene with the behaviors and referrals made for , , and mental health evaluations. The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses, Certified Nursing Aides and Social Services regarding behavioral health with emphasis on monitoring residents with , and diagnosis and to ensure referrals are made for mental health evaluations. Social services and nursing staff was educated on a one-to-one basis by Administrator/DON on informed care including a newly added questionnaire regarding . Newly hired staff will be educated during orientation on behavioral health with emphasis on monitoring residents with , and diagnosis and to ensure referrals are made for mental health evaluations. The facility has conducted an audit of all active residents with a diagnosis of , and to ensure behavior monitoring sheets are in place and reflect the behaviors of the resident and that referrals for mental health are conducted as warranted from the audit. The DON or designee will audit 100% of residents with a diagnosis of and , to ensure behavior monitoring sheets accurately reflect resident's behaviors. Data will be collected weekly	{F 689}		

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{F 689}	Continued From page 63	{F 689}		

for a month then twice a week for one quarter then monthly for the next two quarters. Social Services/designee will conduct the informed screening on all active residents.

The facility's removal plan was verified during an onsite visit on and telephone interviews conducted on .

Observations on revealed sampled residents with diagnosis of or , and receiving , medication were being provided care and services and no concerns about the safety and well-being of the residents were noted during observations.

On at 10:00 AM, the Nursing Home Administrator (NHA) stated that she provided education and one to one training session to all staff to ensure staff were fully trained and knowledgeable. The training was provided to all 160 employees to include the monitoring and documenting of any situation with residents assessed and identified for , , , , and to provide the correct information on the behavior monitoring sheets.

Review of the Education/In-Services logs provided dated until topics included: , , Monitoring, Documentation. Progress Notes and behavior sheets. Monitor for . Monitoring for , and , . Monitoring residents prescribed , and , medications effectiveness. Understand Informed Care, , , , behavior, and side effects. Able to identify risk factors and changes in and behavior. Able to identify side effects of , and

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{F 689}	Continued From page 64 medications. Referral for mental health evaluation. Care Plan: , to effectively monitor for effectiveness of meds and side effects. -Documentation accuracy developing and following care plans for residents who have in order to effectively manage their and symptoms. Able to identify -symptoms and effectively manage the resident's . Review of the one to one (1:1) Education/In service dated provided by Corporate to the Administrator, Assistant, Director of Nursing. Review of the in-service logs dated to revealed education was provided to 75 nursing staff. On in-service training was provided by the three staff members of the Social Services Department. (3 staff from Social Services Department), MDS and Care Planning staff. On in-service was provided to 8 staff members. On (1 staff) and (1 staff). On in-service was provided to new hires. Review of the audit logs revealed weekly audits for residents who are on , and medication and side effects of the medication. Record review of the facility's Policy and Procedures for Care Plans, Comprehensive Person-Centered was revised on . The Resident Neglect and Policy 1-800-96- was revised on . The facilty's Behavioral Assessment, Intervention and Monitoring last revised was reviewed with no concerns. The facility's policy for Informed Care revised was reviewed.	{F 689}		

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{F 689}	Continued From page 65 Interviews conducted with 21 licensed nurses and 34 Certified Nursing Assistants between and the telephone interviews on revealed that the inservices provided to the facility's staff and that the staff were able to explain understanding of the education received in the trainings provided.	{F 689}		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of and , , which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and records reviewed, the facility failed to ensure a resident's mental health care needs was adequately supervised by a psychiatrist for one (Resident #1) out of ten residents sampled as evidenced by facility failure to effectively monitor behaviors and report said behaviors related to Resident #1's diagnoses of and , and episodes of afraid/panic to the psychiatrist. The facility failure led to Resident #1 while unsupervised in his room	F 711	F711 Resident #1 no longer resides in the facility The Administrator/designee educated Licensed Nurses and Certified Nursing Aides on the policy; Physician Services - regarding notification to providers of changes in Resident's behaviors to obtain a Mental Health Referral. All Residents who are being monitored for	

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F 711	Continued From page 66 inflicted self-harm and suffocated himself by placing a trash bag over his , resulting in by as a result of the deficient practice. There were 17 residents receiving medications and 47 residents receiving , medications residing in the facility at the time of this survey. The findings of the survey posed immediate jeopardy to the health and safety of all residents admitted to the facility. The Findings Included: Record review of the facility's undated policies and procedures titled, Medication, general statement noted: , , medications include any drug that affects activities associated with meant process and behavior, including , , and , classes of drugs. Physicians and physician -extenders (Ex. Physician Assistant, Nurse Practitioner) will use medications appropriately, working with the interdisciplinary team nurse to ensure appropriate use, evaluation, and monitoring. Standards included: C. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical and /or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of individual resident. G. Psychopharmacological medications will be used to enhance the quality of life for the resident and will never be used for the purpose of discipline or convenience. Procedures followed by the Primary Care Physician, PA [Physician's Assistant], or NP	F 711	behaviors due to a diagnosis of , / , or those prescribed a medication have the potential to be affected. Resident's clinical records were reviewed to note those with a diagnosis of , / , and for those Residents prescribed a medication to ensure that behavior monitoring is in place, monitored and reported to the provider for a potential Mental Health Referral as warranted and to ensure the resident's mental health care needs are adequately supervised by a psychiatrist/psychologist Policies: Physician Services and Behavior Health Services were reviewed. The Administrator/designee educated Licensed Nurses and Certified Nursing Aides on the Physician Services policy and Behavioral Health Policy The Administrator/designee educated licensed nurses and Certified Nursing Aides on residents with a diagnosis of and/or , and are prescribed , , medication, are monitored for new or worsening behaviors. If a New or Worsening behavior is identified, those behaviors will be reported to the provider for a potential Mental Health referral as warranted and to ensure the resident's mental health care needs are adequately supervised by a psychiatrist/psychologist Newly hired staff will be educated during orientation regarding residents with diagnosis of and/or ,	

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F 711	Continued From page 67 [Nurse Practitioner] Noted: 2. Documents rationale and diagnosis of the use and identifies target symptoms. 4. Evaluates with the interdisciplinary team, effects, and side effects of medications within 14 days of initiating, increasing, or decreasing dose and during routine visits thereafter. Procedures Followed by the Psychiatrist / mental health included: 1. , assist the facility in establishing appropriate guidelines for use, dosage and monitoring of medications. 5. Helps develop behavior management plans. Procedures Followed by Nursing: 1. Monitors drug use daily, noting any adverse effects such as increased somnolence or functional decline. 2. Will monitor for the presence of target behaviors on a daily basis. Behaviors will be documented as warranted. 3. Reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behavior and or the presence of any adverse effects of the medication use. 4. [,] will be performed on any resident and on on a quarterly basis change will be reported to the physician. 5. , develop behavioral care plans that include individualized non-pharmacological interventions. Social Services: Coordinates the interdisciplinary team resident reviews of medications. Record review of Resident #1's behavior	F 711	and are prescribed medication, are monitored for new or worsening behaviors, and report the behaviors to the provider for a potential Mental Health referral as warranted and to ensure the resident's mental health care needs are adequately supervised by a psychiatrist/psychologist Residents with a change in or behavior are reviewed in the clinical meeting to ensure those behaviors are reported to the provider for potential referral for Mental Health to ensure the resident's mental health care needs are adequately supervised by a psychiatrist/psychologist The DON/designee will audit residents with a diagnosis of and/or and are prescribed a medication weekly X4 then monthly X3 to ensure the provider is notified of any new or worsening behaviors for a potential Mental Health referral. The DON/designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for review and feedback Responsible Party: DON/designee Date of Compliance	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 711	Continued From page 68 monitoring sheets for and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of , 1 milligram (mg) tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as changes or danger to self. There was no behavior record to indicate that he was monitored for his diagnosis of , and for the use of , . Further review of the behavior monitoring sheets showed that Resident #1 had multiple episodes documented as "Afraid/Panic". The behavior monitoring sheet initiated on indicated Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred during the hours of 7:00 AM to 7:00 PM on , , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between the hours of 7:00 PM to 7:00 AM, on , , , 27 and 28. The documented interventions for each episode noted "Routine." Review of the nurses' progress notes for the month of , showed no record that addressed any of the episodes of exhibited by Resident #1. Review of the behavior sheets for documented an initiated date of , but the behavior monitoring sheet showed no record (left blank) for , , and during the day shift (7:00 AM to 7:00 PM) on , indicating that Resident #1's behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records for showed that Resident #1 had 15 different episodes of Afraid/Panic during the 7:00 PM to 7:00 AM shift. The Afraid/Panic behaviors noted to have occurred on , 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29. Review	F 711		

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F 711	Continued From page 69 of the nurses' progress notes for , showed no recorded documentation that addressed any of the afraid/panic episodes exhibited by Resident #1. Review of Resident # 1's behavior sheets for (initiated on) showed Resident #1 had a total of 17 different episodes of Afraid / Panic during the month of , . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7:00 PM on , , 3, 4, and 5. The intervention documented noted "Routine QHS [nightly at bedtime]". Further review of , 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) on , , 7, 12, 13, 14, 17, 19, 20, 21, 24, 26, 27 and 28. The documented intervention noted "Refer to Nurses Notes." Review of Nurses Notes for showed no recorded documentation that addressed the episodes of afraid/panic exhibited by Resident #1. Review of the behavior monitoring sheet dated , showed that Resident#1 had a total of three Afraid/Panic episodes. Resident #1 had one episode of Afraid/Panic between 7:00 PM to 7:00 AM on . Resident #1 had two episodes of the Afraid/Panic that occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his , . Interventions for each episode noted "Routine QHS." Review of the progress notes for , showed no recorded documentation that addressed any of the episodes exhibited by Resident #1.	F 711		

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F 711	Continued From page 70 On at 12:15 PM, during an interview and record review with the Director of Nursing (DON), and the Clinical Regional Nurse. The DON explained; the nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors, the CNA would report each behavior to the nurses. Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as . The clinical records were discussed related to the Plan of care the DON explained diagnoses of , , depends on the patient. For just about anybody, the care planned interventions include provide emotional support. Activities, whatever they are interested in encouraging them to talk about their feelings. Encourage socialization, provide feedback to reinforce positive behaviors. Notify MD of changes as needed. Review of the investigative report and interview with the Clinical Regional Nurse on at approximately 2:30 PM revealed, the Clinical regional nurse had reviewed the facility's video recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday at 2:54 PM Resident #1's CNA, [Staff A] went into the residents' room [room #] at 4:18 PM. Nurse [Staff B] was passing meds. The Clinical Regional Nurse stated: "You can see her going in and out of rooms." At 4:30 PM the friend [Resident #4] leaves Resident # 1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His door	F 711		

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F 711	Continued From page 71	F 711		

remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM [Staff C], LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area. gets the nurse and the crash cart... The Regional nurse explained that The CNA had to push the door opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . The CNA stated that he pulled the bag off Resident #1's and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs [Emergency Medical Technician] responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.

On , , at 10:01 AM, Staff B Registered Nurse (RN) revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. The resident was alert and oriented times three and communicated his needs well and normally slept until about 9:00 AM to 10:00 AM, participated in and activities and liked to come out of the room. Staff B explained that on the day of the incident Resident

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F 711	Continued From page 72 #1 was on isolation precautions due to a , ( ). Staff B, RN stated: " I worked from Thursday, to Saturday ... I monitored for behaviors related to his use of , we monitored for , , fear, or , I don't remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed ...I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and , the day that he . What I documented was that he had one behavior of ." Staff B, RN explained that Resident #1 kept asking about the ( ) treatment. The intervention, during the episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. Staff B stated that her documentation on the behavior monitoring sheets about the afraid/panic episode was related to the treatment, that Resident #1 received the treatment and that it was effective. Staff B stated: "I did not document in the nurses notes that the resident was having episode of , because I did my action, I did not see him to be desperate, he allowed me to administer his treatment." Staff B reported that the purpose of the behavior monitoring sheet is to follow for a prescribed , medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was to refer to nurses' notes. Staff B agreed there was no record to explain anything about the resident's or behavior. Staff B stated: " It's established that a	F		

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F 711	Continued From page 73 patient can have at least three small episodes of , , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month ...what the behavior monitoring sheet shows is that the medication is effective. I documented that he had , on , 3rd, and 4th. The one episode could have been something like, "I don't want to shower, I don't know the behavior." Staff B then agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know and could not recall the behavior. Staff B stated: I also documented no behavior on , 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report to anyone. I did not think that I needed to communicate it to the psychiatrist. We did not monitor him for , . I did not know he had any or diagnoses of . With a diagnosis of , " Staff B explained that she would have reacted differently and that , are very dangerous, levels of in a person's can change and cause them to have a crisis. "On that day he seemed well, he did not seem depressed. He did not reject care, or complaint of , ." Upon discussion of Resident #1's Diagnoses, Staff B reported: "I am surprised that he had diagnosis of ...when I left on that day he remained in his bed. I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." (Investigative report and interview with The Clinical Regional Nurse on at approximately 2:30 PM showed that per surveillance video, Staff B last saw the resident in his room at approximately 5:21 PM).	F 711		

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F 711	Continued From page 74 During an interview on ... at 10:56 AM the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1's clinical record. The Psychiatrist explained that he met with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of the multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware and that the nurses had not communicated the behaviors to him. The Psychiatrist explained that the facility staff should have communicated ., afraid/panic episodes and any other behavior exhibited by Resident#1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, I would have gone to see him, maybe change the medication ..."	F 711		
{F 726} SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and ... well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	{F 726}		

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{F 726}	Continued From page 75 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff were competent in providing adequate care and supervision of residents with special behavioral care needs. As evidenced by the facility's failure to ensure staff received and implemented training in informed care, accident prevention, documenting, monitoring of behaviors and communicating behavior with the Psychiatrist. Resident #1 was an English-speaking resident cared for by staff not fluent in the English language. Resident #1's diagnoses of , , , , and , as well as episodes of afraid/panic went unaddressed and/or unrecognized, leading to his decline and self-inflicted harm. As a result of the facility's deficient practice one (Resident #1) out of 10 residents sampled Resident #1 suffocated himself by placing a plastic trash bag over his ..., resulting in his .... by	{F 726}	F726 Resident #1 no longer resides in the facility Nursing Staff Cared for resident #1 were educated on informed Care, accident preventing, monitoring behavior, and communicating behavior with psychiatrist All Nursing staff were audited to ensure they have been educated on informed Care, accident preventing, monitoring behavior, and communicating behavior with psychiatrist Policies: Informed Care, Accidents and Incidents – Investigating and Reporting Behavioral Health Services, Safety and supervision of	

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The findings included:

Record review of the facility's assessment tool dated revealed, "All potential admissions are reviewed by qualified nursing personnel to determine if needs can be met at the facility.

The assessment noted; "Our facility's resident come from different ethnic backgrounds, (ex: Hispanics, whites, blacks) ... Staff speaks Spanish, English, Creole.

Resident support /care needs included Mental Health and Behavior, with Specific Care Practices to Manage the medical conditions and medications-related issue causing , symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with , care of someone with , care of individual with , or other diagnosis, intellectual or

Staffing Plan included, "Direct care staff is given consistent assignments to promote and establish meaningful relationships with the residents and families ... All personnel training competencies related to resident care. Including staff managers, contract employees and volunteers.

Orientation is required for all newly employed personnel. Evaluations and competencies are annually completed for all direct care staff ... During orientation competencies are completed on all direct care staff.

During an interview with the Director of Nursing (DON) on at 2:00 PM, the DON

{F 726}

residents were reviewed
The Administrator/designee educated Nursing Staff on the above policies.
The Administrator/designee educated Nursing Staff on the completion of behavior monitoring sheets
The Administrator/designee educated Nursing Staff on monitoring behaviors, and communicating behaviors with the psychiatrist/psychologist
informed care will be added to the facility orientation and annual trainings for nursing staff.
Behavioral health will be added to annual trainings of Licensed Nursing Staff
The DON/designee will audit Behaviors sheets for accuracy and correct documentation weekly X 4 then monthly X 3

The DON/designee will audit new admissions for Informed Care assessments weekly X 4 then monthly X 3

The DON/designee will audit all new Nursing Staff for receiving education on Informed Care and behavioral Health weekly X 4 then monthly X 3

The DON/designee will report the results of all audits to the QAPI committee for review and feedback.

Responsible party: DON/Designee
Date of Compliance

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{F 726}	Continued From page 77 explained, after the incident, she initiated in service training for staff on the topic of and accident prevention. "Staff have begun to have education on mental illness with emphasis on and reporting ." During an interview and record review with the Human Resources Manager on at 3:39 PM, review of employee files showed no record to indicate staff received individualized training or competencies on behavior monitoring, mental health, care, monitoring for diagnoses of , or monitoring , . Record Review of the education calendar for the year showed monitoring and documenting for diagnoses of , and/or , was not part of the facility's education plan. The education calendar did not show a training plan for informed care. During an interview on at 1:40 PM, the DON and the Social Services Assistant reported that Resident #1 took medications for , and for , because he was taking them prior to admission to the facility. The medication was routine, and he would take them whether or not he displayed signs and symptoms of . "The nurse might interpret the request for meds as an episode of ." The DON and the Social Services Assistant explained that a policy for informed care was recently added to the scope of care the facility provided and, the facility have been in the planning , a new process. For new admissions Social Services started mid- , or early , to incorporate questions about stressful life experiences and	{F 726}		

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their effect on resident's .... and behavior. At the time that Resident #1 was admitted to the facility, those questions were not asked. The DON and the Social Services Assistant revealed that the facility did not ask about Resident #1's life experiences and did not ask if the resident had any ... ... life experiences and added that the nurses that cared for him did not know about any past .... Resident # .., have experienced.

Record review of Resident #1's Behavior Monitoring Sheets for the months of ..,, ..,..., , and , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of , 1mg tablet. No record to indicate that Resident #1 was not monitored for any other behavior such as ... changes or danger to self. There were no behavior records to indicate that he was monitored for his diagnosis of ..,. .... for the use of , or for his diagnosis of .. ..

Review of the behavior monitoring sheets showed the resident had multiple episodes documented as "Afraid/Panic": For of .., ... Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred between the hours of 7:00 AM to 7:00 PM, on , , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between 7:00 PM to 7:00 AM, on .., ..., ..., 27 and 28. Interventions for each episode noted "Routine." The nursing notes for .., showed no record that addressed any of the episodes of , exhibited by Resident #1.

During the Month of , (Initiated on ....), The behavior monitoring sheet showed

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{F 726}	Continued From page 79	{F 726}		

no record (left blank) for , , and during the day shift (7AM - 7PM) of , indicating that the behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring record showed that Resident #1 had 15 different episodes of Afraid/Panic during the evening shift (7PM-7AM). The Afraid/Panic behavior occurred on , 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29. The Nurses Progress Notes for , showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1.

For , Resident #1's had a total of 17 different episodes of Afraid/Panic during the month. Four out 17 different episodes of Afraid/Panic occurred between 7 AM - 7 PM: on , 3, 4, and 5. The intervention noted Routine QHS(Every hour of sleep). Further review of 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7PM-7AM). The new intervention noted "Refer to Nurses Notes" The Afraid/Panic behavior occurred on , 7, 12, 13, 14, 17, 19, 20, 21, 24, 26, 27 and 28. Review of Nurses Progress Notes for the month of , showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1.

The behavior monitoring sheet dated , showed that Resident #1 had a total of three episodes. Two episodes of Afraid/Panic occurred during the day shift (7 AM - 7 PM) of and on the day of his , . He also had one episode of Afraid/Panic between 7PM - 7 AM on . Interventions for each episode noted "Routine

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{F 726}	Continued From page 80 QHS." Review of the progress notes for the month of , showed no record that addressed any of the episodes exhibited by Resident #1. On at 8:40 AM, Registered Nurse Supervisor, Staff I revealed: " I remember filling out the behavior monitoring, when a resident has a routine medication for diagnosis of , we check the number or episodes, whether or not the medication was effective." Staff I explained that an episode of , is if staff noticed a behavior such as trying to get out of bed, trying to get up from the wheelchair, if they show aggressive behavior with the staff, if they throw the medications and the number of times that an episode happened is recorded. Staff I stated that the intervention for when the routine medication is not working is to call the psychiatrist for evaluation of the resident and follow orders and also monitor for side effects and observe for effectiveness and side effects. Staff I, RN reported that she documented on Resident #1's Behavior Monitoring sheet on and on . Staff I stated that she documented zero to represent no episodes of during the shift. Staff I reported that she also worked on , and did not document any behavior. Interview on at 3:53 PM with Spanish speaking Certified Nursing Assistant (CNA), Staff A revealed he worked in the facility for about one year and floated to a different unit every week. Staff A reported that he provided care to Resident #1 on Friday, , and on Saturday, , the day Resident #1 . Staff A, CNA reported that Resident #1 was alert and liked to stay in his room alone with the door	{F 726}		

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{F 726}	Continued From page 81 closed and required assistance to go to bathroom and was on isolation precautions. Staff A, CNA explained his schedule for that weekend; on Friday, he worked a double shift from 7:00 AM to 3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday to again work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, ( ) he came from break which was from 8:00 PM to 8:30 PM. Staff A stated that during rounds he noticed that Resident #1's door would not open, and he pushed the door. Staff A stated that he thought the resident may have blocked the door with something. Staff A: " When I finally opened the door, I noticed the resident was sitting on his chair with a plastic bag on his . The wheelchair was locked. He normally had two trash containers, one on each side of his bed, with plastic bag inside of it. Once I opened the door, I noticed the plastic bag on his . I took the plastic bag; I threw it on the floor and cried for help. The floor nurse was on the hallway. We went to get the crash cart, she called code blue, the nurse and I transferred the resident from the chair to the wheelchair, they initiated the until the ambulance arrived ... The police arrived they interviewed me ... I could not leave the facility until after the detective interviewed me. During the interview, Staff A explained that Resident #1 Sometimes was aggressive and had behaviors like refusing care such as a haircut and refused to shave. Staff A reported that he had to convince Resident #1 and he allowed him to shave him. Staff A reported that not that long ago, maybe two weeks Resident #1 would sometimes get angry and yell at staff and one time Resident #1 took off his gown and threw it at him. Staff A reported that he reported the behavior to the floor nurse and asked the nurse to come to the room	{F 726}		

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{F 726} Continued From page 82 {F 726}

and help him translate and explain to Resident #1 that he (Staff A) here to take care of him, and that there was no need to be aggressive and Resident #1 understood and even apologized.

Review of the investigative report and interview with the Clinical Regional Nurse on ... at approximately 2:30 PM revealed, the Clinical regional nurse had reviewed the facility's video recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday ... at 2:54 PM Resident #1's CNA, [Staff A] went into the residents' room [room #] at 4:18 PM. Nurse [Staff B] was passing meds. The Clinical Regional Nurse stated: "You can see her going in and out of rooms." At 4:30 PM the friend [Resident #4] leaves Resident # 1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His door remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM [Staff C], LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area, gets the nurse and the crash cart... The Regional nurse explained that The CNA had to push the door

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{F 726}	Continued From page 83 opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . . . . The CNA stated that he pulled the bag off Resident #1's . . . and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office. On . . . . , ... , at 10:01 AM, with Spanish speaking Registered Nurse (RN), Staff B revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. The resident was alert and oriented times three and communicated his needs well. Staff B, RN was asked about Resident #1' , . . Staff B, RN acknowledged that Resident #1 had , . at times; " I remember he did at some point take , medications, , and . For about three days" Staff B, RN was not able to explain why the Medication Administration Records (MAR) indicated zero for , . level the entire month of , and . . , . Staff B insisted that the resident did not have , . the last times she cared for him (Thursday, ... to Saturday . . . . , ...); "Those last three days he did not have , ." Staff B explained that on the day of the incident Resident #1 was on isolation precautions due to a , ... (.). Staff B, RN stated: " I worked from Thursday, , . to Saturday . . . . I monitored for behaviors related to his use of , , we monitored for , ... , fear, or . . . , I don't	{F 726}		

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{F 726}	Continued From page 84 remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed ...I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and , the day that he . What I documented was that he had one behavior of ." Staff B, RN explained that Resident #1 kept asking about the ( ) treatment. The intervention, during the episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. Staff B stated that her documentation on the behavior monitoring sheets about the afraid/panic episode was related to the treatment, that Resident #1 received the treatment and that it was effective. Staff B stated: "I did not document in the nurses notes that the resident was having episode of , because I did my action, I did not see him to be desperate, he allowed me to administer his treatment." Staff B reported that the purpose of the behavior monitoring sheet is to follow for a prescribed medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was to refer to nurses' notes. Staff B agreed there was no record to explain anything about the resident's or behavior. Staff B stated: " It's established that a patient can have at least three small episodes of , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month ...what the	{F 726}		

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{F 726}	Continued From page 85 behavior monitoring sheet shows is that the medication is effective. I documented that he had on , 3rd, and 4th. The one episode could have been something like, "I don't want to shower, I don't know the behavior." Staff B then agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know and could not recall the behavior. Staff B stated: I also documented no behavior on , , 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report to anyone. I did not think that I needed to communicate it to the psychiatrist. We did not monitor him for . I did not know he had any , or diagnoses of , . With a diagnosis of " Staff B explained that she would have reacted differently and that are very dangerous, levels of in a person's can change and cause them to have a crisis. "On that day he seemed well, he did not seem depressed. He did not reject care or complain of ." Upon discussion of Resident #1's diagnoses, Staff B reported: "I am surprised that he had diagnosis of , ...when I left on that day he remained in his bed. I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." (Note: The investigative report and interview with the Clinical Regional Nurse on at approximately 2:30PM showed that per surveillance video, Staff B last saw the resident in his room at approximately 5:21 PM). On at 10:56 AM, the Psychiatrist reported he did not review the above-mentioned behavior monitoring sheets in Resident #1's	{F 726}		

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{F 726}	Continued From page 86 clinical record. He explained that he met with facility staff and discussed residents' behavior and if any adjustments needed. When asked, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware; the nurses did not communicate the behaviors to him, and the facility's staff should have communicated . . . , afraid/panic episodes and any other behavior exhibited by Resident#1. The psychiatrist stated: "If they told me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, would have gone to see him, maybe change the medication."	{F 726}		
{F 867} SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on records reviewed and interviews, the facility failed to demonstrate an effective plans of action was implemented to correct identified quality deficiencies in problem-prone areas, related to . . . . . , accuracy of assessments, development and implementation of care plan, quality of care, accidents hazards/supervision and quality assurance and performance improvement (QAPI) as evidenced by repeated deficient	{F 867}	F867 The facility Developed a new QAPI plan and the facility QAPI Committee will monitor the following: . . . . and Neglect, . . . informed care and behavioral health with emphasis on monitoring residents prescribed , and , medications and identifying possible risk	

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{F 867}	Continued From page 87 practice found in these areas during consecutive surveys. (Cross Reference F600, F641, F656, F684, F689, F867). The findings included: Record review of the facility's survey history revealed, during the annual survey exit dated and during this complaint survey with the exit date repeated deficient practice was cited related to: Free from /Neglect (F600), Accuracy of Assessments (F641), failure to develop and implement a comprehensive care plan (F656), Accidents, Hazards, Supervision, Devices related to facility failure to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents (F689) and failure to ensure an effective Quality Assurance and Performance Improvement (QAPI) program, (F867). Interview with the Nursing Home Administrator (NHA) on at 10:50 AM revealed, the NHA reported the facility had a Quality Assessment and Assurance (QAA) program that met at least once a month; on the third Thursday of every month. The participants included the Director of Nursing (DON), the Medical Director, the Assistant Director of Nursing (ADON), Medical Records participates, and Registered Nurses (RN) Supervisors. Participants included all department heads including the Maintenance Director and the Housekeeping Director. Since the last annual survey, the committee continued to meet once a month and the DON was the of the QAPI committee.	{F 867}	factors and changes in and behavior as well as side effects. MDS accuracy of coding residents' active diagnosis Developing and following the care plan regarding residents who are prescribed , , , and medication to effectively monitor for the effectiveness and side effects of the medication Developing and implementing a plan of care for diagnosis of , and , and management management with developing a plan of care, and monitoring the resident's for effectiveness Identifying other areas of quality concern through the quality improvement (QI) review process as described in the QAPI plan to: Identify and monitor the facilities performance, Establish goals and thresholds for the facilities performance measurement, Utilize resident, staff, and family input, Identify and prioritize problems and opportunities for improvement, Systematically analyze underlying causes of systemic problems and adverse events and Develop corrective action or performance improvement activities. Residents with a diagnosis of , and , have the potential to be affected. Residents that are prescribed , , , and/or	

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{F 867}	Continued From page 88 During the interview, the NHA did not present a QAPI plan that met regulatory requirements. The NHA explained, "We have a system that we use to identify systemic issues in our facility, everyone in the committee brings up any issue that has been identified within their department, the Social Services Director for example, will express if any issue he addressed might require more attention. Then discuss a possible plan, the Director of Nursing (DON) documents everything that is brought to the meeting. She types up the report from the last meeting report and whatever intervention was put into place are discussed at the start of the next QAPI meeting. The last time we had a QAPI meeting on . The NHA described the committee had identified quality deficiency related to COVID -19 and with communication / expectations from state agencies. (Referred only to deficient practices that AHCA (Agency for Health Care Administration) cited during last annual survey and subsequent complaint / control surveys). The NHA stated: "We understand that repeated deficient practice might be an indication of staff lack of adherence in following the procedures, therefore we will be doing more education." The NHA expressed understanding that repeated deficient practices, including QAA might be cited.	{F 867}	medications have the potential to be affected. Residents who experience , have the potential to be affected. Residents that have an MDS and require the coding of their active diagnosis have the potential to be affected The facility has conducted an audit on the following: Residents with a diagnosis of , and who are prescribed , and , medication to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in and behavior as well as side effects and effectiveness of these medications and to ensure behavior monitoring sheets are in place and reflect the behaviors of the resident and that side effects are monitored. Resident's recent MDS was reviewed for accurate coding of the resident's active diagnosis. Any inaccurate coding identified will be modified Residents who are prescribed , and , medications were audited to ensure a care plan has been developed to monitor	

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{F 867}	Continued From page 89	{F 867}	for effectiveness and side effects of the medication. Residents that have a diagnosis of , and , were audited to ensure a care plan has been developed for behaviors related to their diagnosis of , and ,. Residents who have a diagnosis of , and , were audited to ensure behavior sheets are in place to identify behaviors, interventions placed to intervene with the behaviors and referrals made for , and mental health evaluations Residents who experience , or have a prescribed , medication were audited to ensure a care plan is developed to manage their , and to monitor the effectiveness and side effects of the medication Residents Medication Administration Record was reviewed for , monitoring. In addition, Residents who are prescribed a , medication were reviewed to ensure residents that are experiencing , noted is being addressed. QA assurance committee minutes for the last month reviewed to ensure follow up to identified concerns have been addressed The policies labeled were reviewed by the Administrator and adopted with no changes.	

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{F 867}	Continued From page 90	{F 867}	-Quality Assurance and Performance Improvement (QAPI) Program-Analysis and Action - Quality Assurance and Performance Improvement (QAPI) Program-Design and Scope -Quality Assurance and Performance Improvement (QAPI) Program-Feedback, Data, and Monitoring -Quality Assurance and Performance Improvement (QAPI) Program -Governance and Leadership -Quality Assurance and Performance Improvement Program (QAPI) Program Resident , Neglect and Policy, Informed Care, Behavioral Health Services, Medication, – Clinical Protocol, Care Plans, Comprehensive Person-Centered, Certifying Accuracy of the Resident Assessment, -Clinical Protocol, Accident & Incident- Investigation and Reporting The Consultant educated the Administrator regarding the above policies and the facilities QAPI plan. Administrator/designee educated facility staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed and medications and identifying possible risk factors and changes in and	

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{F 867}	Continued From page 91	{F 867}	behavior as well as side effects and efficacy of medication Administrator/designee educated all staff on a one-to-one basis regarding and Neglect. Nurse consultant educated administrative staff on a one-to-one basis regarding , neglect. informed care and behavioral health. The Administrator/designee educated Licensed Nurses on Developing and following the care plan regarding residents who are prescribed , and , medications to monitor the effectiveness and side effects of the medication MDS consultant educated MDS staff regarding developing and implementing a plan of care for diagnosis of , and The Administrator/designee educated Licensed Nurses, Certified Nursing Aides and Social Services regarding behavioral health with emphasis on effectively monitoring residents with , and diagnosis and to ensure referrals are made for mental health evaluations. Social services and nursing staff were educated by Administrator/designee on informed care including a newly added questionnaire regarding Social Services/designee completed informed screening on all current residents. New admission will include informed screening The Administrator/designee educated Licensed Nursing Staff on Developing and	

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{F 867}	Continued From page 92	{F 867}	following the care plan for Residents who have , to manage the Residents , and monitor the effectiveness and side effects of the medication The Administrator/designee educated Licensed Nurses and Certified Nursing Aides regarding , assessment, documentation and monitoring for , relief after interventions are placed. MDS consultant educated MDS staff regarding developing and implementing a plan of care for , . The MDS Consultant educated the MDS staff on accurately coding the resident's active diagnosis The Interdisciplinary Team will review the MDS coding for accuracy during the resident's care plan review Newly hired staff will be educated during orientation by the DON/designee on monitoring residents with diagnosis of , and , and to monitor for behaviors related to , and , and any noted side effects and efficacy of , and , medication as well as informed care. Newly hired staff will be educated by the DON/designee during orientation on residents who are prescribed , , , and , medication to monitor for the effectiveness and side effects of the medication Newly hired staff will be educated during orientation regarding , assessment, documentation and monitoring for , relief after interventions are placed. Newly hired staff will be educated during	

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{F 867}	Continued From page 93	{F 867}	orientation on behavioral health with emphasis on monitoring residents with , and diagnosis and to ensure referrals are made for mental health evaluations. During the clinical meeting any changes noted in resident's and behavior and noted side effects or any changes in the effectiveness of the resident's or , medication will be communicated to the practitioner for potential mental health referral. New admissions with a diagnosis of or , and that are prescribed an , , , or medication will be reviewed in the clinical meeting to ensure a comprehensive plan of care will be developed and the medications will be monitored for effectiveness and side effects Residents who experience will be reviewed in the clinical meeting to ensure effective management. New admissions will be reviewed in the clinical meeting to ensure effective management New admissions will be reviewed during clinical meeting for Informed Care assessment and behavioral Monitoring sheet as indicated per diagnosis of , and and referrals to behavioral health will be initiated as needed The facility will follow their developed QAPI plan The facility will utilize their revised QAPI minute's structure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105910	A. BUILDING ______ B. WING ______	R-C 11/02/2021

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{F 867}	Continued From page 94	{F 867}	The following will be audited: The Administrator/designee will audit current residents with a diagnosis of , and weekly x4 and monthly x3 to ensure behavior sheets reflect the resident's behaviors, that those behaviors have interventions placed to intervene with the behavior, and the efficacy and any side effects of the and medications are monitored The MDS Nurse/designee will conduct an audit of residents MDS coding for active diagnosis with each submission for 3 months to ensure the Resident's MDS is coded accurately for active diagnosis The DON/designee will audit current residents who are on , , and , medication weekly x 4 and monthly x 3 to ensure care plans have been developed to monitor the effectiveness of the medications and monitor for side effects. The DON/designee will audit Residents Medication Administration Record weekly X4 then monthly X3 to ensure Resident's management is effective. The DON/designee will audit residents with a diagnosis of , and weekly x4 and monthly x3 to ensure	

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{F 867}	Continued From page 95	{F 867}	behavior monitoring sheets accurately reflect resident's behaviors and referrals are made for [illegible] and mental health evaluations as needed Social Services/designee will audit newly admitted residents weekly X4 and monthly X 3 to ensure they have been screened for [illegible] informed care The Administrator/designee will audit the facilities QAPI plan x 3 months for the key elements of the program to assure that they are occurring and that the program is efficient. The Administrator/designee will review results of the audits with the QAPI Committee for review and feedback. Responsible Party: Administrator/Designee Date of Compliance [illegible]	