Southridge Rehab & Living Center
March 5, 2025 Complaint Survey
Plan of Correction (POC)

Please note the filing of this plan of correction does not constitute an admission of allegations set forth in the statement of deficiencies. The facility is filing this plan of correction in accordance with applicable law.

F580 – Notify of Changes (Injury/Decline/Room, etc.)

All residents have the potential for being affected by the identified deficient practice. One resident was identified as being affected – no others were identified.

When Resident #1 was discovered outside, the facility called EMS and notified the daughter. The physician was made aware when she arrived at the facility that morning. The resident was admitted to the hospital and returned on Thursday, February 20, 2025. The facility coordinated a meeting between the family (Daughter) and medical director upon her return to review and modify interventions and the care plan.

The facility provided on-the-spot education to all licensed staff between February 17, 2025 and February 19, 2025 by the Administrator, who is also a registered nurse. This training included when to notify the physician and resident's responsible party of a change in condition, when interventions are ineffective at relieving a resident's distress, documentation and safety protocols for residents with behaviors. This education also included notifying the physician and responsible party when a resident is missing, requiring a search per the facility's Resident Elopement Policy. Please see attachment #1.

In addition, the facility also provided formal education covering the aforementioned to the broader direct care staff on "Safety Plan for Exit Seeking Residents" and CARE Path for Mental Status Change, Caring for Residents Who Wander (See the attached agenda and sign-in sheets – Attachments #5, #6 and #7).

The quality assurance component of this correction plan will be daily monitoring of when there is a Change of Condition note in MyUnity (facility's electronic health record) which will be noted in the 24 Report generated by the E.H.R. The 24 Hour report will be reviewed daily for 90 days to ensure the physician and responsible parties are notified of changes in condition or elopement.

The results of these of the audits will be reported to the facility's monthly QAPI Committee to ensure compliance. If compliance is not attained the audit will continue for another 90 days.

Date of Completion: March 21, 2025.

F655 – Baseline Care Plan

All residents have the potential for being affected by the identified deficient practice. One resident was identified as being affected – no others were identified.

Prior to her return to the facility, a IDT meeting was held on the resident in question and her care plan was updated to include the following: High Risk for Elopement, secondary to wandering as evidenced by poor safety awareness, wandering behavior, attempt to leave environment, expressed desire to leave facility and exit seeking behaviors.

Education was provided on Documentation Requirements at Licensed Staff Meeting held on February 25, 2025 and February 27, 2025 (Attachment #3 - e-mail from Paula Chizmar, DNS to the SA summarizing the content of the meetings). The facility has instituted a protocol in which when a resident triggers as At Risk for Elopement through the Elopement Risk Assessment that will be flagged on the direct care assignment sheets.

The quality assurance compliance will be an audit of the behavior sheets in the TAR to ensure that any resident on a psychotropic and antianxiety medication is appropriately assessed and documented for behaviors and efficacy. The audits will be conducted for 90 days and reported at the facility's monthly QAPI committee meetings. If compliance is not attained the audit will continue for another 90 days.

Date of Completion: March 21, 2025

F689 – Free of Accident Hazards/Supervision/Devices

It is important to note that Southridge Rehab and Living Center is requesting an Informal Dispute Resolution (IDR) regarding factual content of this finding. We are disputing the facts and timeline associated with this accident.

All residents have the potential for being affected by the identified deficient practice. One of two residents identified as an elopement risk was affected – no other residents were identified.

The IJ Removal Plan was accepted on March 5, 2025 by the State Agency for the identified resident (Attachment #4). In addition to the actions related to the Removal Plan, the facility has implemented the measures contained in the POC's related to the findings F580, F655 and F757.

REVISED -

The facility coordinated a meeting between the family (Daughter) and medical director upon her return from the hospital to review and modify interventions in place and her care plan. Resident #1 was admitted to the secure Nursing Facility Level Memory Care neighborhood at Fallbrook Commons on March 5, 2025.

Upon admission, all residents will receive an elopement assessment. The result of the assessment determines if the resident receives a wander guard. Wander guard placement is checked and documented every shift in the TAR. Functionality is checked and documented daily in the TAR. Assignment sheets have been updated to include identifiers of all elopement risks and photos continue to be posted throughout the facility.

Residents who are actively exit seeking will be redirected. If that proves to be unsuccessful, activities and frequent monitoring will be utilized. If exit seeking continues, possible medication interventions will be reviewed and implemented. The resident's family will be contacted for support, the supervisor, and the provider will be notified, and 15 minute checks will be implemented should exit seeking continue. Medication

effectiveness will be evaluated and addressed with provider if needed. If ineffective, the provider will be contacted and one on one staffing will be maintained until the resident is determined to be safe.

To ensure compliance, residents determined to be at risk for elopement will be audited for prn administration, documentation of effectiveness, and follow up. Additionally, all elopement risk will be reviewed at the next monthly safety meeting. All measures implemented to prevent elopement (window blocking, etc.) will be added to monthly environmental audits and reported in the safety meeting (monthly) and QAPI.

Date of Completion: March 21, 2025

NOTE: *The POC of F689 was revised on March 27, 2025 but the facility is alleging compliance as of the original Date of Completion of March 21, 2025. No additional interventions have been put in place as a result of the revised POC. The interventions have simply been more specifically summarized in the revised POC.*

F757 – Drug Regimen is Free from Unnecessary Drugs

All residents have the potential for being affected by the identified deficient practice. One resident was identified as being affected – no others were identified.

Education provided on Documentation Requirements at licensed Staff Meeting held on February 25, 2025 and February 27, 2025 (Attachment #3). Topics covered during these meetings include when PRN's are administered documenting the reason and if they were effective, and if the medication is not effective, the physician must be notified.

The physician order sheet populates MyUnity (facility's electronic health record) to generate a TAR with the Behavioral/Psychotropic Medication Monitor treatment. This is part of the facility's standing physician orders. The notes related to the order sheet would be on the Behavior monitoring sheets in the TAR.

The quality assurance compliance will be an audit of the behavior sheets in the TAR to ensure that any resident on a psychotropic and antianxiety medication is appropriately assessed and documented for behaviors and efficacy. The audit will also include a review of PRN administration documentation in the MAR. The audits will be conducted for 90 days and reported at the facility's monthly QAPI committee meetings. If compliance is not attained the audit will continue for another 90 days.

Date of Completion: March 21, 2025

Respectfully submitted,

Cassandra Byorak, RN Administrator

Cassandra Byorak, RN Administrator
Southridge Rehab & Living Center

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205136	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHRIDGE REHAB & LIVING CTR	10 MAY ST BIDDEFORD, ME 04005

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F 000	INITIAL COMMENTS	F 000		

On 2/19/25 and 3/5/25, the Division of Licensing and Certification conducted on-site visits at Southridge Rehab & Living Center for the purpose of completing a complaint investigation for #ME00050625. It was determined that Southridge Rehab & Living Center was not in compliance with 42 Code of Federal Regulation (CFR) Part 483, Subpart B, Requirements for Long Term Care Facilities.

At 42 Code of Federal Regulations (CFR) Part 483, Subpart §483.25(d)(2), - F689; the facility failed to provide supervision to a resident after staff found resident in closet in another resident room, with an open window, for a resident identified as an elopement risk and had previous exit seeking attempts. Shortly after, the resident was found outside in a snowbank with a second story window open. Noncompliance with this requirement constituted a determination of immediate jeopardy (IJ), beginning on 2/17/25. Immediate jeopardy is defined as a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment, or death as a result of a provider's noncompliance with one or more health and safety requirements. See §483.25(d)(2), also known as F689, for details.

On 3/4/25 at 12:26 p.m., the Administrator was provided written notification (IJ template for F689) related to the IJ situation, and a removal plan was requested.

On 3/5/25 at 2:43 p.m., the facility summitted an acceptable removal plan. The removal plan was reviewed and approved by the State Agency on

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cassandra Bryant — TITLE: Administrator — REVISED — (X6) DATE: 3-27-25

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 3/5/25 at 2:58 p.m. This removal plan indicated the following: - Windows of B2 and A1 Units were retrofitted to limit opening distance. - Staff education provided for Safety protocols for residents with behaviors, when to call Doctor or on call provider, one on one, and documentation requirements. - Secure doors checked on 2/18/25. - A Root Cause Analysis was completed. - Staff education provided to Nursing Staff on Exit Seeking Safety Plan which includes the following: 1. Stay with resident. 2. Medicate if necessary. 3. Observe medication efficacy. 4. Call provider to report exit seeking behaviors and to report if medication not effective. 5. Call family for support, if available. 6. Documentation of behaviors. 7. Contact Director of Nursing or Administrator. On 3/5/25, a surveyor verified that the facility's removal plan was implemented and effective by the observations of window stops, interviews with staff regarding education and understanding, review of educational content and staff completion of education. The surveyor determined the removal of the IJ was on 3/5/25.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580	SEE ATTACHED POC	

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F 580	Continued From page 2 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580		

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F 580	Continued From page 3 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the physician when interventions were ineffective in relieving resident's distress. In addition, the facility failed to notify the physician after the resident was missing and required a search to locate or when the resident experienced a life-threatening elopement. Findings: On 2/17/25 the Division of Licensing and Certification received a facility reported incident, which indicated Resident #1 was found outside in a snowbank having fallen from a second story window. Review of facility policy "Resident Elopement Policy" last revised 9/23 states under: II. PROCEDURE -Section D vii - "The physician and resident's responsible party will be notified." -Section G. "The resident's plan of care is to be updated with appropriate interventions to meet the resident's current needs" -Section H "Document in medical record. Indicate time the search began and the time the search ended." On 2/19/25, druing review of Resident #1's the Medication Administration Record, stated a PRN (as needed) medication for anxiety was given with	F 580		

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F 580	Continued From page 4 no effect on 2/15/25 at 7:34 p.m. and 2/16/25 at 6:00 p.m.. There is no evidence to support that other interventions were tried and effective/ineffective or that a physician was notified. On 2/19/25, during review of Resident #1's electronic medical record (EMR), Clinical notes stated that Resident#1 had been found missing from his/her bed on 2/16/25 and located in the closet of another room where a window had also been found open. The notes lacked evidence the time the search began and time when resident was found. The notes also stated that interventions and medications had been unsuccessful to relieve resident's agitation. There is no evidence that a provider was notified. On 2/17/25 at approximately 1:00 a.m., Resident #1 was found outside in a snowbank underneath an open second story window. Resident #1 was transferred to the hospital and diagnosed with hypothermia and frostbite. The medical record lacked evidence that the facility physician was notified. On 2/19/25 at 12:15 p.m., a surveyor discussed the above findings with the Administrator and Director of Nursing and confirmed that physician was not notified of resdient behaviors and elopement.	F 580		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655	SEE ATTACHED POC	

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F 655	Continued From page 5 implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.	F 655		

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F 655	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow the baseline care plan implemented for Resident #1 in the area of Behaviors for 5 of 5 days that resident was in the facility. Findings: On 2/19/25, during review of Resident #1's baseline care plan, dated 2/12/25, stated in the area for Behaviors: Document behaviors in Treatment Administration Record (TAR) or on behavior monitoring form every shift. A review of Resident #1's Electronic Medical record (EMR) under TAR and Clinical Notes, failed to show documented behaviors for every shift between 2/12/25 and 2/17/25. On 2/28/25 at 8:51a.m., during an interview with CNA #1, who worked shifts with Resident #1 on 2/12/25, 2/13/25, 2/14/25, 2/15/25 and 2/16/25. CNA #1 stated that Resident #1 was wandering, exit seeking, refusing care, distressed frequently since arrival on B2 Unit. CNA #1 states that he/she was not told Resident #1 had eloped several times in Residential Care. On 2/28/25 at 9:49 a.m., during an interview with CNA #2, who worked shifts with Resident #1 on 2/12/25, 2/13/25, 2/15/25 and 2/16/25. CNA #2, confirmed that Resident #1 had been experiencing frequent wandering and exit seeking behaviors and was very difficult to manage when his/her family was not present. On 2/19/25 at 12:15 p.m., during an interview with	F 655		

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F 655	Continued From page 7 the Administrator and the Director of Nursing, were unable to provide additional evidence or an explanation for not following the care plan for montoring behaviors.	F 655		
F 689 SS=J	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 §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 interviews, observations and record reviews, the facility failed to provide supervision to a resident after staff found resident in closet in another resident room, with an open window. Resident was previously identified as an elopement risk and had previous exit seeking attempts for 1 of 2 residents identified for elopement risk. Shortly after, the resident was found outside in a snowbank with a second story window open. This failure created an immediate jeopardy situation. (Resident #1) Findings: On 2/17/25 the Department of Licensing and Certification received a facility reported incident indicating [Resident #1] fell into snow from second floor on 2/17/24. [Resident #1] found in snowbank at approximately 1:00 a.m. Medical record indicated that on 2/12/25,	F 689	SEE ATTACHED POC	

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F 689	Continued From page 8	F 689		

Resident #1 was transferred from the facility residential care unit to a secured long term care unit(B1 Unit). The transfer was related to safety due to increased dementia behaviors including exit seeking and recent elopements from the residential care facility.

Resident #1 is 92 years old with a diagnosis of dementia. On 2/12/25 the facility completed elopement assessment and determined Resident #1 was a High Risk for elopement. Resident#1 was wearing a Secure Care anklet (monitor for wandering residents).

On 2/19/25, during review of Resident #1's nursing progress notes, stated on 2/14/25 at 11:51 a.m., a nurse administered as needed medication for anxiety and initiated a 1:1 for safety from staff due to wandering, exit seeking and refusal of care. Documentation states that medication was effective and daughter visiting.

Resident #1's Medication Administration Record (MAR), stated on 2/15/25 at 1:29 p.m., and on 2/15/25 at 7:34 p.m., a nurse administered as needed medication for anxiety and both times the response was "not effective."

Resident #1's nursing progress notes stated on the night of 2/16/25 and into the early morning of 2/17/25, Resident #1 exhibited exit seeking behaviors, pacing, not responding to redirection and medications were not effective.

On 2/28/25 at 9:49 a.m. during an interview with CNA#1, by phone, stated a bed check was done on 2/17/25 around 12:20 a.m. and Resident #1 was found missing. The staff searched and found Resident #1 in the closet of another resident

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F 689	Continued From page 9	F 689		

room. The window in that room was also found open. The residents in that room were both asleep when Resident #1 was found. CNA #1 stated that neither resident sleeping in that room would have been able to exit their bed independently to open the windows.

On 2/28/25 at 11:41 a.m., during an interview with PSS #1 stated that at on 2/17/25 1:00 a.m. he/she was taking a break outside with another staff member from Residential Care and found Resident #1 on a snowbank underneath an open second floor window. Resident #1 was assessed by a facility nurse and found to be alert, tearful, oriented to self, scrapes on knees and a bump on his/her head. PSS#1 called 911 and went to alert the facility staff that resident was outside. The long-term care unit staff were unaware Resident #1 had gone missing again. Resident #1 was transferred by Emergency Medical Services (EMS) to the Emergency Room.

During review of Residents #1 Hospital Discharge Summary, dated 2/20/25, stated that Resident #1 was diagnosed with hypothermia, metabolic encephalopathy secondary to hypothermia and hypoxia and frostbite. Resident discharged back to facility on 2/2025 with orders by facility provider included comfort measures only and hospice.

According to the archived records from the National Weather Service, the temperature range on 2/16/25 was 17-23 degrees Fahrenheit with light snow.

On 2/19/25 at 10:00 a.m., during an interview with the facility Maintenance Director, all facility windows on B2 and A1 units had been assessed and retrofitted with window blockers that limited

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F 689	Continued From page 10 opening windows to 6 inches. Prior to this, according to the Maintenance Director, the windows could be easily opened. Some of the facility windows had very low sills and could be easily accessed. This was completed by 2/18/25 around 11:00 a.m. "Resident Elopement policy" last revised 9/2023 and found under section II (Procedure), Item G. "The resident's plan of care is to be updated with appropriate interventions to meet resident's current needs." And under section II, Item H. "Document in medical record. Indicate time the search began and the time the search ended." There is no documentation to support that staff followed the facility's policy when Resident #1 went missing the first time on the night of 2/17/25. Based on the above information, IJ was called on 3/4/25 for the facility's failure to provide adequate supervision to a resident with a history of exit seeking and elopement that resulted in a fall from a second story window into a snowbank. Staff on B2 were unaware the resident had been missing a second time until alerted by residential care staff after the fall. The facility's failure to provide these services constituted an immediate jeopardy situation. Please see F-0000 Initial Comments related to the IJ removal plan.	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757	SEE ATTACHED POC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205136	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHRIDGE REHAB & LIVING CTR	10 MAY ST BIDDEFORD, ME 04005

(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 757	Continued From page 11 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to monitor targeted behaviors to support the use of antipsychotic and antianxiety medications for 1 resident reviewed for unnecessary medications and behavior monitoring. Findings: Review of Resident #1's Physician Order Sheet has the following orders for Psychotropic Medications: -Sertraline 100 mg(milligram) tablet one time daily oral for Unspecified dementia, Moderate, with mood disturabance. -Clonazepam 0.5 mg tablet two times daily oral for Generalized Anxiety disorder -Lorazepam 100 % power (0.25 ml) topical As needed Every Four Hours for Ninety Days for Generalized Anxiety Disorder	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205136	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHRIDGE REHAB & LIVING CTR	10 MAY ST BIDDEFORD, ME 04005

(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 757	Continued From page 12 Review of Resident #1's Physician Order Sheet order, dated 2/12/25 that states: "Behavioral/Psychotropic Medication Monitor Notes: Behavior monitoring for psychotropic medications below: Antipsychotics, Antianxiety, Antidepressants, Sedative/hypnotics *Please document ALL behaviors including those "Normal" for the resident. Physical Monitors: 1. Behavioral Symptoms/Effective?/Non-Pharmacological Interventions/Number of Episodes/Psychoactive Side Effects" Frequency: Three Times Daily (Nurse Day Shift, Nurse Evening Shift, Nurse Night Shift). Review of Resident #1's Care plan included under interventions "Monitor, report and document changes in mentation" and "If [Resident #1] is agitated or restless, provide distration" Resident #1 was admitted to Long Term Care Unit from Residential Care with diagnosis of dementia due to with exit seeking and wandering behaviors. On 2/19/25, during review of the Treatment Administration Record (TAR) for Resident #1, between the dates of 2/12/25 and 2/17/25 there is no documentation on the TAR that nursing followed this monitoring behaviors ad physician order directed. The Medication Administration Record (MAR) showed 4 documented times that an "as needed" psychotropic medication was given between 2/12/25 and 2/17/25. There is no documentation as to why this drug was administered for 3 of 4	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205136	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHRIDGE REHAB & LIVING CTR	10 MAY ST BIDDEFORD, ME 04005

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F 757	Continued From page 13 times it was administered to Resident #1. During review of progress notes for Resident #1, between the dates of 2/12/25 and 2/17/25, the nursing notes failed that supported the ordered behavior monitoring for psychotropic medications. In addition, nursing notes do not explain why an "as needed" medication was administered or what nonpharmacological interventions were attempted prior to administering an as needed medication. On 2/19/25 at 12:15 p.m., during an interview with the Administrator and the Director of Nursing and discussed the above findings.	F 757		

ATTACHMENT #1

Education to Licensed Staff on Incident from 2-17-25

This writer verbally educated licensed staff on the incident, when to call provider, documentation, safety protocol for residents with behaviors and one to ones between 2-17-25 and 2-19-25.

Kim Adams, LPN

Meredith Belanich, LPN

Karalyn Hayward, LPN

Dina Brochu, RN

Kelly Brooks, RN

Vance Brooks, LPN

Paula Chizmar, RN

Anne Davis, RN

Leslie Goodwin, RN

Lori Kent, RN

Tammy Rabida, RN

Melissa Stubbs, RN

Gergana Yorgova-Rosencranse, LPN

Cassandra Byorak, RN, BSN

Cassandra Byorak, RN, BSN

Administrator

ATTACHMENT #3

Cassandra H. Byorak

From: Paula Chizmar <PChizmar@ncahcf.com>
Sent: Monday, March 3, 2025 3:23 PM
To: Connolly, Amy
Cc: Cassandra H. Byorak
Subject: Re: Request

CAUTION: This email originated from outside your organization. Exercise caution when opening attachments or clicking links, especially from unknown senders.
Amy,
I hope this answers your question.

Please provide the items listed in the Agenda for the nurses training:
Safety protocols for residents with behaviors
*When is a resident presenting unsafe behaviors
*If resident is unmanageable alert Dr./ On call.
*Address the issue(s) right away
Consider nonpharmacological interventions.
*Check care plan for any behavior plan.
* How to keep the resident and other residents safe?
*Alert the Director of Nursing
*Once there are unsafe behaviors plan to document the behaviors and plan q shift until resolved.
*Add the behavioral plan to care plan if it isnt already there.
The above was discussed it hasnt been formalized yet.

-

When to call the DR or ON call see Care path. And whenever you feel a resident is unsafe, or exhibiting new behaviors, new clinical issues and or exacerbations of clinical conditions.

One on One's - There have been times when the nurse has instituted One on One's In the past week. We can only support one on one's when the staffing supports it. If a resident is at the point when the nurse feels they need a one on one. Call the Dr. call the DON. Transfer to the hospital.

Documentation requirements- If a resident has a behavior sheet please make sure it reflects the residents behavior for your shift. The sheets are used to reflect behaviors and the efficacy of medications. Documentation is also under the safety protocol above.

Paula Chizmar RN
Director of Nursing
Southridge Rehab and Living Center
10 May Street
Biddeford, ME 04005
207-282-4138
(c) 207-333-2060
pchizmar@ncahcf.com

ATTACHMENT #4

Southridge Rehabilitation & Living Center
10 May Street, Biddeford, ME 04005 Tel. (207) 282-4138 Fax (207) 282-8242

Southridge Rehab & Living Center

IJ Removal Plan

At 12:25 PM on March 4, 2025 the Administrator and Director of Nursing Services were notified that Southridge Rehab & Living Center had an Immediate Jeopardy finding based on an accident that occurred in the early morning of February 17, 2025. The accident was reported to DHHS that same day, Monday, February 17, 2025. DHHS, Division of Licensing & Certification was onsite Wednesday, February 19, 2025 to conduct an investigation of the accident. It is worth noting the DLC representative did not indicate a finding of Immediate Jeopardy upon Exit. As noted in the IJ Template received on March 4, 2025, Southridge Rehab & Living Center took the following steps (taken from the IJ Template):

1. The windows on Units B2 and A1 were retrofitted to limit the opening distance prior to surveyor arrival at facility. Completed on 2/28/25. EDITORIAL: ***Please note this work was completed on 2/18/2025 not 2/28/2015 as reported on the IJ Template.***

2. Education provided to licensed nursing staff on 2-25-25 and 2-27-25 at staff meetings in the areas of:
    a. Safety Protocols for Residents with Behaviors
    b. When to call the DR or On-Call Provider
    c. One on one's
    d. Documentation requirements

3. On 2/18/25, the facility had secure doors check and were found to be working properly.

4. A root cause analysis (RCA) was completed on 2/29/2025.
5. *Time line of facility actions: On 2/17/2025 through 2/19/2025, real time education provided to majority of licensed staff on the incident that occurred on 2/17/2025. Discussed when to call provider, documentation requirements, one to one's, and safety protocols. Staff meetings were held on 2/18/25, 2/20/25, 2/25/25, and 2/27/2025, with incident reviewed, and staff were educated on safety measures, medication effectiveness and required documentation. Prior to residents return from hospital on 2/20/25, the staff were educated on safety measures, new medication ordered, and when to call on call. The Medical Director met with the daughter, and agreement was made to place resident on Hospice. On 2/20/25, staff were directed to do q 15 minute checks for 24 hours and per nursing judgement thereafter. Staff to sign off on q 15 minute check sheet and give to nurse when complete.*
6. *Reviewed other elopement risk residents. # 2 resident is not an elopement risk due to change in condition.*

NC Southridge Rehabilitation & Living Center
10 May Street, Biddeford, ME 04005 Tel. (207) 282-4138 Fax (207) 282-8242

In addition to the aforementioned, since the accident the facility

has been working with the family of this particular resident on an alternate placement in a fully secure NF Memory Care Facility. Resident will be going to Fallbrook Commons on March 5th, 2025.

Since receiving the attached notice, the following steps have also been taken to address the Immediate Jeopardy determination:

1. Education packets out on all units for staff addressing wandering, with the majority of active staff completed by 3/5/2025
2. Ongoing education to nursing staff re the Exit Seeking Safety Plan, with the majority of active staff completed by 3/5/2025

Southridge Rehab and Living Center

Safety Plan for exit seeking residents

When a resident is showing signs of exit seeking:

- Verbalizing wanting to leave
- Standing by an exit door
- Pushing on exit doors
- Opening windows

1. Stay with resident
2. Medicate if necessary
3. Observe medication efficacy
4. Call provider to report exit seeking behavior and to report if medication is not effective.
5. Call family for support if available.
6. Document behaviors
7. Contact Director of Nursing/Administrator.

ATTCHMENT #5

Southridge Rehab and Living Center

Safety Plan for exit seeking residents

When a resident is showing signs of exit seeking:

- Verbalizing wanting to leave
- Standing by an exit door
- Pushing on exit doors
- Opening windows

1. Stay with resident
2. Medicate if necessary
3. Observe medication efficacy
4. Call provider to report exit seeking behavior and to report if medication is not effective.
5. Call family for support if available.
6. Document behaviors
7. Contact Director of Nursing/Administrator.

Completed

Safety Plan for **Exit Seeking** Residents

Staff Name	Date Completion
Adams, Klijewski, Kimberly	3/5/2025
Alling, Irene	3/8/2025
Audet, Jennifer	3/6/2025
Belanich, Meredith	3/4/2025
Boothby Hayward, Karalyn	3/5/2025
Borra, Christine	3/6/2025
Brochu, Dina	3/7/2025
Brooks, Kelly	3/7/2025
Chizmar, Paula	3/11/2025
Cognato,"Cook", Michelle	3/5/2025
Cotter, Hannah	3/4/2025
Davis, Anne	3/11/2025
Donegan, Caitlyn	3/4/2025
Farrow, Libby Contract	3/5/2025
Gatson, Petra	3/5/2025
Gerry, Marie	3/4/2025
Goodwin, Leslie	3/5/2025
Ham, Beth	3/5/2025
Haycock, Kirsten	3/13/2025
Hilsinger, Robin	3/9/2025
Hodge, Eugene Contract	3/20/2025
Irish, Vanessa	3/5/2025
Judd, Hope "Susan"	3/5/2025
Kent, Lori	3/11/2025
Leavitt, Nicholas	3/15/2025
Lenth, Brenda	3/5/2025
Lewis. Carol	3/5/2025
Macdougal, Julie	3/5/2025
Mageles, Megan	3/4/2025
Matos, Ana	3/15/2025
Matthews, Keven	3/4/2025
McCoy, Tiffany Contract	3/5/2025
Mckay, Taylor	3/4/2025

Initiated 3/4/2025

Completed

Safety Plan for **Exit Seeking** Residents

Credit - 0.5 hrs

Staff Name	Date Completion
Adams, Klijewski, Kimberly	3/5/2025
Alling, Irene	3/8/2025
Audet, Jennifer	3/6/2025
Belanich, Meredith	3/4/2025
Boothby Hayward, Karalyn	3/5/2025
Borra, Christine	3/6/2025
Brochu, Dina	3/7/2025
Brooks, Kelly	3/7/2025
Chizmar, Paula	3/11/2025
Cognato,"Cook", Michelle	3/5/2025
Cotter, Hannah	3/4/2025
Davis, Anne	3/11/2025
Donegan, Caitlyn	3/4/2025
Farrow, Libby Contract	3/5/2025
Gatson, Petra	3/5/2025
Gerry, Marie	3/4/2025
Goodwin, Leslie	3/5/2025
Ham, Beth	3/5/2025
Haycock, Kirsten	3/13/2025
Hilsinger, Robin	3/9/2025
Hodge, Eugene Contract	3/20/2025
Irish, Vanessa	3/5/2025
Judd, Hope "Susan"	3/5/2025
Kent, Lori	3/11/2025
Leavitt, Nicholas	3/15/2025
Lenth, Brenda	3/5/2025
Lewis. Carol	3/5/2025
Macdougal, Julie	3/5/2025
Mageles, Megan	3/4/2025
Matos, Ana	3/15/2025
Matthews, Keven	3/4/2025
McCoy, Tiffany Contract	3/5/2025
Mckay, Taylor	3/4/2025

Initiated 3/4/2025

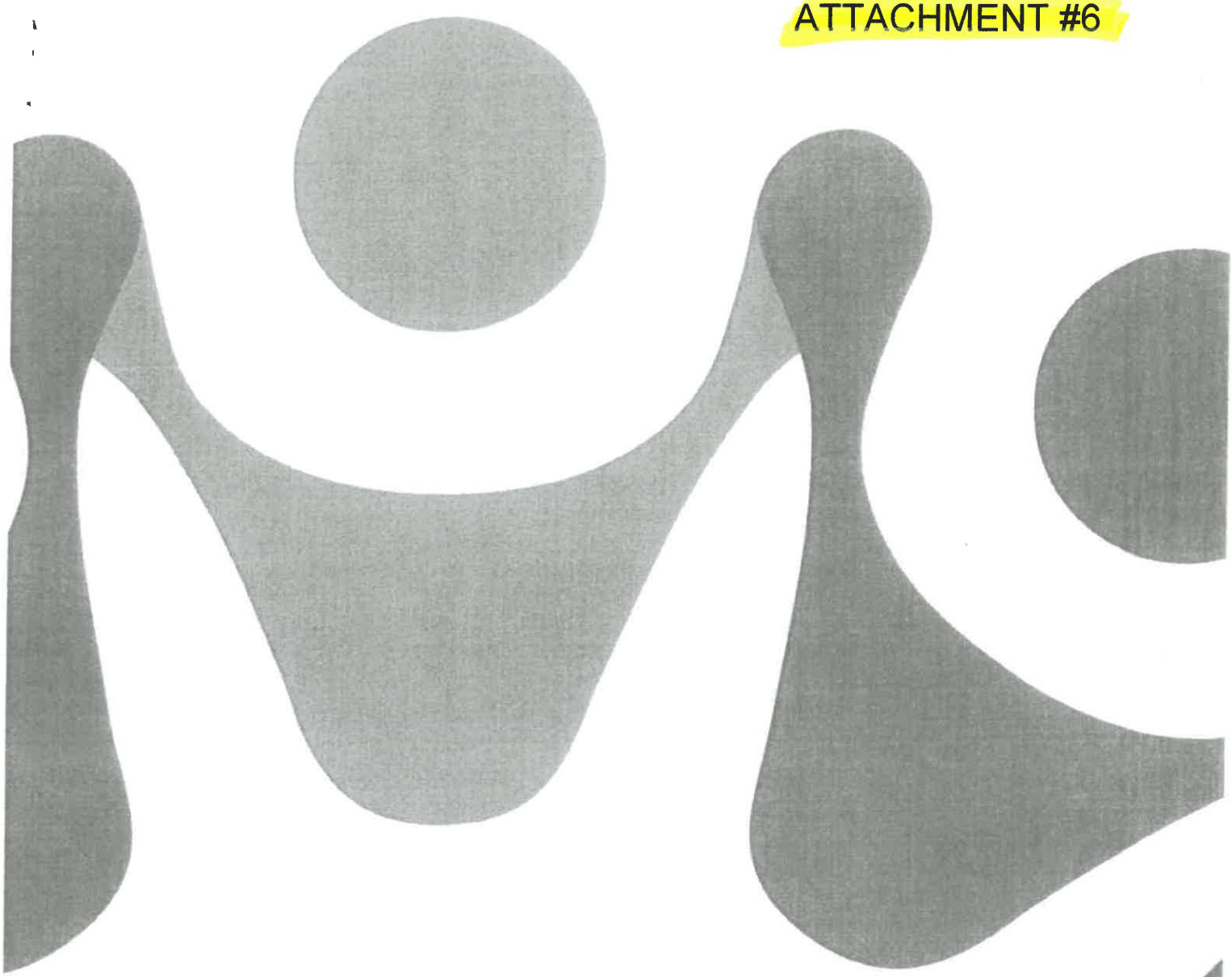
Completed

Safety Plan for **Exit Seeking** Residents

Credit - 0.5 hrs

Morton, Kirsten	3/5/2025
Nzwilli, Mercy Contract	3/20/2025
Okonda, Shonda	3/5/2025
Perkins, Stacy	3/15/2025
Rabida, Tammy	3/4/2025
Richards, Stephanie	3/11/2025
Rowe, Sharon	3/8/2025
Smith, Tiffany	3/4/2025
Stubbs, Melissa	3/11/2025
Trefrey, Christine	3/5/2025
Walls, Elizabeth	3/4/2025
Whittemore, Catherine	3/7/2025
Whitten, Cory	3/7/2025
Williams, Selena	3/5/2025
Wilson, Olivia	3/12/2025
Woodruff, Linda	3/21/2025
Yorgova-Rosencranse, Gergana	3/17/2025

ATTACHMENT #6



AADNS Staff Educator

Caring For Residents Who Wander

American Association of
Directors of Nursing Services

AADNS Staff Educator – Caring For Residents Who Wander

Content Outline

Causes of wandering:

- Overstimulation
- Physical needs
- Pain
- Forgetfulness
- Anxiety
- Boredom
- Environmental factors

Measures to help residents who wander:

- Assess causes, characteristics, helpful measures
- Be firm but kind
- Adjust the environment
- Provide ample activity
- Supervise
- Report incidents and accidents

Related Learning Activities

To reinforce the theory presented in this learning activity, instruct the learners to:

1. Identify at least two residents who wander and discuss the factors that could cause their wandering
2. Guide learners in developing a plan to reduce these residents' wandering based on their unique causes
3. Observe the unit for environmental factors and activities that could contribute to wandering behavior
4. Discuss the impact this has on residents and actions that could be taken to improve the conditions
5. Discuss co-workers' reactions to residents' wandering behavior

Caring for Residents Who Wander

There is a commotion in Mr. Hammond's room. Mrs. Carlson has wandered into his room and is rummaging through his closet. When Mr. Hammond shouts at her to "get out," she repeatedly states, "I've got to find my baby," and continues.

At change of shift rounds, it is noted that Mr. Fitch is not on the unit. A search through the facility fails to find him. The local police are notified and shortly thereafter an officer appears at the facility with him. The officer reports that Mr. Fitch was found walking in the middle of a busy street and when confronted told the officer that "he had to get to work because they could not start without him."

Miss Sippy has just been bathed and dressed and left sitting in a chair in her room, quietly watching television. A short time later, she casually strolls by the nursing station, thoroughly nude.

Situations like these may not be foreign to you if you work in an average long-term care facility. Wandering—the aimless walking of a person who has a cognitive impairment—is a common problem in long-term care facilities. Although it seems to be a harmless act, wandering can be a serious problem. Residents who wander can subject themselves to safety risks by entering unsupervised areas, leaving the facility, or coming in contact with harmful items. They can bother other residents by wandering into rooms uninvited. Residents who wander can also cause themselves more distress due to the anxiety and fear that results when they find themselves in an unfamiliar place or confronted by an unfriendly resident.

Wandering: A Challenge to Staff

Wandering behavior is very challenging for nursing staff. On one hand, accidents and complications related to wandering need to be prevented. On the other hand, unnecessary restraint needs to be avoided and activity promoted. It is important to develop an understanding of wandering behavior and learn helpful approaches to assisting residents who wander.

Causes of Wandering

Residents can vary in their reasons for wandering. In order to assist residents who wander, the underlying causes must be understood. Causes of wandering can include factors in the environment or within the individual, such as:

Overstimulation

Residents who are confused have a difficult time interpreting information that is received through their senses (sight, hearing, taste, touch, and smell). When the stimulation is excessive, this can be particularly overwhelming for these residents. Examples of how this can happen are listed in the box on the next page.

Physical Needs

Residents who have dementias are often unable to understand or express their needs. They may be hungry, tired, thirsty, or in need of toileting but unable to express this. In some cases, their brains may not remember what certain bodily signals, such as the urge to void, mean. The uneasiness or discomfort that results from their unmet need can cause them to pace and wander.

Pain

Anyone who has ever thrashed about in bed because of a bad headache or been unable

to sit still because of gas pains can understand that sometimes pain seems to make it hard to be still. People who are confused may experience pain that stimulates their need to move. Their reduced ability to understand their symptoms and communicate appropriately can prevent their pain from being recognized.

Forgetfulness

The loss of memory accompanies dementia. People with this disorder may not remember which room is theirs or how to retrace their steps. They may begin walking to a destination but before they get there forget where they intended to go. They may want to find an object but not remember where it is. Often, they forget that they live in the facility and believe they have another home to go to. Wandering can result.

Anxiety

Many of us pace when we are nervous. Likewise, anxiety can cause residents to wander. Situations that can contribute to their anxiety include having an unfamiliar caregiver, a change in routine, or a new roommate, or being rushed or unprepared for an activity or procedure.

Boredom

Just as overstimulation can cause wandering, so can understimulation. The lack of companionship and communication can lead residents who are confused to wander for the purpose of seeking human contact. With nothing to do except sit on a chair and stare at a wall, even aimless walking may be preferable.

Environment

The environment can do much to enhance or interfere with residents' function. Common noises can overstimulate and agitate residents, which contributes to wandering behavior. The noise levels of common sounds in the environment are described on the next page. You need to be alert to the fact that although staff may have learned to block out environmental noise, residents will still be bothered by it and suffer ill effects.

Lighting in the environment can be another factor that contributes to wandering. Bright, harsh lights can increase wandering behavior. Soft, nonglaring lighting is best. Odors such as those from cleaning solutions and full bedpans can be annoying to residents who have dementias. These residents may not be able to understand what the cause of their annoyance is and react by becoming agitated and wandering. Busyness also can increase wandering behavior. The heavy traffic flow of staff, visitors, and other residents can overwhelm some residents and contribute to wandering behavior.

The senses can be overstimulated by:

- Bright lights
- Loud noises
- Paging systems
- Monitors or machine noises
- Cold or hot temperatures
- Crowded areas
- Televisions and radios
- Too much talking or movement

Noisy Environments Contribute to Wandering Behavior

A noisy environment can overstimulate the senses. This can be particularly bothersome to the person who has dementia.
A decibel is a unit of sound. Normal conversation falls in the range of 30-–60 decibels (dB). Decibel levels of common sounds in the environment are often much higher:

Refrigerator 40 dB
Paging system 70 dB
Call bell 60 dB
Slamming door 80 dB
Vacuum cleaner 60–85 dB
Loud talking, shouting 80 dB
Ringing phone 60–70 dB
Emergency siren 130 dB

Permanent hearing loss can occur from chronic exposure to noise levels above 85 dB. Noise exposure above 100 dB causes the blood vessels to constrict and raises blood pressure.

Change in Status
People with dementias may be unable to report that they are having palpitations, shortness of breath, gas pains, or strange sensations. The uncomfortable feelings may cause them to pace aimlessly.

Medications can cause side effects, one of which can be a change in mental status. In the person who is already confused, this can be difficult to identify. However, new wandering behavior or a change in wandering can be clues to a drug reaction. Sometimes the change in wandering can be so slight that it is missed by people who do not know the resident well.

How to Help
Many safety risks are present when residents wander. These residents may:

- Exit the facility and become exposed to extreme weather or wander into traffic
- Ambulate without needed assistance and fall
- Become locked in remote parts of the facility
- Violate the privacy of other residents
- Become anxious and fearful because they have wandered into unfamiliar surroundings
- Place extra demands on their bodies through excess activity

Control of wandering behavior aids in preventing these types of incidents and accidents.

Assessment is an important first step to helping residents who wander. Although nurses are responsible for the overall assessment, your input is very valuable. Some of the information that you would want to provide is described on page 5.

Be firm but kind. Because residents who wander tend to have poor judgment and mental function, they need to have direction and limits. In simple terms, tell them what they can and cannot do. Explaining to these residents the reasons why it is unsafe for them to walk outside does little good, as they lack the mental ability to understand and remember. Instead, state a simple "No, do not go to the door."

Adjust the environment. Look for sources of stimulation in the environment and try to reduce them (e.g., loud televisions, bright

lights). Remove objects such as coats and boots that could encourage wandering to unsafe areas. Be sure windows and doors that lead to restricted areas are properly locked. Keep harmful chemicals and toxic agents in secure areas. Even some materials that would not be considered harmful could pose a hazard to residents who accidentally ingest or make contact with them (e.g., fluoride toothpaste, alcohol-based hand sanitizers). The Material Safety Data Sheet (MSDS) is one source of information that contains information regarding the hazards of materials. The location of these sheets varies by facility. They could be located at the nursing station or within the maintenance department; if unsure, ask your immediate supervisor or the facility administrator for assistance.

Provide ample activity. Supervised walks can aid in using up some of the energy that could cause wandering. Consider taking a few residents on walks to other parts of the facility or outdoors. A supervised dayroom or other area in which residents can safely walk can prevent them from wandering to unsafe situations, too.

Some suggestions for helping residents who wander are summarized on the next page.

Tips for Helping Residents Who Wander

Share with the healthcare team what you observe about the resident's pattern of wandering, such as:

- What causes it?
- What times of day does it most often occur?
- What other behavior accompanies it?
- Where does the resident go?
- What seems to reduce the wandering?
- Keep furnishings in the resident's room in the same location.
- Put the resident's photo and name on the bedroom door to assist the resident in finding his or her own room.
- Regularly check on the resident's location and status.
- Control noise on the unit. Use paging systems only when essential and keep televisions and radios from blaring.
- If the facility has an area in which residents can freely wander under supervision, take the resident there.
- Take residents who wander on walks to help use up their energy.
- When planning activities, keep them short. Do not expect these residents to sit or stay in one place for an extended period of time.
- Help keep residents calm and as oriented as possible. Allow them ample time to complete tasks, and offer clear, simple directions.

AADNS Staff Educator – Caring For Residents Who Wander

Knowledge Check

1. Both overstimulation and understimulation can be causes of wandering.
   a. True
   b. False

2. What does exposure to loud noises do?
   a. Lowers the blood pressure
   b. Raises the blood pressure
   c. Does not affect the blood pressure

3. Which is the best method for controlling wandering behavior?
   a. Keeping the resident in a room with the door closed
   b. Using soft restraints to tie the resident to a chair
   c. Taking the resident for a walk

4. Wandering may be related to unmet needs or boredom.
   a. True
   b. False

5. Resident Adams comes to the nursing station and says, "I need to go home so my mother can get me ready for school." What is your best response?
   a. Explain to her that she is a grown woman, her mother is deceased, and she has been out of school for many years.
   b. Tell her, "You need to stay here."
   c. Inform her that there is no fact to her statement and that she must stop making up stories.

For questions 6–10, give five possible *causes* of wandering:

6.
7.
8.
9.
10.

Form the Words

Form words that are examples of the types of things that can overstimulate residents. Hints are provided at the bottom of the page.

1. _ _ _ **W** _
2. _**A** _ _ _ _ _
3. **N** _ _
4. _**D**_ _ _
5. _ **E** _ _ _ _ _ _ _ _ _
6. **R** _ _ _ _
7. _**I** _ _ _ _
8. _ _ _ _ _ _ **N** _
9. _ _ **G** _ _ _

Hints

1. Large group of people
2. Verbal communication
3. Not familiar or old
4. Unpleasant smell
5. Extremes of this cause sweating or chill
6. Can produce pleasant sounds or noise
7. Can be harsh, bright, or glaring
8. Opposite of immobility
9. Done with intercom systems

Caring for Residents Who Wander
With Competency (Credit 1.25 hr)

Initiated 3/3/2025

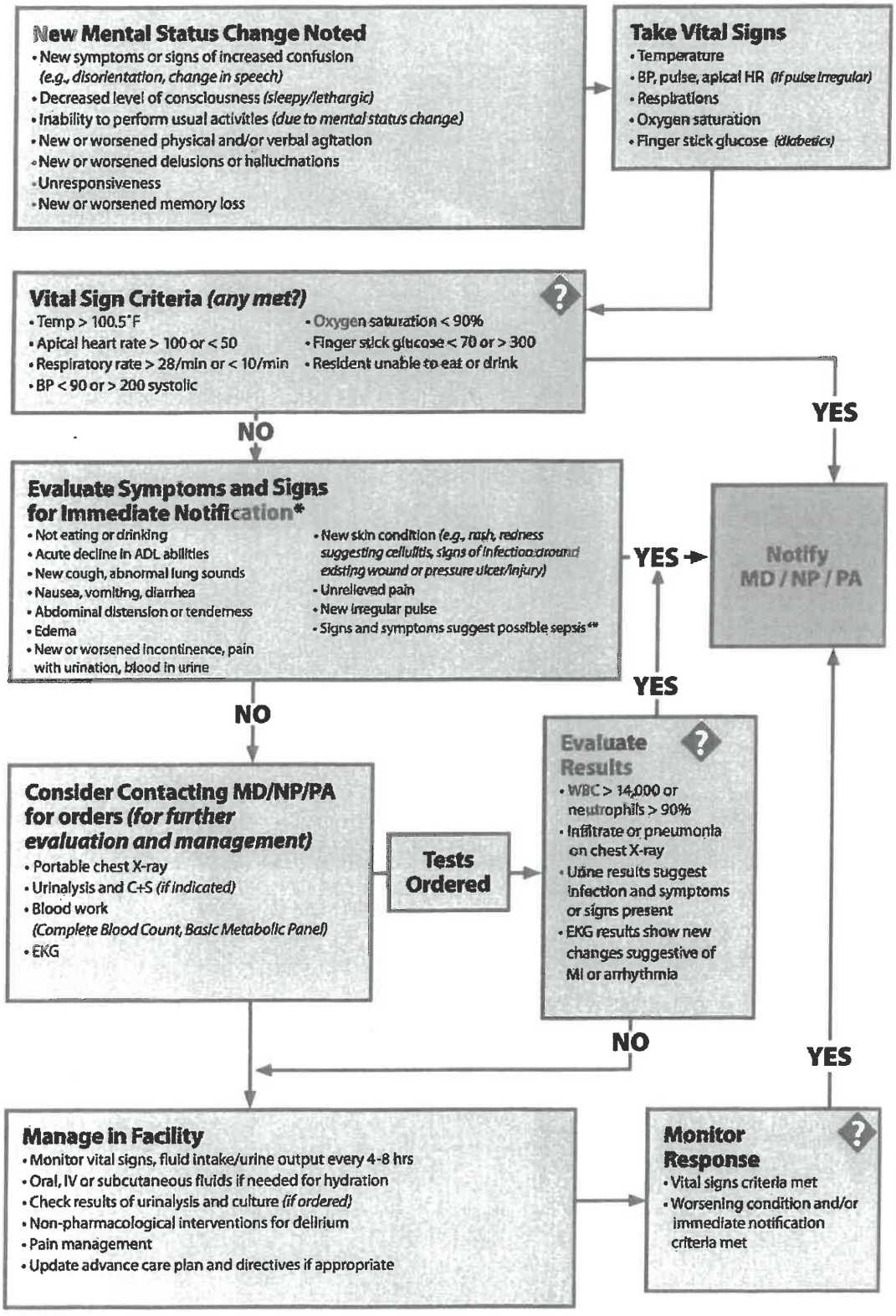
Staff Name	Date Completion	Signature	Supervisor Initial Confirming receipt of competency
Adams, Klijewski, Kimberly	3/3/2025		
Alling, Irene	3/8/2025		
Audet, Jennifer	3/6/2025		
Belanich, Meredith	3/4/2025		
Boothby Hayward, Karalyn	3/5/2025		
Borra, Christine	3/6/2025		
Brochu, Dina	3/7/2025		
Brooks, Kelly	3/7/2025		
Chizmar, Paula	3/11/2025		
Cognato,"Cook", Michelle	3/3/2025		
Cotter, Hannah	3/11/2025		
Davis, Anne	3/11/2025		
Donegan, Caitlyn	3/3/2025		
Farrow, Libby Contract 4/	3/7/2025		
Gatson, Petra	3/5/2025		
Gerry, Marie	3/4/2025		
Goodwin, Leslie	3/5/2025		
Ham, Beth	3/5/2025		
Haycock, Kirsten	3/12/2025		
Hilsinger, Robin	3/9/2025		
Hodge, Eugene Contract	3/19/2025		
Irish, Vanessa	3/8/2025		
Judd, Hope "Susan"	3/6/2025		
Kent, Lori	3/5/2025		
Leavitt, Nicholas	3/15/2022		
Lenth, Brenda	3/5/2025		
Lewis. Carol	3/3/2025		
Macdougal, Julie	3/5/2025		
Mageles, Megan	3/9/2025		
Matos, Ana	3/9/2025		
McCoy, Tiffany Contract	3/6/2025		
Mckay, Taylor	3/5/2025		
Morton, Kirsten	3/10/2025		
Nzwilli, Mercy Contract	3/7/2025		
Okonda, Shonda	3/5/2025		
Perkins, Stacy	3/15/2022		

Rabida, Tammy	3/4/2025	Test	
Richards, Stephanie	3/11/2025	*Test*	
Richards, Stephanie	3/12/2025		
Rowe, Sharon	3/8/2025	Test	
Smith, Tiffany	3/15/2022		
Stubbs, Melissa	3/11/2025		
Trefrey, Christine	3/8/2025		
Walls, Elizabeth	3/5/2025		
Whittemore, Catherine	3/7/2025		
Whitten, Cory	3/7/2025		
Williams, Selena	3/14/2025		
Wilson, Olivia	3/5/2025		
Woodruff, Linda	3/21/2025		
Yorgova-Rosencranse, Ger	**3/16/2025**		

ATTACHMENT #7

CARE PATH *Symptoms of Acute Mental Status Change*

INTERACT
Version 4.5 Tool



** Refer also to other INTERACT Care Paths as indicated by symptoms and signs*

*** If sepsis is been considered, refer to INTERACT Guidance on Possible Sepsis and INTERACT Guidance on Infections*

Using CarePath and Competency
Education Credit 1.0 hr

Staff Name	Date Completion	
Adams, Klijewski, Kimberly	3/11/2025	
Belanich, Meredith	3/17/2025	
Boothby Hayward, Karalyn	3/16/2025	
Brochu, Dina	3/11/2025	
Brooks, Kelly	3/13/2025	
Chizmar, Paula	3/11/2025	
Davis, Anne	3/11/2025	
Farrow, Libby	3/13/2025	
Goodwin, Leslie	3/14/2025	
Hodge, Eugene	3/12/2025	
Kent, Lori	3/11/2025	
Rabida, Tammy	3/13/2025	
Rowe, Sharon	3/17/2025	Texted
Stubbs, Melissa	3/11/2025	
Whittemore, Catherine	3/14/2025	
Yorgova-Rosencranse, Gergana	3/17/2025	

Initiated 3/11/2025