STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	60 MAGNOLIA CASPER, WY 82604

(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 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 8/26/19 to 8/27/19. The survey was prompted by complaint intakes WY00002852, WY00002858, WY00002863, WY00002872, WY00002905, and WY00002919. The following common abbreviations are used through this document: CNA: Certified Nurse Aide DON: Director of Nursing ADON: Assistant Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		9/30/19

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

Electronically Signed | 09/19/2019

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to promote dignity for 1 of 3 sample residents (#3) with incontinence. The findings were: 1. Review of the 7/22/19 quarterly MDS assessment showed resident #3 had diagnoses which included hemiplegia or hemiparesis, and muscle weakness. Further review showed the resident required extensive assistance of 1 person for toilet use and personal hygiene. The following concerns were identified: a. Observation on 8/26/19 at 12:48 PM showed a urine odor was present outside room 14 and resident #3 was in the room, in bed, with his/her eyes closed.	F 550	The facility will ensure residents rights to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. This will be accomplished by: Resident #3 is receiving the required assistance of 1 person for toilet use and personal hygiene. Residents who require assistance with toilet use are at risk. The nursing staff will be educated to the above deficiency. The DON or Designee will audit 10	

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F 550	Continued From page 2 b. Observation on 8/26/19 at 2:32 PM showed the odor remained outside room 14 and the resident remained in bed. c. Observation on 8/26/19 at 3:24 PM showed the resident exited his/her bed and the bedding was visibly wet and smelled of urine. The resident's pants were visibly wet on the outer right side. The resident traveled to an office and spoke with the ADON. d. Observation 8/26/19 at 3:35 PM showed the resident returned to his/her room and the comforter had been pulled up, which made the bed appear to be made. Further observation at that time showed the bed sheets remained wet under the comforter. Interview with the ADON on 8/26/19 at 3:55 PM confirmed the resident's bed sheets were wet and revealed the wet sheets should have been removed before the bed was made. e. Observation on 8/26/19 at 4 PM showed the resident's pants remained wet. f. Observation on 8/26/19 at 4:45 PM showed the resident was in the dining room eating and dinner and his/her pants remained wet. g. Interview with resident #3 on 8/27/19 at 12:07 PM revealed s/he became incontinent when staff did not provide toileting assistance soon enough and s/he didn't "like it" when it occurred. h. Interview with the ADON on 8/26/19 at 5:05 PM revealed staff should assist the resident when his/her pants were wet and confirmed the pants were wet at that time. i. Interview with the assistant administrator on 8/27/19 at 5:45 PM revealed staff should strip a resident's bed if it is wet and should change a resident when his/her clothing was wet.	F 550	random residents each week to ensure proper toileting assistance is provided. Immediate correction will be initiated when deficient practice is noted. Results of audits will be reviewed at monthly QAPI meetings X 3 months to address findings and determine continuation.	
F 641	Accuracy of Assessments	F 641		9/30/19

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F 641 SS=D	Continued From page 3 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 medical record review and staff interview, the facility failed to ensure MDS assessments were accurate for 1 of 5 sample residents (#1) reviewed for MDS accuracy. The findings were: 1. Review of the admission MDS assessment dated 7/1/19 showed resident #1 was admitted on 6/24/19 and had diagnoses which included delirium due to known physiological conditions. Further review showed the resident was not coded as having verbal, physical, or other behavior symptoms. Review of the care area assessment dated 7/9/19 showed the resident did not trigger for behavior symptoms or indicate the facility should proceed with care planning. The following concerns were identified: a. Review of the admission progress note dated 6/24/19 and timed 4 PM showed "...Has medication allergies to Sulfa drugs-which resident believes is the same class as sodium (paranoid belief that [s/he] is allergic to sodium, being the same thing as sulfa). Family reports that resident has been refusing medications but will take if crushed and mixed with yogurt/pudding/ice cream-they give permission to give resident medications without telling [him/her] what they are...Resident repeatedly has stated that [s/he] wants to be home and not here, but family states [s/he] will not try to leave unless with family..." b. Review of a progress note dated 6/26/19 and timed 8:35 AM showed "...This RN tried to	F 641	The facility will ensure MDS assessments are accurate. This will be accomplished by: Resident #1 no longer resides at the care center. IDT will review each resident to ensure that dx of delirium is properly addressed on the MDS and benefit from appropriate care planning. The MDS staff will be educated to the above deficiency. The DON or Designee will audit 10 random resident MDS's each week to ensure they accurately reflect the resident. Immediate correction will be initiated when deficient practice is noted. Results of audits will be reviewed at monthly QAPI meetings X 3 months to address findings and determine continuation.	

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F 641	Continued From page 4 administer resident [his/her] AM medications, resident started screaming, yelling and slapping at staff. Resident stated [s/he] was not going to take anything and to get the hell out. This RN will try again later to get resident to take [his/her] medications." c. Review of a progress note dated 6/26/19 and timed 3:51 PM showed "Resident has continued to refuse all [his/her] medications today, RN was unable to get [him/her] to take them with, sherbet, yogurt or anything, I crushed them and put it in tomato soup and resident still would not eat [his/her] soup as we are poisoning [him/her]." d. Review of an administration note dated 6/27/19 and timed 5:05 AM showed "...Resident refused blood glucose. Resident states, "That would make me dead."..." e. Review of a progress note dated 7/1/19 and timed 5:44 AM showed "...Resident has been going into other residents [sic] rooms. Came out of room yelling at staff telling staff [s/he] eats with dead people. Resident is on the phone right now with one of [his/her] daughters talking nonsense Stating everyone her [sic] has fake names. Resident thinks that resident in room 202 is [his/her] sister and keeps looking for her. Staff has tried to redirect resident without success..." 2. Interview with the DON on 8/27/19 at 6:40 PM revealed the resident's MDS assessment was not accurately coded and should have included the behaviors. Further, she confirmed the behavior care area assessment should have triggered so the facility could proceed with care planning.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		9/30/19

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F 645	Continued From page 5 §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was	F 645		

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F 645	Continued From page 6 transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASSAR) level I & II was performed for 1 of 3 sample residents (#2) with a qualifying diagnosis. The findings were: Review of the medical record for resident #2 showed the resident was admitted to the facility on 5/20/15. Review of the care plan showed a care plan was initiated on 8/27/15 for a diagnosis	F 645	The facility will ensure there is preadmission screening for individuals with a mental disorder and individuals with intellectual disability. This will be accomplished by: Resident #2 has been screened with a PASARR level II. Residents have been reviewed for qualifying screening criteria of the	

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F 645	Continued From page 7 of depression. Further review showed the resident had diagnoses which included other developmental disorders of speech and language and major depressive disorder. Review of the resident's PASARR assessments showed a level I was completed on 3/1/15 and 5/20/15 and the assessments indicated the resident did not have any diagnoses related to mental illness and mental retardation. Review of a PASARR Level I completed on 5/29/19 showed the resident was marked as having a psychiatric diagnosis and a diagnosis of mental retardation or developmental disability. Further review showed the 5/29/19 PASARR triggered the completion of a PASARR level II. Interview with the assistant administrator and the admission coordinator on 8/27/19 at 6 PM revealed a PASARR level I should be completed upon admission, significant change, or with a new diagnosis and confirmed the PASARR assessments completed for resident #2 prior to 5/29/19 were not accurate. Further interview revealed the resident should have had a PASARR level II requested when the resident received the major depressive disorder diagnosis.	F 645	PASARR I and/or II and a PASRRI or PASRRII was initiated for identified residents. Admissions Coordinator will generate a weekly report to identify any changes in diagnoses and initiate necessary screenings. The Admissions Coordinator and Social Service Director have been educated to the above deficiency. The ED or designee will audit 10 random resident records each week to ensure residents who trigger a PASARR I or II are accurately completed. Immediate correction will be initiated when deficient practice is noted. Results of audits will be reviewed at monthly QAPI meetings X 3 months to address findings and determine continuation.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		9/30/19

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F 690	Continued From page 8 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure residents received timely toileting assistance for 1 of 3 sample residents (#3) with incontinence. The findings were: 1. Review of the 7/22/19 quarterly MDS assessment showed resident #3 had diagnoses which included hemiplegia or hemiparesis and muscle weakness. Further review showed the resident required extensive assistance of 1 person for toilet use and personal hygiene. The following concerns were identified: a. Observation on 8/26/19 at 12:48 PM	F 690	The facility will ensure residents who are continent of bladder and bowel will receive timely toileting assistance. This will be accomplished by: Resident #3 is receiving timely toileting assistance and incontinent care including the changing of clothing and bed linens. Residents who require assistance with toilet use and hygiene are at risk.	

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F 690	Continued From page 9 showed a urine odor was present outside room 14 and resident #3 was in the room, in bed, with his/her eyes closed. b. Observation on 8/26/19 at 2:32 PM showed the odor remained outside room 14 and the resident remained in bed. c. Observation on 8/26/19 at 3:24 PM showed the resident exited his/her bed and the bedding was visibly wet and smelled of urine. The resident's pants were visibly wet on the outer right side. The resident traveled to an office and spoke with the ADON. d. Observation 8/26/19 at 3:35 PM showed the resident returned to his/her room and the comforter had been pulled up, which made the bed appear to have been made. Further observation at that time showed the bed sheets remained wet under the comforter. Interview with the ADON on 8/26/19 at 3:55 PM confirmed the resident's bed sheets were wet and revealed the wet sheets should have been removed before the bed was made. e. Observation on 8/26/19 at 4 PM showed the resident's pants remained wet. f. Observation on 8/26/19 at 4:45 PM showed the resident was in the dining room eating dinner and his/her pants remained wet. g. Interview with resident #3 on 8/27/19 at 12:07 PM revealed s/he became incontinent when staff did not provide assistance soon enough and s/he didn't "like it" when it occurred. h. Interview with the ADON on 8/26/19 at 5:05 PM revealed staff should assist the resident when his/her pants are wet and confirmed the pants were wet at that time. i. Interview with the assistant administrator on 8/27/19 at 5:45 PM revealed staff should strip a resident's bed if it is wet and should change a resident when his/her clothing was wet.	F 690	The nursing staff will be educated to the above deficiency. The DON or Designee will audit 10 random residents each week to ensure proper and timely toileting assistance is provided. Immediate correction will be initiated when deficient practice is noted. Results of audits will be reviewed at monthly QAPI meetings X 3 months to address findings and determine continuation.	

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F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure behavioral health services were provided to 1 of 3 sample residents (#1) with identified behaviors. The findings were: 1. Review of the admission MDS assessment dated 7/1/19 showed resident #1 was admitted on 6/24/19 and had diagnoses which included delirium due to known physiological conditions. Further review showed the resident was not coded as having verbal, physical, or other behavior symptoms. Review of the care area assessment dated 7/9/19 showed the resident did not trigger for behavior symptoms or indicate the facility should proceed with care planning. The following concerns were identified: a. Review of the care plan last revised on 7/9/19 showed the resident used psychotropic medications and the facility was monitoring for side effects of the medication; however, there was no evidence the facility identified specific target behaviors for the medication use. Further review showed there was no indication	F 740	The facility will ensure each resident receives necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This will be accomplished by: Resident #1 is no longer residing in the care center. Residents receiving antipsychotic medication will benefit from the identification of specific target behaviors for the medication use as well as ensuring non-pharmacological interventions were implemented and care planned. Nursing Staff, MDS Coordinators and IDT including all Social Service staff will be educated to the above deficiency. The facility will utilize an Interdisciplinary team to convene a weekly “Psychotropic Meeting” in which a quarterly review of all	9/30/19

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F 740	Continued From page 11 non-phamalogical interventions had been implemented. b. Review of the admission progress note dated 6/24/19 and timed 4 PM showed "...Has medication allergies to Sulfa drugs-which resident believes is the same class as sodium (paranoid belief that [s/he] is allergic to sodium, being the same thing as sulfa). Family reports that resident has been refusing medications but will take if crushed and mixed with yogurt/pudding/ice cream-they give permission to give resident medications without telling [him/her] what they are...Resident repeatedly has stated that [s/he] wants to be home and not here, but family states [s/he] will not try to leave unless with family..." c. Review of a progress note dated 6/26/19 and timed 8:35 AM showed "...This RN tried to administer resident [his/her] AM medications, resident started screaming, yelling and slapping at staff. Resident stated [s/he] was not going to take anything and to get the hell out. This RN will try again later to get resident to take [his/her] medications." d. Review of a progress note dated 6/26/19 and timed 3:51 PM showed "Resident has continued to refuse all [his/her] medications today, RN was unable to get [him/her] to take them with, sherbet, yogurt or anything, I crushed them and put it in tomato soup and resident still would not eat [his/her] soup as we are poisoning [him/her]." e. Review of an administration note dated 6/27/19 and timed 5:05 AM showed "...Resident refused blood glucose. Resident states, "That would make me dead."..." f. Review of a progress note dated 6/28/19 and timed 1:14 PM showed "...Family voiced concern yesterday, 06-27-19, regarding this patient calling [his/her] family members at all	F 740	residents receiving antipsychotic medications are reviewed for identification of target behaviors as well as non-pharmacological interventions. The Social Services Director or designee will audit 10 random residents each week to ensure that residents with behavioral health needs are identified, interventions put in place including non-pharmacological and care planned. Immediate correction will be initiated when deficient practice is noted. Results of audits will be reviewed at monthly QAPI meetings X 3 months to address findings and determine continuation.	

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	535042	A. BUILDING _____ B. WING _____	C 08/27/2019

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hours of the night. Daughter asked if staff could help patient turn [his/her] phone off at night. I explained that we can offer assistance to turn [his/her] phone off with patient's permission. This nurse then put reminder in [the resident's] MAR. Today, daughter reports that patient did call family member last night at 1 AM. RN explained to family that staff is not allowed to take [the resident's] phone away, they voiced understanding. They said they will try to block patient's phone number (On their own phone) during night time hours..."

g. Review of a progress note dated 7/1/19 and timed 5:44 AM showed "...Resident has been going into other residents [sic] rooms. Came out of room yelling at staff telling staff [s/he] eats with dead people. Resident is on the phone right now with one of [his/her] daughters talking nonsense Stating everyone her [sic] has fake names. Resident thinks that resident in room 202 is [his/her] sister and keeps looking for her. Staff has tried to redirect resident without success..."

h. Review of a physician note dated 7/5/19 and timed 8:28 AM showed "...Following up on [resident's name] due to [his/her] history of hyponatremia and psychosis. Per nursing staff [s/he] continues to have behaviors of agitation and aggressiveness towards others as well as speaking of dead people that [s/he] sees and speaking of people that were killed or people that [s/he] did not kill. When I saw [him/her] today [s/he] was also speaking to [him/herself] and answering to [him/herself] as well to in regards to the above subject matter. [S/he] seems to have a sense of impending doom that [s/he's] going to die soon and that something is wrong with [him/her] that [s/he] does not know what it is. Also I had a thorough discussion with the daughter today, [name] on the phone

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regarding these behaviors and the fact that they have not improved despite slight improvements in [his/her] sodium levels which we had originally anticipated as a cause for [his/her] symptoms... [Resident's name] is an unreliable historian due to [his/her] psychosis but [his/her] daughter states there is no family history of psychiatric disorders. There is some remote family history of dementia..."

i. Review of a progress note dated 7/5/19 and timed 10:52 PM showed"...Resident noted to be entering other resident room and removing items not belonging to [him/her]. When attempt to redirect resident, resident becomes verbally aggressive and yells at staff. If redirection continues resident gets louder and louder..."

j. Review of a progress note dated 7/7/19 and timed 12:24 AM showed "...Resident seems to have extreme agitation, threatening to harm self and others, yelling and screaming, lashing out, irrational thoughts, and throwing objects. Resident has papers and clothes thrown throughout the room. Resident noted to be in and out of other resident rooms. Resident is redirected, but not easily. Resident noted to be banging on walls and yelling, "Get up, I don't want you dead." Resident again is redirected. Resident states [s/he] will kill staff with this redirection. Resident has shown poor impulse control and almost falls. Resident noted to be uncooperative at times and does show hostility with staff interactions. Resident noted to be turning the bathroom light on and off and states, 'I wonder how long it will take for someone to answer this light.' When staff answers the light all needs are met, however, resident turns bathroom call light on as staff exits the room. When staff approach resident, resident is noted to be standing in the way of the call light and states [s/he] does not

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need anything but will not allow staff to turn the light off. Resident noted to be verbally aggressive toward staff. These behaviors are lasting into the early morning hours. This is the second night in a row with these types of behaviors. Please advise..."

k. Review of a progress note dated 7/7/19 and timed 8 AM showed "...This RN took resident breakfast into [him/her], found resident with a glass of ice water, soiled wipes with feces on them in the cup and resident was drinking the water. Resident stated this is [his/her] special potion that heals [him/her]. RN attempted to talk resident into giving up the cup and drinking [his/her] orange juice, the CNA'S were able to get it from [him/her] and throw it out, am unsure of how much [s/he] drank. Resident is also going into other residents room and taking their wipes, other resident are complaining about this residents disruptive behaviors..."

l. Review of a progress note dated 7/7/19 and timed 6:06 PM showed "...Pt [patient] noted to be pounding on the walls in the hallway out side [his/her] room with [his/her] hands and quad cane. [S/he] also hits the walls in [his/her] room as stated by [his/her] neighbors..."

m. Review of a progress note dated 7/10/19 and timed 8:30 AM showed "...Reported by staff that resident has had increased behaviors throughout the night with suicidal behaviors. Resident has tried to push the AC out of [his/her] window and stated [s/he] was going to 'follow it out', also had a plastic trash bag over [his/her] head and stated to the staff 'I am dead'. This AM CNA noted [him/her] to have a call light cord wrapped around [his/her] neck. All items have been removed from resident room and 1:1 placed with [him/her] for safety. Resident has also been pounding on the walls and other resident doors

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and hollering loudly in the hall. Refuses to allow staff to assist [him/her] with cares, give meds, etc...[Physician] notified and received order to send resident to ER due to psychosis and suicidal actions. Spoke with residents daughter, [name] and let her know that we were sending [him/her] to the ER and she was in agreement and stated that she would meet [him/her] there but she wanted [him/her] to go by emergent..."

n. Review of a progress note dated 7/10/19 and timed 10:30 AM showed "...Resident has been observed by CNA this morning on 3 separate occasions performing self-harming behaviors of attempting to kick out [his/her] air conditioning unit from the window, stating [s/he] was going to go out the window behind it (being a 2 story drop to the ground), placing a garbage bag over [his/her] head and stating to the CNA 'Can't you see I'm dead?', and wrapping the call light cord around [his/her] neck. CNA's performed a safety sweep in resident's room between [his/her] placing the bag over [his/her] head and wrapping the call light cord around [his/her] neck. Dangerous items were removed from room. 15 minute checks initiated and nursing management placed resident with 1:1 observation. This writer called resident's daughter, [name], shortly after resident wrapping call light cord around [his/her] neck, as it was a very short time (approximately 15-20 minutes) between the garbage bag and call light cord. Explained all 3 self-harming behaviors to [name] and explained that we would be getting resident evaluated for being a harm to self/others. Nursing manager, [name], was in contact with [physician] who gave a verbal order to have resident evaluated in ER for safety...LPN staff member placed the call to 911 and explained behaviors and doctor recommendation. Three police officers responded and interviewed

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resident. They determined resident would go to the ER for evaluation. When they told the resident that [s/he] would be going to the ER, resident became instantly verbally aggressive and attempted to run away from the officers. Two of the officers were able to stop the resident from running and attempted to calm [him/her] down, unsuccessfully. Resident continued to resist the officers, who placed her in handcuffs. Resident was escorted out of the facility with 2 of the officers in a wheelchair...

o. Review of the physician orders for July 2019 showed the resident was ordered Seroquel 12.5 milligrams by mouth 2 times per day related to delirium due to known physiological condition. Further review showed there was no evidence target behaviors were identified.

2. Interview with the DON on 8/27/19 at 6:40 PM revealed the resident did not have any behavioral health services ordered while at the facility and confirmed there were no identified target behaviors for the use of the Seroquel.