STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E210	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Mental Health	500 Peabody Peabody, KS 66866

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 43 residents, with six residents sampled and one resident reviewed for the right to be free from physical restraints. Based on interview and record review, the facility failed to ensure Resident (R) 3, who had a history of self-harm and physically and verbally aggressive behaviors, remained free of physical or chemical restraints when on 09/18/24, 09/19/24, and 09/20/24 the resident attempted to injure himself and became combative with staff and the facility staff chemically and physically restrained the resident. The facility failed to identify the resident's medical/behavioral symptoms that warranted the use of chemical restraint, physical restraint of five to six staff, and the use of a bedsheet to further restrain the resident. The resident's record lacked any physician orders related to the use of the restraints, any specific documentation related to assessment of the resident for restraint use and/or person-centered care planning, which included the use of a physical restraints or the least amount of restriction/time possible and/or ongoing evaluation. This deficient practice placed R3 in immediate jeopardy. Findings included: - The Medical Diagnosis tab for R3 included diagnoses of bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods) with psychotic features, major depressive disorder (major mood disorder which causes persistent feelings of sadness), attention deficit hyperactivity disorder (ADHD - a chronic condition including attention difficulty, hyperactivity, and impulsiveness), post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), and autistic disorder (a developmental disorder that impairs the ability to communicate and interact). The Admission Minimum Data Set, dated dated dated [DATE], revealed the facility did not assess R3's Brief Interview for Mental Status and did not complete the staff assessment for mental status. R3 did not have any hallucinations (sensing things while awake that appear to be real, but the mind created) or delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) during the assessment period, and no behavioral symptoms or rejection of care. R3 did not require restraints. The Psychotropic Drug Use Care Area Assessment (CAA) dated 09/11/24, revealed R3 had a baseline for delusions and hallucinations. R3 required psychiatric medications on a daily basis. R3 did not trigger for further development of the following CAA's: Cognitive loss/Dementia, Psychosocial Well-being, Mood, Behavioral symptoms, or Physical Restraints. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER: Access Mental Health		STREET ADDRESS, CITY, STATE, ZIP CODE: 500 Peabody, Peabody, KS 66866	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Care Plan dated 09/18/24, revealed R3 had behavior problems related to impulsivity and poor judgement. The staff were to monitor behavior episodes and attempt to determine underlying causes, provide a program of activities that was of interest, accommodate his status, and assist R3 to develop more appropriate methods of coping and interacting. R3's preferred activities were watching television, going on outings, and playing video games. He had the potential to be verbally aggressive and threatening others on social media related to ineffective coping skills, poor impulse control, and severe and persistent mental illness (SPMI - a group of mental health disorders that cause significant functional impairment). When R3 became agitated the staff were to intervene before agitation escalated, guide him away from source of distress, engage calmly in conversation, and if response was aggressive the staff were to walk calmly away and approach later. On 09/23/24, the facility added R3 was physically aggressive related to anger and poor impulse control and the trigger identified was anxiety related to legal issues and R3's behaviors were de-escalated by medication/sedation and physical restraint by personnel. On 09/18/24, R3 was upset about violating a PFA (protection from abuse) order and wanted to go to jail and turn himself in. The staff advised R3 it was still in the investigation stage, and he did not need to worry about it. R3 threw desk tools, a hole punch, and a water bottle that was in Administrative Nurse's D's office. R3 tried to stab himself and staff with a pen and made several threats he was going to harm himself and others. The event lasted three hours. The facility called the Sheriff to assist and had the resident screened for placement at a hospital, which treats adults diagnosed with psychiatric disorders. R3 calmed down with medications and placement was deferred as he did not meet current criteria for admission. The facility placed R3 on one-to-one monitoring and his medications were reviewed and adjusted by the psychiatric provider. On 09/19/24, R3 called 911 and stated he was going to blow up the (specified name) county courthouse. The facility advised R3 it was illegal to make threats like that and that it would not help his court case. R3 became aggressive stating he was going to hurt everybody. R3 threw items from the desk and five staff members restrained R3, sedated him, and four hours later he ceased trying to hurt other and himself. The facility called the Sheriff, had him screened for hospital placement and accepted, however, on a waiting list. After several hours the facility receive information that another local mental health facility would take R3 until he could be placed and required medical clearance. The facility took R3 to a local hospital where R3 was medically cleared, however the local mental health facility rejected the admission and R3 returned to the facility where he was placed on one-to-one and medicated with Haldol (antipsychotic - class of medications used to treat major mental conditions which cause a break from reality) and Ativan (antianxiety - class of medications that calm and relax people). On 09/20/24, R3 was medicated all day but was able to function, walk in the hall, go to meals, and watch television. R3 became angry and violent as he was upset another resident was on the phone he wanted to use and R3 stated he was going to hurt all the (explicit language) and called everyone a (explicit language). The care plan revealed the staff placed R3 in a chair and took him to Administrative Nurse D's office where he had to be physically restrained as he was biting, spitting in staff's face, head butting, and trying to punch, kick, and pinch. The facility called the Sheriff to assist, utilized intramuscular injection of Haldol and Ativan, and R3 was taken to the local hospital where he was admitted . Record review of R3's Electronic Medical Record (EMR) lacked a physician order to the facility to physically restrain R3. (continued on next page)

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	17E210	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Mental Health	500 Peabody Peabody, KS 66866

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Notes dated 09/17/24 at 07:33 PM, by Administrative Staff A revealed the staff removed R3's PlayStation per the request of his Guardian since R3 violated the no contact order and emailed the person who had the no contact order against him over five times on 09/16/24 and 09/17/24, threatening that person and saying hateful things, and caused the facility she was at to be placed on lock down due to R3's threats. The facility staff and the Guardian spoke with R3 regarding complying with the no contact order and why the PlayStation had been removed. The Progress Notes dated 09/18/24 at 01:49 AM, by Administrative Nurse D revealed R3 was up in the hall pacing with repetitive motion of hands. R3 stated he did not want to go to jail. R3 was advised he needed to stop worrying about things in the world he cannot change. R3 stated he was stupid and did not know what to do. R3 continued to say over and over he did not know what to do while pacing the floor. Administrative Nurse D called Administrative Staff A, then administered lorazepam (Ativan) for agitation. The Progress Notes dated 09/18/24 at 01:59 AM, by Administrative Nurse D revealed resident was in bed sleeping and talking in his sleep. The Progress Notes dated 09/18/24 at 04:27 PM, by Licensed Nurse (LN) G revealed R3 paced a lot today and when he started talking to Administrative Nurse D, he became very anxious, started twisting his hands fast, crying, and picking at his arms. R3 became more agitated so Administrative Nurse D called Administrative Staff A who ordered clonazepam (benzodiazepine class of medication - depressant medication that produces sedation and can be used to treat anxiety), every evening at 04:00 PM, for seven days. The staff administered the medication. The Progress Notes dated 09/18/24 at 05:07 PM, by Administrative Nurse D revealed R3 was upset and believed there was a warrant out for his arrest, could not wait for them to come get him, could not go to prison, and stated he knew he did wrong. Administrative Nurse D asked the resident not to worry about what he cannot change and R3 stated he was so screwed. R3 then switched to being bored, needed his PlayStation stating his Guardian did not have the right to take his stuff, and stated he could not live without his gaming system. R3 stated he needed someone to give back the PlayStation, then said he was killing his Guardian and hated everyone. R3 was scratching his arm, making rapid movements back and forth and was given clonazepam, one milligram. After 15 minutes, R3 started to settle down, talking quietly, and stated he was hungry. Then R3 became loud, insisted he had nothing to live for, wanted to kill himself, became belligerent and combative, then started to hit his head with fist, bang his head on the wall, and hit his face with his knee. Five staff assisted to restrain R3 from hurting himself. R3 was crying, yelling, relentless to hurt self, and tried to staff himself with a paperclip. R3 was given Haldol, five milligrams (mg), intramuscular, for agitation. R3 slowed down after 15 minutes remaining awake and alert, continued to need someone to hang onto him, screened for aggressive behavior, with request it be rushed. The Progress Notes dated 09/18/24 at 05:12 PM, by LN G revealed R3 had been in Administrative Nurse D's office much of the afternoon talking about the consequences of his behaviors, worked up, and sobbing. He then started hitting himself and tried to injure himself and the staff tried to hold him. R3 required clonazepam, orally, and Haldol, IM this afternoon and was a little calmer now. Call made (specified name) for a screen (lacked what type) for him. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Notes dated 09/18/24 at 07:03 PM, by Administrative Nurse D revealed a call back received from (specified organization) to advise because of R3's diagnosis of intellectual and developmental disability- (IDD- a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life), he did not qualify to go to the state hospital. The Progress Notes dated 09/18/24 at 10:33 PM, by LN I revealed R3 was one-on-one for behaviors, was in his bed, he was being monitored every 15 minutes sitting outside his door, and he was sleeping. The Progress Notes dated 09/19/24 at 07:09 PM, by LN G revealed a call received from Administrative Staff A on how R3 was doing now and told he was still sleeping. Administrative Staff A ordered haloperidol (Haldol), five mg, by mouth, every day, for seven days, for psychotic behaviors. The Progress Notes dated 09/19/24 at 04:19 PM, by LN G reveled R3 was calm today and had good insight on how things worked and could calmly discuss his situation with staff. R3 was currently resting in bed. The Progress Notes dated 09/19/24 at 06:01 PM, by LN H revealed R3 continued yelling out I am going to kill you (explicit language), I will find you and I will kill you. R3 stated he wanted to be like all the men in his family, they were in jail or the penitentiary and we were all going to pay. The Progress Notes dated 09/19/24 at 06:15 PM, by Administrative Nurse D revealed R3 called 911 and reported he was going to bomb the (specified place). R3 was confronted with calling in a terroristic threat, he became agitated, stated he was going to kill his (specified family member), myself, and other people. R3 stated he was in a gang and wanted to go to prison and he violated the PFA, so he deserved the death penalty. R3 became increasingly agitated and started to throw objects at staff such as water bottles and clipboards, then grabbed a pen and stabbed Administrative Nurse D in the leg. Other staff members (lacked names) responded while R3 was throwing things from the shelves and the desk, he tried to punch staff, pinch, kick, spit in staff's face, and tried to head butt. R3 was placed in a sheet restraint to protect self and others, hands restrained, resident very wild and not listening to anyone. Resident broke free of sheet restraint and slid to floor. Resident required several people to sit on his legs and arms to control resident from hurting himself and others. R3 was given Haldol, five mg, and Ativan, one mg, to decrease agitation. R3 continued to fight and threaten to kill people. Sheriff officers arrived and assisted to keep R3 from hurting himself and others. After given Haldol, 15 mg, and Ativan, four mg, and three hours later R3 was calmer. After helped to a chair R3 complained of being thirsty, provided water and when water was gone, he threw ice and glass at Administrative Nurse D and tried to stab her with a pen. R3 was given another mg of Ativan and then began to calm down. R3 was screened by (specified organization), was awake and alert, answered questions, and tried again to stab a nurse (lacked name) with a pen. Police were still here assisting with restraining R3, who began to hit himself and police officers while calling them names. R3 banged head with knee several times stating he wanted to kill himself. R3 given Ativan, two mg at 10:30 PM, and then he asked to go to bed as he was very sleepy. R3 assisted to bed and was dozing with a one-to-one staff member. The Progress Notes dated 09/19/24 at 11:00 PM, by Administrative Nurse D revealed (specified organization) screener called to do screening and since R3 escalated to harming others as well as himself he was to be sent to the state hospital. (continued on next page)

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Access Mental Health	500 Peabody Peabody, KS 66866

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Notes dated 09/20/24 at 01:19 AM by LN H revealed R3 left the facility and was being transported (lacked by who) to the local hospital. The Progress Notes dated 09/20/24 at 05:20 AM by LN G revealed R3 was out of control and was physically and verbally aggressive. Administrative Nurse D spent five hours in the screening process. R3 was taken to local hospital as instructed once made aware R3 was too acute, and they denied him. The Progress Notes dated 09/20/24 at 01:06 PM, by LN J revealed R3 rested in bed most of the day, continued to be a one-on-one at this time, and new orders were noted for Ativan, two mg, by mouth, every two hours. The Progress Notes dated 09/20/24 at 04:31 PM, by LN J revealed the order for Ativan changed to one mg tablet or 1 mg/0.5 milliliters (ml) IM, every three hours. The Progress Notes dated 09/20/24 at 06:30 PM, by Administrative Nurse D on 10/07/24 at 09:55 PM, revealed R3 was waiting for the phone and upset that another resident was using the phone. R3 yelled to the resident to get off the phone (explicit language) that he needed to use it. R3 was directed to Administrative Nurse D's office to use the phone and advised not to call names, the phone was a community phone, and needed to be shared. R3 picked up a hole punch and tried to hit Administrative Nurse D, and it was taken away by Certified Nurse Aide (CNA) O. R3 turned to hit CNA O and Administrative Nurse D, pushed (lacked name) an office chair underneath R3 to try and calm him. R3 stated he was going to kill everyone here, torture other (explicit language), stated he wanted to be a criminal like his biological family, and began to hit and bite staff. A speakerphone used to call 911 as R3 was hitting, kicking, spitting, pinching, biting staff and himself. R3 tried to raise his knee to his head to headbutt himself and continued to threaten to hurt staff and others. R3 made several connections that caused injuries to all six staff members. The staff placed a sheet over R3's arms and chest to prevent him from hurting himself and others. R3 continued to spit, a small corner of the shift placed over his face, and a Sheriff arrived and assisted to try and keep R3 safe as he was still trying to hurt himself and staff and call racist names. Administrative Staff A came to assess situation as we had been trying to find placement elsewhere all day. The Sheriff was unable to arrest or press charges and R3 stated they could not do anything and continued to try and injure the officer and the staff. Another state hospital was unable to take R3 because he was not in a catchment area and advised to have R3 arrested. The Sheriff suggested to take R3 to the local hospital as they can call another county Sheriff to arrest. Administrative Staff A took R3 to the local hospital. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/17/24 at 04:06 PM CMA R stated R3 was suicidal and very combative (could not recall date), spitting at us, kicking, and at one point he grabbed a pen and tried to stab Administrative Nurse D. CMA R stated R3 had a PFA order on him and R3 contacted the person the PFA was related to, we told R3 he could not do that, and we took the game system away so he could not contact that person. The next night, R3 would be okay one minute and the next minute he was going off the charts cussing (explicit language). CMA R stated R3 was in Administrative Nurse D's office .and he was trying to destroy the whole room. CMA R stated CNA M, Administrative Nurse D, and herself were in the office with R3 holding his hands down with ours so he could not hit us when two members from law enforcement came. CMA R stated R3 was sweaty from all the commotion, and we put a sheet across his arms, it was never tied, while sitting in a chair with his arms to his sides. CMA R stated the sheet went across his stomach and lower arms and kept in place for 15 to 20 minutes while Administrative Nurse D held it. CMA R stated at one point, R3 calmed down and they removed the sheet, he was calm and just sit there then all of a sudden, he would start throwing things. CMA R stated she was sitting on R3 in the chair, R3 was trying to get up, and we did not want him to get up and go where everybody else was. CMA R stated R3 tried to get up and scooted himself out of the chair and R3 and her both went to the floor and during that time he was kicking trying to destroy a monitor or television on a shelf and law enforcement held his feet down. CMA R stated she usually take her break at 06:00 PM and when she returned that night, she had heard the commotion and R7 stated they needed our help and at that time R3 and Administrative Nurse D was in Administrative Nurse D's office. After R3 was in the office for a while, he asked to go to his room and go to bed and law enforcement walked R3 to his room, one stayed and talked to R3 for a bit then he fell asleep, and we did one-on-one with him. On 10/07/24 at 04:35 PM, CNA N recalled a night when R3 was upset in Administrative Nurse D office, he would calm down for a little bit, then get agitated again. CNA N stated R3 started throwing things and Administrative Nurse D held a sheet in place so R3 would not hit while CNA N got him to calm down then the sheet was not used again. CNA N stated R3 was sitting in a chair and LN H and Administrative Nurse D tried to keep R3 from getting up by using their hands. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/07/24 at 04:48 PM, Administrative Nurse D stated on 09/19/24, every staff member she had on 09/19/24 and 09/20/24, held R3's hands, as it took 45 minutes for law enforcement to show up. Administrative Nurse D both days R3 came in my office, and you could see in his eyes, this kid go from Dr. Jekyll to Mr. [NAME] and when asked if he was alright, he picked up a [NAME] cup and threw it hitting my head and then started to tear everything off of my desk. Administrative Nurse D stated she thought the staff, CNA M, doing one-on-one was with him, and R3 went ballistic tearing things off my desk, throwing things after told to settle down, tried to stab at me, bit my finger. Administrative Nurse D stated the sheet I put across him. I held on to it, never tied. Basically, a band to keep his arms down. Administrative Nurse D stated R3 would try to hit them, and they did hold him with their hand on top of his and used the least amount of force we could then R3 struggled, for I don't know how long and we were having a terrible time trying to get R3 to calm down, he was given Ativan and Haldol. Administrative Nurse D stated she did not want R3 to hurt himself or her staff and he tried to bite himself, hit himself in the head, head butts against us, and on 09/20/24 he brought in an electric razor and was going to stab me, but law enforcement took it. R3 had cleared off the counter and grabbed different objects, throwing a stapler that hit my shoulder, and threw ice at me, calling us names. Administrative Nurse D stated at one point on 09/19/24 R3 was on the floor, law enforcement showed up, we let loose of the sheet, and R3 popped up and hit the officer and back down he went, where he was on the floor for about 15 minutes, hitting, scratching, kicking, clearing things off the desks in the room and basically the officer pinned him down. R3 tried to bite the officer, which did not work to well, and he tried to spit in my face. Administrative Nurse D stated on 09/20/24, she put sheets around R3's legs while he was sitting, so he would not kick us. Administrative Nurse D stated she did not have an order to use a sheet on R3. On 10/07/24 at 06:24 PM Administrative Staff B stated the facility did not have a policy for use of restraints. The facility failed to ensure Resident (R)3, who had a history of self-harm and physically and verbally aggressive behaviors, remained free of physical or chemical restraints when on 09/18/24, 09/19/24, and 09/20/24 the resident attempted to injure himself and became combative with staff and the facility staff chemically and physically restrained the resident. On 10/07/24 at 06:45 PM, Administrative Staff B was provided a copy of the Immediate Jeopardy template and notified of the facility's failure to ensure R3 remained free of physical or chemical restraints. The facility provided an acceptable plan for removal of the immediacy on 10/08/24 at 09:40 PM which included the following: 1. The facility completed a violence risk screening on all current residents by 10/09/24 at 12:30 AM. 2. The facility revised care plan for residents identified at high risk for assault identified in the screening tool. 3. The facility began educating staff on the Federal Guidelines on the use of restraints on 10/09/24. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. The facility assigned online training on 10/07/24 and staff began training on 10/08/24 for Handling Aggressive Behaviors, Overview of Abuse and Neglect of Individuals with IDD, Understanding Wandering and Elopement, and the Meaning Behind Behaviors. The onsite surveyor verified the implementation of the above corrective actions on 10/10/24 at 09:45 AM and the deficient practice remained at a G scope and severity.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 43 residents, with six residents sampled and one resident reviewed for treatment and services for mental/psychosocial concerns. Based on interview and record review, the facility failed to acknowledge and respond appropriately to Resident (R) 3's behaviors which aligned to treatment and services related to his psychosocial disorder and physical aggression related to his diagnoses. The resident made statements such as I will kill my guardian and comments regarding killing himself on 09/18/24 at 05:07 PM. The resident became loud, insisted he had nothing to live for and wanted to kill himself. R3 became very belligerent and combative. R3 stated he just wanted to die and then started to hit his head with his fist, banged his head on the wall, hit himself in his own face with his knee, and five staff assisted in restraining the resident from hurting himself. Resident was crying, yelling, and was relentless to hurt himself. R3 attempted to stab himself with a paperclip. On 09/19/24 at 06:15 PM, R3 became agitated stating he was going to kill his aunt, himself, and other people. His agitation increased and he started to throw objects at staff, stabbed at a nurse's leg with a pen, tried to punch staff, pinch, kick, spit in staff's face, and tried to head butt staff. The staff placed the resident in a sheet restraint to protect him and others and restrained his hands. R3 was very wild, was not listening to anyone, and broke free of a sheet restraint and slid himself to the floor. R3 required several people to sit on his legs and arms to control him from hurting himself and others. The police came and assisted in restraining R3. R3 banged his head with his knee several times, stating he wanted to kill himself. On 09/20/24 at 06:30 PM, R3 made further statements he was going to kill everyone here and was hitting, kicking, spitting, pinching, and biting staff and himself. The facility chemically and physically restrained R3 on 09/18/24, 09/19/24, and 09/20/24. With this deficient practice, the likelihood of harm could occur due to the aggressive behaviors related to the restraining of R3 placing him in immediate jeopardy. Findings included: - The Medical Diagnosis tab for R3 included diagnoses of bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods) with psychotic features, major depressive disorder (major mood disorder which causes persistent feelings of sadness), attention deficit hyperactivity disorder (ADHD- a chronic condition including attention difficulty, hyperactivity, and impulsiveness), post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), and autistic disorder (a developmental disorder that impairs the ability to communicate and interact). The Admission Minimum Data Set(MDS) dated [DATE] revealed the facility did not assess R3's Brief Interview for Mental Status and did not complete the staff assessment for mental status. R3 did not have any hallucinations (sensing things while awake that appear to be real, but the mind created) or delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) during the assessment period, and no behavioral symptoms or rejection of care. The MDS indicated R3 did not require restraints. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Access Mental Health		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Peabody Peabody, KS 66866	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Psychotropic Drug Use Care Area Assessment (CAA) dated 09/11/24, revealed R3 had a baseline for delusions and hallucinations. R3 required psychiatric medications on a daily basis. R3 did not trigger for further development of the following CAAs: Cognitive Loss/Dementia, Psychosocial Well-Being, Mood State, Behavioral Symptoms, or Physical Restraints. The Care Plan dated 09/18/24, revealed R3 had behavior problems related to impulsivity and poor judgement. The staff were to monitor behavior episodes and attempt to determine underlying causes, provide a program of activities that was of interest, accommodate his status, and assist R3 to develop more appropriate methods of coping, and interacting. R3's preferred activities included watching television, going on outings, and playing video games. He had the potential to be verbally aggressive and threatening others on social media related to ineffective coping skills, poor impulse control, and severe and persistent mental illness (SPMI - a group of mental health disorders that cause significant functional impairment). When R3 became agitated the staff were to intervene before agitation escalated, guide him away from source of distress, engage calmly in conversation, and if response was aggressive, the staff were to walk calmly away and approach later. On 09/23/24, the facility added R3 was physically aggressive related to anger and poor impulse control and the trigger identified was anxiety related to legal issues and R3's behaviors were de-escalated by medication/sedation and physical restraint by personnel. On 09/18/24, R3 was upset about violating a PFA (protection from abuse) order and wanted to go to jail and turn himself in. The staff advised R3 it was still in the investigation stage, and he did not need to worry about it. R3 threw desk tools, a hole punch, and a water bottle that was in Administrative Nurse's D's office. R3 tried to stab himself and staff with a pen and made several threats he was going to harm himself and others. The event lasted three hours. The facility called the Sheriff to assist and had the resident screened for placement at a hospital, which treats adults diagnosed with psychiatric disorders. R3 calmed down with medications and placement was deferred as he did not meet current criteria for admission. The facility placed R3 on one-to-one monitoring and his medications were reviewed and adjusted by the psychiatric provider. On 09/19/24, R3 called 911 and stated he was going to blow up the (specified name) county courthouse. The facility advised R3 it was illegal to make threats like that and that it would not help his court case. R3 became aggressive stating he was going to hurt everybody. R3 threw items from the desk and five staff members restrained R3, sedated him, and four hours later he ceased trying to hurt other and himself. The facility called the Sheriff, had him screened for hospital placement and accepted, however, on a waiting list. After several hours the facility received information that another local mental health facility would take R3 until he could be placed and required medical clearance. The facility took R3 to a local hospital where R3 was medically cleared, however the local mental health facility rejected the admission and R3 returned to the facility where he was placed on one-to-one and medicated with Haldol (antipsychotic- class of medications used to treat major mental conditions which cause a break from reality) and Ativan (antianxiety- class of medications that calm and relax people). On 09/20/24, R3 was medicated all day but was able to function, walk in the hall, go to meals, and watch television. R3 became angry and violent as he was upset another resident was on the phone he wanted to use and R3 stated he was going to hurt all the (explicit language) and called everyone a (explicit language). The care plan revealed the staff placed R3 in a chair and took him to Administrative Nurse D's office where he had to be physically restrained as he was biting, spitting in staff's face, head butting, and trying to punch, kick, and pinch. The facility called the Sheriff to assist, utilized intramuscular injection of Haldol and Ativan, and R3 was taken to the local hospital where he was admitted . The Electronic Medical Record (EMR) lacked a physician order for the facility to physically restrain R3. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Notes dated 09/17/24 at 07:33 PM by Administrative Staff A revealed the staff removed R3's PlayStation per the request of his Guardian since R3 violated the no contact order. R3 had emailed the person who had the no contact order against him over five times on 09/16/24 and 09/17/24, threatening that person and saying hateful things, and caused the facility she was at to be placed on lock down, due to R3's threats. The facility staff and the Guardian spoke with R3 regarding complying with the no contact order and why the PlayStation was removed. The Progress Notes dated 09/18/24 at 01:49 AM by Administrative Nurse D revealed R3 was up in the hall pacing with repetitive motion of hands. R3 stated he did not want to go to jail. R3 was advised he needed to stop worrying about things in the world he cannot change. R3 stated he was stupid and did not know what to do. R3 continued to say over and over he did not know what to do, while pacing the floor. Administrative Nurse D called Administrative Staff A, then administered lorazepam (Ativan) for agitation. The Progress Notes dated 09/18/24 at 01:59 AM, by Administrative Nurse D revealed R 3 was in bed sleeping and talking in his sleep. The Progress Notes dated 09/18/24 at 04:27 PM by Licensed Nurse (LN) G revealed R3 paced a lot today and when he started talking to Administrative Nurse D, he became very anxious, started twisting his hands fast, crying, and picking at his arms. R3 became more agitated so Administrative Nurse D called Administrative Staff A who ordered clonazepam (benzodiazepine class of medication - depressant medication that produces sedation and can be used to treat anxiety), every evening at 04:00 PM, for seven days. The staff administered the medication. The Progress Notes dated 09/18/24 at 05:07 PM by Administrative Nurse D revealed R3 was upset and believed there was a warrant out for his arrest, could not wait for them to come get him, could not go to prison, and stated he knew he did wrong. Administrative Nurse D asked the resident not to worry about what he cannot change and R3 stated he was so screwed. R3 then switched to being bored, needed his PlayStation stating his Guardian did not have the right to take his stuff, and stated he could not live without his gaming system. R3 stated he needed someone to give back the PlayStation, then said he was killing his Guardian and hated everyone. R3 was scratching his arm, making rapid movements back and forth and staff administered clonazepam, one milligram. After 15 minutes, R3 started to settle down, talking quietly, and stated he was hungry. Then R3 became loud, insisted he had nothing to live for, wanted to kill himself, became belligerent and combative, then started to hit his head with fist, bang his head on the wall, and hit his face with his knee. Five staff assisted to restrain R3 from hurting himself. R3 was crying, yelling, relentless to hurt self, and tried to staff himself with a paperclip. The staff administered Haldol, five milligrams (mg), intramuscular (IM), for agitation to R3. The resident slowed down after 15 minutes remaining awake and alert, continued to need someone to hang onto him, and screened for aggressive behavior, with request it be rushed. The Progress Notes dated 09/18/24 at 05:12 PM by LN G revealed R3 had been in Administrative Nurse D's office much of the afternoon talking about the consequences of his behaviors, worked up, and sobbing. He then started hitting himself and tried to injure himself and the staff tried to hold him. R3 required clonazepam, orally, and Haldol, IM this afternoon and was a little calmer now. Call made (specified name) for a screen (lacked what type) for him. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Notes dated 09/18/24 at 07:03 PM by Administrative Nurse D revealed a call back received from (specified organization) to advise because of R3's diagnosis of intellectual and developmental disability-(IDD- a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life), he did not qualify to go to the state hospital. The Progress Notes dated 09/18/24 at 10:33 PM by LN I revealed R3 was one-on-one for behaviors, was in his bed, he was being monitored every 15 minutes sitting outside his door, and he was sleeping. The Progress Notes dated 09/19/24 at 07:09 PM by LN G revealed a call received from Administrative Staff A on how R3 was doing now and told he was still sleeping. Administrative Staff A ordered haloperidol (Haldol), five mg, by mouth, every day, for seven days, for psychotic behaviors. The Progress Notes dated 09/19/24 at 04:19 PM by LN G revealed R3 was calm today and had good insight on how things worked and could calmly discuss his situation with staff. R3 was currently resting in bed. The Progress Notes dated 09/19/24 at 06:01 PM, by LN H revealed R3 continued yelling out I am going to kill you [explicit language, I will find you and I will kill you. R3 stated he wanted to be like all the men in his family, they were in jail or the penitentiary and we were all going to pay. The Progress Notes dated 09/19/24 at 06:15 PM by Administrative Nurse D revealed R3 called 911 and reported he was going to bomb the (specified place). R3 was confronted with calling in a terroristic threat, he became agitated, stated he was going to kill his (specified family member), myself, and other people. R3 stated he was in a gang and wanted to go to prison and he violated the PFA, so he deserved the death penalty. R3 became increasingly agitated and started to throw objects at staff such as water bottles and clipboards, then grabbed a pen and stabbed Administrative Nurse D in the leg. Other staff members (lacked names) responded while R3 was throwing things from the shelves and the desk, he tried to punch staff, pinch, kick, spit in staff's face, and tried to head butt. R3 was placed in a sheet restraint to protect self and others, hands restrained, resident very wild and not listening to anyone. Resident broke free of sheet restraint and slid to floor. Resident required several people to sit on his legs and arms to control resident from hurting himself and others. R3 was given Haldol, five mg, and Ativan, one mg, to decrease agitation. R3 continued to fight and threaten to kill people. Sheriff officers arrived and assisted to keep R3 from hurting himself and others. After given Haldol, 15 mg, and Ativan, four mg, and three hours later R3 was calmer. After helped to a chair R3 complained of being thirsty, provided water and when water was gone, he threw ice and glass at Administrative Nurse D and tried to stab her with a pen. R3 was given another mg of Ativan and then began to calm down. R3 was screened by (specified organization), was awake and alert, answered questions, and tried again to stab a nurse (lacked name) with a pen. Police were still here assisting with restraining R3, who began to hit himself and police officers while calling them names. R3 banged head with knee several times stating he wanted to kill himself. R3 given Ativan, two mg at 10:30 PM, and then he asked to go to bed as he was very sleepy. R3 assisted to bed and was dozing with a one-to-one staff member. The Progress Notes dated 09/19/24 at 11:00 PM by Administrative Nurse D revealed (specified organization) screener called to do screening and since R3 escalated to harming others as well as himself he was to be sent to the state hospital. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Notes dated 09/20/24 at 01:19 AM by LN H revealed R3 left the facility and was transported (lacked by who) to the local hospital. The Progress Notes dated 09/20/24 at 05:20 AM by LN G revealed R3 was out of control and was physically and verbally aggressive. Administrative Nurse D spent five hours in the screening process. R3 was taken to the local hospital as instructed, and once made aware R3 was too acute, and they denied admitting him. The Progress Notes dated 09/20/24 at 01:06 PM by LN J revealed R3 rested in bed most of the day, continued to be a one-on-one at this time, and new orders were noted for Ativan, two mg, by mouth, every two hours. The Progress Notes dated 09/20/24 at 04:31 PM by LN J revealed the order for Ativan changed to one mg tablet or 1 mg/0.5 milliliters (ml) IM, every three hours. The Progress Notes dated 09/20/24 at 06:30 PM by Administrative Nurse D, a late entry on 10/07/24 at 09:55 PM, revealed R3 was waiting for the phone and upset that another resident was using the phone. R3 yelled to the resident to get off the phone [explicit language] that he needed to use it. R3 was directed to Administrative Nurse D's office to use the phone and advised not to call names, the phone was a community phone, and needed to be shared. R3 picked up a hole punch and tried to hit Administrative Nurse D, and it was taken away by Certified Nurse Aide (CNA) O. R3 turned to hit CNA O and Administrative Nurse D pushed (lacked name) an office chair underneath R3 to try and calm him. R3 stated he was going to kill everyone here, torture other (explicit language), stated he wanted to be a criminal like his biological family, and began to hit and bite staff. The staff used a speakerphone to call 911 as R3 was hitting, kicking, spitting, pinching, biting staff and himself. R3 tried to raise his knee to his head to headbutt himself and continued to threaten to hurt staff and others. R3 caused injuries to all six staff members. The staff placed a sheet over R3's arms and chest to prevent him from hurting himself and others. R3 continued to spit, and staff placed a small corner of the sheet over his face. The Sheriff arrived and assisted to keep R3 safe as R3 continued to try and hurt himself and staff and called out racist names. Administrative Staff A came to assess the situation as we had been trying to find placement elsewhere all day. The Sheriff was unable to arrest or press charges and R3 stated they could not do anything and continued to try and injure the officer and the staff. Another state hospital was unable to take R3 because he was not in a catchment area and advised to have R3 arrested. The Sheriff suggested to take R3 to the local hospital as they can call another county Sheriff to arrest. Administrative Staff A took R3 to the local hospital. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/17/24 at 04:06 PM, CMA R stated R3 was suicidal and very combative (could not recall date), spitting at staff, kicking, and at one point he grabbed a pen and tried to stab Administrative Nurse D. CMA R stated R3 had a PFA order on him and R3 contacted the person the PFA was related to. CMA R said the staff told R3 he could not do that, and staff took the game system away so he could not contact that person. The next night, R3 would be okay one minute and the next minute he was going off the charts cussing (explicit language). CMA R stated R3 was in Administrative Nurse D's office, and he was trying to destroy the whole room. CMA R stated CNA M, Administrative Nurse D, and herself were in the office with R3, holding his hands down so he could not hit us when two members from law enforcement came. CMA R stated R3 was sweaty from all the commotion, and the staff put a sheet across his arms, noting it was never tied, while R3 sat in a chair with his arms to his sides. CMA R stated the sheet went across his stomach and lower arms and was kept in place for 15 to 20 minutes while Administrative Nurse D held it. CMA R stated at one point, R3 calmed down and they removed the sheet, he was calm and just sat there, and all of a sudden, he would start throwing things. CMA R stated she was sitting on R3 in the chair, R3 was trying to get up, and the staff did not want R3 to get up and go where everybody else was. CMA R stated R3 tried to get up and scooted himself out of the chair and R3 and her both went to the floor. CMA R said, during that time he was kicking trying to destroy a monitor or television on a shelf and law enforcement held his feet down. CMA R stated she usually took her break at 06:00 PM and when she returned that night, she had heard the commotion and R7 stated they needed our help, and at that time R3 and Administrative Nurse D were in Administrative Nurse D's office. After R3 was in the office for a while, he asked to go to his room and go to bed and law enforcement walked R3 to his room, and one officer stayed and talked to R3 for a bit, then he fell asleep, and the staff did one-on-one with him. During an interview on 10/07/24 at 04:35 PM, CNA N recalled a night when R3 was upset in Administrative Nurse D office, he would calm down for a little bit, then get agitated again. CNA N stated R3 started throwing things and Administrative Nurse D held a sheet in place so R3 would not hit while CNA N got him to calm down then the sheet was not used again. CNA N stated R3 sat in a chair and LN H and Administrative Nurse D tried to keep R3 from getting up by using their hands. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/07/24 at 04:48 PM, Administrative Nurse D stated on 09/19/24, every staff member she had on 09/19/24 and 09/20/24, held R3's hands, as it took 45 minutes for law enforcement to show up. Administrative Nurse D said both days R3 came into her office could see in his eyes this kid go from Dr. Jekyll to Mr. [NAME] and when asked if he was alright, he picked up a [NAME] cup and threw it, hitting Administrative Nurse D's head and then started to tear everything off of her desk. Administrative Nurse D stated she thought the staff, CNA M, doing one-on-one was with him, and R3 went ballistic tearing things off her desk, throwing things after being told to settle down, tried to stab at her, and bit her finger. Administrative Nurse D stated the sheet I put across him. I held on to it, never tied. Basically, a band to keep his arms down. Administrative Nurse D stated R3 would try to hit them, and they did hold him with their hand on top of his and used the least amount of force we could then R3 struggled, for I don't know how long and we were having a terrible time trying to get R3 to calm down. She stated the staff administered Ativan and Haldol to R3. Administrative Nurse D stated she did not want R3 to hurt himself or her staff and he tried to bite himself, hit himself in the head, head butts against the staff, and on 09/20/24 he brought in an electric razor and was going to stab her, but law enforcement took it. She said R3 had cleared off the counter and grabbed different objects, throwing a stapler that hit her shoulder, and threw ice at her, and called staff names. Administrative Nurse D stated at one point on 09/19/24 R3 was on the floor, law enforcement showed up, staff let loose of the sheet, and R3 popped up and hit the officer and back down he went, where he was on the floor for about 15 minutes, hitting, scratching, kicking, clearing things off the desks in the room and basically the officer pinned him down. R3 tried to bite the officer, which did not work to well, and he tried to spit in Administrative Nurse D's face. Administrative Nurse D stated on 09/20/24, she put sheets around R3's legs while he sat, so he would not kick us. Administrative Nurse D stated she did not have an order to use a sheet on R3. On 10/07/24 at 06:24 PM, Administrative Staff B stated the facility did not have a policy for use of restraints. The facility failed to acknowledge and respond appropriately to Resident (R) 3's behaviors which aligned to treatment and services related to his psychosocial disorder and physical aggression related to his diagnoses, who had a history of self-harm and physically and verbally aggressive behaviors, remained free of physical or chemical restraints when on 09/18/24, 09/19/24, and 09/20/24 the resident attempted to injure himself and became combative with staff and the facility staff chemically and physically restrained the resident. On 10/07/24 at 06:45 PM, Administrative Staff B was provided a copy of the Immediate Jeopardy template and notified of the facility's failure to ensure R3 remained free of physical or chemical restraints, placed R3 in immediate jeopardy. The facility provided an acceptable plan for removal of the immediacy on 10/08/24 at 09:40 PM which included the following: 1. The facility completed a violence risk screening on all current residents by 10/09/24 at 12:30 AM. 2. The facility revised care plan for residents identified at high risk for assault identified in the screening tool. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. The facility began educating staff on the Federal Guidelines on the use of restraints on 10/09/24. 4. The facility assigned online training on 10/07/24 and staff began training on 10/08/24 for Handling Aggressive Behaviors, Overview of Abuse and Neglect of Individuals with IDD, Understanding Wandering and Elopement, and the Meaning Behind Behaviors. The onsite surveyor verified the implementation of the above corrective actions on 10/10/24 at 09:45 AM and the deficient practice remained at a G scope and severity.