STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225002	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holden Rehabilitation & Nursing Center	32 Mayo Road Holden, MA 01520

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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 - Minimal harm or potential for actual harm 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** 50138 Based on record review, observation, and interview, the facility failed to provide an environment free from physical restraints for one Resident (#42) out of a total sample of 22 residents. Specifically, the facility failed to ensure that Resident #42 was free from physical restraints when CNA #1 used a locked wheelchair at the foot of the Resident's bed to prevent him/her from getting out of bed. Findings include: Review of the facility policy titled Physical Restraint Policy, revised 2/26/21, included but was not limited to the following: Operative Definitions: -PHYSICAL RESTRAINT- Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot easily move which restricts freedom of movement normal access to one's own body. >Physical restraints include but are not limited to: leg restraints ., lap buddy/seat belts. Also included are chairs which prevent rising. -Convenience - Any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the resident's best interest. Policies: -The facility shall, in addition to the MDS (Minimum Data Set Assessment), use an interdisciplinary assessment which will examine the following: In addition to the Physical Restraint Assessment, supporting documentation may be found in the following documentation: <History of falls, MDS, Physician history and physical .restraint assessment. -This assessment will be performed on a periodic basis: (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Upon admission, at least quarterly, if a significant change has occurred, when use of a new restraint is . occurring. -A physician's order will be required for restraint use and will include the following: Type, time frame, . circumstances when the resident is to be restrained. -For the resident to make an informed choice about the use of restraints, the facility will explain to the resident and or family the potential risks .of the restraint in use. Resident #42 was admitted to the facility in January 2025 with diagnoses including Dementia, Muscle Weakness and Glaucoma. Review of the MDS dated [DATE], indicated that Resident #42 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of nine out of a total possible score of 15. Review of the Resident's comprehensive person-centered Falls Risk Care Plan, revised 1/27/25, indicated: -Resident #42 was at risk for falls. >Interventions for falls prevention included: *bed sensor alarm for safety *non-skid footwear *well-lit environment free of clutter Review of the Resident's comprehensive person-centered Resident Care Needs Care Plan, revised 1/28/25, indicated: -Resident #42 had care needs that would be met. >Interventions for care needs included: *Mobility assist of one (one staff member) with a rolling walker. *Transfers assist of one with a gait belt. Review of Resident 42's complete medical record indicated: -An Invoked Health Care Proxy (HCP- person that makes health care decisions for a patient when patient is unable to do so for themselves), effective 1/24/25. -An order for two half side rails while in bed as enabler with staff repositioning and security at patient/HCP request, effective 1/23/25. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A Physician order for a bed alarm, effective 1/23/25. Review of Nursing Progress Notes dated 1/31/25, 2/3/25, 2/7/25 and 2/8/25 indicated: -Resident #42 frequently self-transfers with poor safety awareness. Review of Resident #42's Nurse Practitioner (NP) Progress Note dated 2/10/25, indicated that Resident #42 was ambulating (walking) functional distances up to 80 feet with a walker and CGA (Contact Guard Assist [caregiver places 1-2 hands on the patient's body to help with balance but provides no other assistance])/minimum assistance. Review of the Social Services Progress Note dated 2/11/25, indicated Resident #42: -was working with PT (Physical Therapy)/OT (Occupational Therapy) services. -was ambulating with a RW (rolling walker) in his/her room to the bathroom with CGA. -was performing STS (sit to stand) with CGA. -performed a tub transfer with tub seat and CGA and verbal cues. On 2/12/25 from 10:30 A.M. to 12:00 P.M. the surveyor observed Resident #42 lying in bed with 1/2 side rails up bilaterally (both sides) and a bed sensor alarm in place. The surveyor also observed a manual wheelchair with the left brake locked and inward facing positioned against the mattress and blocking the lower quarter of Resident #42's bed on the right-hand side. During an interview and observation on 2/12/25 at 12:00 P.M. Certified Nurses Aide (CNA) #1 said that she was providing care to Resident #42. CNA #1 said that she was the staff member that assisted Resident #42 back to bed mid-morning and put the bed alarm in place. CNA #1 said that the bed alarm was in place because Resident #42 tries to get out of bed without help. CNA #1 said that Resident #42 is able to stand independently. The surveyor and CNA #1 observed the locked inward facing wheelchair positioned against the lower quarter of the right sided mattress of the Resident's bed. CNA #1 said that she put the wheelchair against the lower mattress and locked the brake to keep Resident #42 safe, so that Resident #42 would not get out of the bed independently. During an observation and interview on 2/12/25 at 12:08 P.M., the surveyor and Nurse #1 observed the inward facing wheelchair positioned against the lower quarter of the right sided mattress of the Resident's bed. Nurse #1 said that the wheelchair should not be locked because Resident #42 already had a bed alarm in place and the alarms could alert the staff if Resident #42 were to get up without help from staff. Nurse #1 said that a locked wheelchair at the foot of the bed would inhibit the resident's ability to get out of bed and was a restraint.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 42761 Based on interview, and record review, the facility failed to accurately code three Minimum Data Set (MDS) Assessments relative to medications administered to the Resident during the Assessment observation periods for one Resident (#16), out of a total sample of 22 residents. Specifically, the facility failed to accurately code three consecutive MDS Assessments for the administration of an antiplatelet medication when Aspirin was ordered by the Physician for the Resident and the Resident received Aspirin during the observation periods for each MDS Assessment. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1, dated October 2024, indicated the following under Section N: Medications: -The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of . select medications were received by the resident. -High Risk Drug Classes included Antiplatelet medications. -Check if an Antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). 1. Resident #16 was admitted to the facility in May 2022 with diagnoses including Hyperlipidemia and Atherosclerotic Heart Disease. Review of Resident #16's active Physician orders, dated 6/5/22, indicated: -Aspirin Tablet Delayed Release 81 milligrams (mg). -Give one tablet by mouth one time a day for prophylactic heart health. Review of Resident #16's MDS Assessment, dated 5/2/24, did not indicate that the Resident had received antiplatelet medication during the Assessment observation period. Review of Resident #16's May 2024 Medication Administration Record (MAR) indicated the Resident received Aspirin as ordered on 5/1/24 and 5/2/24. Review of Resident #16's MDS Assessment, dated 11/1/24, did not indicate that the Resident had received antiplatelet medication during the observation period for the Assessment. Review of Resident #16's October 2024 and November 2024 MARs indicated the Resident received Aspirin daily as ordered from 10/26/24 through 10/31/24 and 11/1/24. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #16's MDS Assessment, dated 1/31/25, did not indicate that the Resident had received antiplatelet medication during the Assessment observation period. Review of Resident #16's January 2025 MAR indicated the Resident received Aspirin daily as ordered, from 1/25/25 through 1/31/25. During an interview on 2/12/25 at 11:23 A.M., the MDS Coordinator said that she did not code Resident #16's MDS Assessments dated 5/2/24, 11/1/24, and 1/31/25, to indicate the Resident had received antiplatelet medication because Aspirin is never coded on MDS's as being an antiplatelet medication.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. 42761 Based on interviews and records reviewed, the facility failed to notify the state mental health authority for resident review after a significant change in the mental health condition of one Resident (#16) out of a total sample of 22 residents. Specifically, the facility failed to notify the State PASRR (Preadmission Screening and Resident Review - federal requirement to help ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) Office of the need for a Resident Review when Resident #16 was newly diagnosed with Auditory Hallucinations and treatment using antipsychotic medications was implemented. Findings include: Resident #16 was admitted to the facility in May 2022 with diagnoses including Major Depressive Disorder and Mild Cognitive Impairment. Review of Resident #16's Level I PASRR dated 5/22/22, indicated the Resident had a negative screen for Serious Mental Illness (SMI). Review of Resident #16's Nursing Progress Note, dated 4/4/24, indicated the following: -Increased paranoia noted in patient today. -Patient vocalized frustration describing staff messing with him/her over the intercom, specifically overnight. -The patient stated staff saying his/her name over and over again through the intercom. Review of Resident #16's Nurse Practitioner (NP) Progress Note dated 5/20/24, indicated: -The Resident had been complaining about people playing tricks on him/her over the intercom at night. -Nursing had completed an investigation and could not find evidence of people playing tricks on the Resident over the intercom at night. -The Resident was quite paranoid about this and could not sleep. -The Resident was mistrustful of staff. -The Resident became very animated and upset when talking about the voices and said, Someone is messing with me. -A medical work-up had been completed in the past for this same complaint and was negative. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The NP suspected the Resident was having auditory hallucinations. -The plan included trialing Seroquel (antipsychotic medication) 25 milligrams (mg) Q (every) HS (Hour of Sleep [night]). Review of Resident #16's clinical record indicated the following: -The Resident was newly diagnosed with Auditory Hallucinations on 5/22/24. -The Resident began treatment with Seroquel for paranoia on 5/22/24. Review of Resident #16's Psychiatric Evaluation dated 6/11/24, indicated: -The Resident denied auditory hallucinations. -The Resident believed staff were messing with him/her, calling his/her name through the intercom at night. -The Resident had auditory hallucinations and paranoia. Review of Resident #16's Physician Order Summary for 5/1/24 through 2/13/25 indicated the following Physician orders: -Seroquel Oral Tablet 25 milligrams (mg), give 25 mg by mouth at bedtime for paranoia, dated 5/22/24 and discontinued 6/7/24. -Seroquel Oral Tablet 25 mg, give two tablets by mouth at bedtime for paranoia, dated 6/7/24 and discontinued 7/16/24. -Seroquel Oral Tablet 25 mg, give 0.5 tablet by mouth in the morning for paranoia, 12.5 mg dose, dated 7/16/24. -Seroquel Oral Tablet 50 mg, give one tablet by mouth at bedtime for paranoia, dated 7/16/24 and discontinued 10/9/24. -Seroquel Oral Tablet 25 mg, give 75 mg by mouth at bedtime for paranoia, dated 10/9/24 and discontinued 11/21/24. -Seroquel Oral Tablet, give 87.5 mg by mouth at bedtime for paranoia, dated 11/21/24 and discontinued 11/21/24. -Seroquel Oral Tablet, give 87.5 mg by mouth at bedtime for Vascular Dementia with Mood Disturbance, dated 11/21/24 with start date of 11/22/24. Review of Resident #16's clinical record indicated the Resident was newly diagnosed with Psychosis on 2/6/25. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the clinical record did not indicate that Resident #16 had been referred to the State PASRR Office for Resident Review anytime between 5/22/24 and the DPH survey date. During an interview on 2/12/25 at 11:35 A.M., the Social Worker (SW) said that she oversaw the PASRR process at the facility. The SW said that if a resident experienced a significant change in mood or behavior and treatment for change in mental condition, the resident would be referred to the State PASRR Office for review. The SW said she was unsure whether Resident #16 had been referred to the State PASRR Office for review when the Resident was newly diagnosed with Auditory Hallucinations and began treatment with Seroquel. The SW further said she would review the Resident's record and get back to the surveyor. During a follow-up interview on 2//12/25 at 12:12 P.M., the SW said that no request for a Resident Review had been submitted to the State PASRR Office for Resident #16 anytime between 5/22/24 and the survey date. The SW further said that the Resident should have been referred to the State PASRR Office for Resident Review when the Resident was newly diagnosed with Auditory Hallucinations and required treatment with antipsychotic medications. Please refer to F740.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, interview, and record review, the facility failed to provide care and services as required for an indwelling urinary/Foley catheter for one Resident (#36) out of a total sample of 22 residents. Specifically, for Resident #36, the facility failed to ensure that a blocked indwelling urinary catheter was replaced with the correct sized catheter balloon as ordered by the Physician. Findings include: Review of the facility policy for Catheter Care, Urinary, updated 12/12/24, indicated: >Preparation -Review the resident's care plan to assess for any special needs of the resident. -Assemble the equipment and supplies as needed. >Reporting -Report other information in accordance with facility policy and professional standards of practice. Resident #36 was admitted to the facility in September 2023 with diagnoses including Multiple Sclerosis, Quadriplegia and Neurogenic Bladder. Review of the Resident's care plan for a Foley Catheter, last revised 9/24/24, indicated: -Change Foley catheter as needed (PRN). -Foley catheter care per facility protocol every shift, and as needed. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #36: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of four out of 15. -was dependent for toileting -had an indwelling urinary catheter. Review of Resident #36's February 2025 Physician's orders indicated: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Foley catheter size 20 French (Fr: French scale or system used to size catheters) with 10 milliliter (ml) balloon, change every 3 months as needed for blockage or leakage, start date 8/11/24. -Foley catheter 20 Fr with 10 ml (balloon), change every 3 months . change with same size catheter, start date 9/5/24 Review of Resident #36's February 2025 Treatment Administration Record (TAR) indicated: -Foley catheter size 20 Fr with a 10 ml balloon. -the Foley catheter had been changed to a size 20 Fr with a 10 ml balloon as needed for a blockage or leakage on 2/1/25. Review of Resident #36's clinical record indicated a Nursing Progress Note dated 2/1/25, that indicated: -the Resident's Foley catheter had been changed due to a blockage. -the Foley catheter size was changed to a 20 Fr with a 10 ml balloon. On 2/13/25 at 9:21 A.M., the surveyor and Unit Manager (UM) #2 observed that Resident #36 had a Foley catheter in place that was a size 20 Fr with a 30 ml balloon. The surveyor and UM #2 also observed a red colored substance on the towel next to the Resident's right leg. During an interview at the time, UM #2 said that the size of the catheter and balloon should reflect what was ordered by the Physician and it did not. UM #2 further said that having a larger balloon size can cause irritation and increase the chances of bleeding to the Resident. During an interview on 2/13/25 at 10:53 A.M., the Director of Nursing (DON) said the facility should have supply of the correct size urinary catheters for all the residents who needed them. During an interview on 2/13/25 at 12:48 P.M., UM #2 said that she had no documented evidence that the wrong balloon size urinary catheter had been placed in Resident #36 on 2/1/25 until 2/13/25, after the initial observation with the surveyor. During an interview on 2/13/25 at 12:54 P.M., the Nurse Practitioner (NP) said that she does receive phone calls from the Nurses if they do not have the correct size catheter equipment and need to change the sizing of urinary catheter. The NP also said that in the case where the correct size catheter balloon was not available, an order should be written to reflect the new catheter balloon size change and this was not done. During an interview on 2/13/25 at 12:57 P.M., Central Supply Staff said that he did not have Foley catheters size 20 Fr with 10 ml balloon on hand until they were delivered to the facility today. Central Supply Staff also said that he was unable to provide evidence on how long the facility had been without 20 Fr/10 ml balloon size urinary catheter. Central Supply Staff said that he was responsible for ordering the building's medical supplies and he is informed of what supplies to order by a list created by the nursing staff on each of the units.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 42761 Based on interview, and record review, the facility failed to provide Behavioral Health Care and services to attain or maintain the highest practicable mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one Resident (#16) out of a total sample of 22 residents. Specifically, for Resident #16, the facility failed to: -obtain psychotherapeutic counseling based on recommendations of a Psychotherapy Evaluation, and consent for the therapy by the Resident. -obtain a Psychiatric evaluation timely for the Resident when the Nurse Practitioner ordered a Psychiatric Evaluation to assess the Resident for auditory hallucinations. Findings include: Review of the facility's policy titled Behavioral Health Services, undated, indicated the following: -The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable . mental and psychosocial well-being in accordance with the . plan of care. -Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care. Resident #16 was admitted to the facility in May 2022 with diagnoses including Major Depressive Disorder and Mild Cognitive Impairment. Review of Resident #16's active Physician orders dated 5/6/22, indicated: -Dentist, Podiatry, Optometrist, Audiology, Behavioral Health, and Wound MD (Physician) with Resident/family consent as needed. Review of Resident #16's Mood Care Plan, initiated 5/6/22, indicated the following: -The Resident had potential for alteration in coping and mood related to a diagnosis of MDD (Major Depressive Disorder), periods of agitation at times, and feeling down on occasion. -Monitor for mood and behavior changes and report to SW (Social Worker) and Nursing for follow-up as indicated (5/6/22). -Obtain Psychological/Psychiatric Consult/Services if indicated (5/6/22). (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #16's Behavioral Health Psychotherapy Evaluation Note, dated 11/3/23, indicated: -The Resident was referred to Psychotherapy for counseling. -An initial evaluation was being conducted. -The Resident reported someone was messing with him/her through the phone and from the hallway, calling his/her name. -The rationale for therapy included identifying changing of negative or repetitive thoughts, engage in or review new interpersonal skills and self management (grounding) activities to control those thoughts . -The Resident agreed with the treatment plan. Review of Resident #16's Behavioral Health Consent, dated 11/3/23, indicated the Resident consented to psychotherapy services. Review of Resident #16's clinical record did not include any evidence that the Resident received psychotherapeutic counseling after his/her evaluation on 11/3/23. Review of Resident #16's Attending Physician Request for Services/Consultation, dated 12/14/23, indicated a request for Behavioral Health Services relative to Dementia and a question of the Resident experiencing auditory hallucinations. Review of Resident #16's Nurse Practitioner (NP) orders, dated 12/14/23, indicated: -Obtain psych (Psychiatric) eval and audiology consult. Review of Resident #16's Audiology Consult, dated 2/1/24, indicated the Resident: -had hearing loss -reported tinnitus (ringing or buzzing in ears) -had hearing aids recommended -had been referred to Behavioral Health Services for a change in behavior and hearing sounds. -reported tinnitus in the left ear. Review of Resident #16's Physician Progress Note, dated 3/6/24, indicated: -The Resident had some issues with staff overnight relative to staff talking through the intercom. -The Resident had mild cognitive impairment. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It was unclear whether the Resident was having delusions. -The Resident had been seen by Psych Services. Review of Resident #16's clinical record did not include any evidence that the Resident was seen by Psychiatric Services since the Behavioral Health Psychotherapy Evaluation on 11/3/23. Review of Resident #16's Nursing Progress Note, dated 4/4/24, indicated: -Increased paranoia noted in patient today. -Patient vocalized frustration describing staff messing with him/her over the intercom, specifically overnight. -The patient stated staff saying his/her name over and over again through the intercom. Review of Resident #16's Social Services Progress Note, dated 5/1/24, indicated: -The Resident reported feeling down at times and was prescribed Lexapro (antidepressant medication) for symptom management. -The Resident was followed by psych services as needed. -The Resident was last seen by psych services for one-to-one counseling on 11/3/23. Review of Resident #16's NP Progress Note, dated 5/20/24, indicated: -The Resident had been complaining about people playing tricks on him/her over the intercom at night. -Nursing had completed an investigation and could not find evidence of people playing tricks on the Resident over the intercom at night. -The Resident was quite paranoid about this and could not sleep. -The Resident was mistrustful of staff. -The Resident became very animated and upset when talking about the voices and said, Someone is messing with me. -A medical work-up had been completed in the past for this same complaint and was negative. -The NP suspected the Resident was having auditory hallucinations. -The plan included trialing Seroquel (antipsychotic medication) 25 milligrams (mg) Q (every) HS (Hour of Sleep [night]). Review of Resident #16's NP Progress Note, dated 6/7/24, indicated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225002	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holden Rehabilitation & Nursing Center	32 Mayo Road Holden, MA 01520

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident reported voices over the intercom at night and was fearful people were trying to poison him/her. -The Resident thought Nurses were trying to kill him/her with medications. -The Resident became very agitated when asked about the intercom. -The Resident had moderate cognitive impairment with paranoia and auditory hallucinations. -The plan included to increase the Resident's Seroquel at night from 15 mg to 50 mg and to add a dose of Seroquel 12.5 mg every morning. -If no improvement, consult Psych. Review of Resident #16's clinical record did not indicate any evidence that a Psychiatric Evaluation was completed as ordered by the NP on 12/14/23, until 6/11/24 (approximately six months after being ordered). Review of Resident #16's Psychiatric Evaluation, dated 6/11/24, indicated: -The Resident denied auditory hallucinations. -The Resident believed staff were messing with him/her, calling his/her name through the intercom at night. -The Resident had auditory hallucinations and paranoia. During an interview on 2/13/25 at 7:40 A.M., Certified Nurses Aide (CNA) #2 said that she cared for Resident #16 and that the Resident sometimes experienced hallucinations where he/she talks about seeing or hearing things that are not there, such as bugs on the wall and voices through the intercom. CNA #2 said she could not recall how long Resident #16 had been having hallucinations and that the hallucinations had decreased significantly over the last month. CNA #2 said that she has not heard the Resident report any hallucinations lately. During an interview on 2/12/25 at 1:35 P.M., the Assistant Director of Nursing (ADON) said he reviewed Resident #16's record and the most recent Behavioral Health visit provided for Resident #16 prior to the Psychiatric Evaluation on 6/11/24 was the Psychotherapy Evaluation completed on 11/3/23. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25 at 8:20 A.M. with the ADON and the Director of Nursing (DON), the ADON said that the Psychotherapist who evaluated Resident #16 on 11/3/23 was no longer providing services to the facility since the end of 2023. The DON said it took a few months for the contracted Behavioral Health Agency to find a replacement for the Psychotherapist and that staff at the facility were providing additional support for Resident #16. When the surveyor asked what support was provided for the Resident, the DON said that she thought the SW was involved with the Resident and that the NP oversaw the Resident and initiated Seroquel for the Resident's behaviors. The DON also said that although the Psychotherapist was no longer providing services to the facility, the contracted Behavioral Health Agency did provide the facility with a Psychiatric NP to evaluate residents at the facility. The surveyor requested evidence as to whether the facility obtained a Psychiatric Evaluation for Resident #16 after one was ordered for the Resident on 12/14/23, prior to the evaluation completed on 6/11/24. The surveyor also requested evidence of any additional Behavioral Health Support provided to the Resident between 12/14/23 and 5/20/24 when the NP assessed the Resident for auditory hallucinations. During an interview on 2/13/25 at 9:45 A.M., the NP said that she referred Resident #16 for a Psych Eval (Psychiatric Evaluation) on 12/14/23. The NP said when Specialists, such as Psych Practitioners, assess Residents, she reviews any recommendations made and will determine whether to accept the recommendations. The NP said when Specialists complete a Consult for a resident, she has access to the Consult notes, but she does not always review the Consult notes if she is not alerted by facility staff that recommendations were made. When the surveyor asked whether the NP was aware that the Psych Evaluation had not been completed as ordered on 12/14/23, the NP said that when she made a referral, she expected that the other professionals would follow through on providing the service. The NP further said there was a period of time when the Resident's hallucinations were not occurring as much, and that the hallucinations were addressed when they increased. The NP said that even if the Psych Provider had evaluated the Resident, she did not think they would have done anything differently than what she did for the Resident. The facility did not provide any evidence to the survey team prior to the end of the survey period relative to: -Any communications made to obtain Psychotherapeutic Counseling for Resident #16 after the Psychotherapist's evaluation of the Resident was completed on 11/3/23 and continued therapy was recommended. -Any Psychiatric Evaluation being obtained between 12/14/23 and 6/11/24. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a post-survey interview on 2/18/25 at 4:32 P.M., the Behavioral Health Manager said that Resident #16 was evaluated by the Psychotherapist in November 2023 and the Psychotherapist had recommended treatment for the Resident. The Behavioral Health Manager said that there may have been a glitch in the computer system and the Resident's enrollment was not processed which resulted in the Resident not being scheduled for Psychotherapy visits. The Behavioral Health Manager said that Resident #16 was enrolled for Psychiatric Services to be evaluated by the Psychiatric Nurse Practitioner (NP) on 12/14/23, but the evaluation was never completed. The Behavioral Health Manager said it was atypical that errors like this occurred and that she hoped this would not happen to other residents. The Behavioral Health Manager also said there was nothing in the Resident's file indicating that the Psychotherapy Services and the Psychiatric Evaluation were not to be completed for the Resident, and that Resident #16 was not evaluated by the Psychiatric NP until 6/11/24. The Behavioral Health Manager further said there was nothing in the Resident's file that indicated the facility had followed-up with the Behavioral Health Agency relative to Psychotherapy Services or the Psychiatric Evaluation.