

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E166	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Care Home		STREET ADDRESS, CITY, STATE, ZIP CODE 715 West 31st Street Minneapolis, MN 55408	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48037</p> <p>Based on observation, interview, and document review the facility failed to implement interventions to prevent elopement, failed to follow safety plan for leaving the premises, and failed to timely report missing person in accordance with care plan and facility policy for 1 of 1 resident (R1) who had a history of multiple elopements related to audible hallucinations.</p> <p>Findings include:</p> <p>During interview on 3/13/24 at 2:20 p.m., R1 stated he enjoyed being able to leave the facility to take walks, use public transportation, go to restaurants, and visiting with his mother. He managed his own money and had a bus card. R1 recalled running away from the facility this week and was not planning on coming back. R1 explained there was two ways he would leave the facility and indicated it was dependent on the voices he heard in his head. The first way was taking his phone, going to the nurses station to sign out, and get his GPS tracker. The other way was when the voices gave him the desire to escape or the need to runaway. He would intentionally not bring his GPS tracker because he did not want staff to know he was running away, and there was nothing stopping him from leaving. R1 stated when he heard those voices he felt claustrophobic, felt like his skin was crawling, and it was almost like an attack and could feel my heart pounding. R1 stated the desire to escape came every couple of months. R1 endorsed smoking cigarettes and the frequency varied.</p> <p>During interview on 3/13/24 at 3:04 p.m., licensed practical nurse LPN-(A) reported R1 had an ongoing history of elopement, however the facility initiated a tracker system with global positioning system (GPS) in which R1 had been compliant with the last couple of months. LPN-A reported R1's voices have been a lot worse recently and the voices tell R1 to do things; the facility was trying to figure out why. LPN-A explained R1 heard voices all the time, however some of the voices were mean and intense; these command voices gave R1 more negative direction by telling him to do things which were uncharacteristic such as take off clothing and leaving without telling anyone. LPN-A indicated when R1 was hearing the command voices that's when he would escape from the facility. LPN-A was able to distinguish when R1 heard the negative voices because his eyes would become big and buggy, he tended to pace more, and would ask for more cigarettes. When R1 would demonstrate these behaviors she implemented more frequent checks on his whereabouts.</p> <p>R1's face sheet identified R1 had diagnoses that included schizophrenia, schizoaffective disorder, other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations and other psychoactive substance dependence.</p> <p>(continued on next page)</p>

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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1's cognition was not assessed. R1 had inattention behaviors that fluctuate and changed in severity, in addition to hallucinations. R1 did not display physical, verbal or other behavioral symptoms directed at others and did not have a behavior of wondering.</p> <p>R1's ability to leave facility safely assessment dated [DATE], identified R1 had a history of elopement due to negative voices telling him to leave. He had displayed unsafe behaviors in the community when leaving due to his voices. R1 desires to go out into the community unsupervised and has an order in place to leave unsupervised. Disposition identified R1 was deemed safe to leave facility unescorted. R1 knows to check in with the nurse before leaving. R1 will keep tracker in his pocket when leaving the facility unsupervised.</p> <p>R1's Safety in the Community Evaluation dated 10/26/23, identified R1 displayed clear understanding of safe behavior in the community at the time of assessment. Resident is safe to go out into the community unsupervised while utilizing safety interventions.</p> <p>R1's care plan dated 11/8/23, identified behavior of wandering and was at risk for elopement. The following history was included in R1's care plan:</p> <p>-On 8/12/23, staff discovered R1 was not in building during hourly checks, not at his moms, hospitals contacted, police report done. R1 returned at 2:00 a.m. 8/13/23/23, was not drinking and physically okay. R1 had been walking. He reports sometimes feels cooped up because of the hourly checks and safety measures in place related to the incident that occurred on 2/12/23.</p> <p>-On 9/1/23 R1 left facility around 5:00 a.m., he was not answering phone or at moms house, missing person report was done and social service director (SSD) was contacted. On 9/2/23 at 8:30 a.m. R1 was afraid to return to the facility. R1 did not want to get locked up, he returned unharmed by self from St. [NAME] at 11:45 on 9/2/23. A tracker device was not available, tracking device was now available.</p> <p>R1's care plan also informed and directed staff of the following:</p> <p>-R1 currently uses a GPS tracker to monitor whereabouts. R1 was to obtain the tracker from charge nurse and charge nurse turns it on, Then R1 confirms he has his cell phone on as well.</p> <p>-Facility staff are to provide ACP (associated clinic of psychology) therapist weekly/biweekly, provide medications per Dr/psychiatrist order, Staff are to call his phone if he does not return when he states.</p> <p>-Staff will follow facility policy regarding MISSING PERSON/WANDERING RESIDENT if resident does not return per statement.</p> <p>-Staff will monitor residents whereabouts hourly and document on hourly monitoring sheets.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff will use the following guidelines when he wants to leave the facility: Ask him if he is hearing voices tell him to leave, take clothes off etc. , ask if he is having any anxiety and/or thinking about drinking alcohol. Note his general appearance, speech, facial expressions, etc. to see if anything is out of the ordinary. Give him the tracking device and activate it. Make sure he has his cell phone with him and it is charged and the ringer is on. Ask him when he will be returning. Inform him to call facility if he plans on being gone longer then planned. He has to return to the facility BEFORE dark. Have him use the sign out book. When he returns he needs to return the device to the nurse and sign back in.</p> <p>R1's progress note dated 3/9/24 identified at 5:15 p.m., writer noticed R1 wasn't in his room or anywhere in the building. Writer gave him some time to see if he would return from where he was, but he did not. At 5:30 writer called his cell phone and left a voicemail asking him to call and let us know where he was and left phone number. Writer then called his mom to see if he was there, and she said, he wasn't. Writer checked the sign-out book and he had not written anything in it from today. He had not taken the tracking device. Writer decided to give him some more time in case he came back on his own. He did not. Writer notified the director of nursing (DON) social worker and administrator. Writer called 911 and filed a missing persons report and officers came out and go over the details. Writer did a vulnerable adult report online and submitted it. At 12:50 a.m. Sunday [3/10/24] morning, resident reported on his own. When writer asked him what happened or was it voices that told him to leave? He said I just was gonna run away. Writer asked if he had a place he was going to run and he said no. Next writer asked why he decided to return and he said, because it was so cold outside.</p> <p>Although, staff identified R1 was not in the building on 3/9/24, at 5:15 p.m. the police report dated 3/9/24, identified the facility had not reported R1 missing until 10:07 p.m. which was not in accordance with the care plan that directed to follow Missing Person Policy.</p> <p>During interview on 3/13/24 at 4:24 p.m., registered nurse (RN)-A indicated she was familiar with R1 however, was not aware of any behavioral triggers R1 displayed when he heard command voices and described him as having a flat affect (without emotion or stoic). RN-A reported she worked the evening shift on 3/9/24. R1 went out of the facility without staff knowing around 5:15 p.m. and returned at 12:50 a.m. on 3/10/24. RN-A explained while R1 was out of the facility she had called the police, his mother, and administration. When R1 returned he had told RN-A his reason for leaving was he wanted to run away and he came back to the facility because he was cold. RN-A stated she increased R1's safety checks from every two hours to every one hour.</p> <p>R1's progress note dated 3/11/24 at 1:47 p.m. identified social services met with R1. Discussed leaving the facility on 3/9/24 without talking to staff. He stated his voices told him to leave, he stated he was getting afraid of all the people around him and having severe ideation about running. He stated it didn't cross his mind to get the tracking device. Will have therapeutic recreation make a sign for his room with a reminder to get the tracking device when he was having a hard time.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's progress note dated 3/11/24, at 9:05 p.m. included staff noted the resident to be missing at 8:30 p.m., last seen between 5:30 p.m. and 6:15 p.m. per trained medication aid (TMA). Call placed to 911 as a missing person, gave description, stated that they'll try to locate him. The DON, social worker and ADMIN notified. Will continue to wait any report from the police or the resident to show up. Secondary note dated 3/11/24 at 9:24 p.m. identified R1 had just walked in stated the crazy thoughts are telling me to leave and can't leave me alone, had to leave for a minute, I feel better now. R1 reminded to take his tracker next time he leaves the facility or at least to let staff know.</p> <p>During interview on 3/14/24 at 1:55 p.m., Minneapolis police department representative MPDR-(A) reported nothing was submitted by the facility on 3/11/24 and the last contact was on 3/9/24. However, a report was received by Minneapolis police on 3/20/24, that identified facility staff member contacted police on 3/11/24 at 8:46 p.m. (between 2.5-3.25 hours since he was last seen) and R1 was located at 9:14 p.m.</p> <p>During interview on 3/14/24 at 10:13 a.m., trained medical aid TMA-(A) indicated on 3/11/24, she provided R1 with his medications at 3:30 p.m. and when she provided medications she was supposed monitor for behavioral symptoms. TMA-A stated she would ask R1 questions like how are you today?, is everything good?, or anything bothering you? but R1 did not typically express a lot. TMA-A did not articulate the questions outlined in the care plan. TMA-A stated R1 had never told her he was hearing the command voices and was not aware of R1's triggers and/or behaviors exhibited when R1 heard command voices. TMA-A stated the first time she had observed anything abnormal in R1's behaviors was on 3/11/24 around 5:30 p.m. He was outside walking away from the facility at a fast pace, his eyes were big, opened wide, and bulging which was abnormal. TMA-A had asked R1 where was he going and told him he needed his tracker, but R1 said No, I will be right back I promise. TMA-A reported R1 was on 2-hour safety checks, did not have any safety concerns for R1 and felt he would come right back. TMA-A indicated she notified another facility staff member around 6:00 p.m. (could not recall who). TMA-A stated around 8:00 p.m. she tried to find R1 however he was missing.</p> <p>During interview on 3/14/24 at 12:06 p.m. nursing assistant NA-(A) indicated she worked with R1 on 3/11/24; she had worked the evening shift. NA-A stated it was her responsibility to check R1's location every hour and document it on his tracking log. NA-A recalled on 3/11/24 at 5:00 p.m., R1 was in the dining room and at 5:08 p.m. R1 was outside smoking. NA-A then went to break. NA-A stated she had returned from break around 5:20 p., did not see R1 but found his cell phone on top of his bed. NA-A recalled documenting out on the tracking log and immediately notifying the nurse. NA-A reported R1 was back in the facility at 9:16 p.m.</p> <p>During interview on 3/15/24 at 11:37 p.m., registered nurse RN-B indicated according to R1's safety monitoring plan, R1 was supposed to be back in the facility before nightfall when it was dark outside because he was a vulnerable adult.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation on 3/14/23 at 10:35 a.m., R1 entered nursing station area and licensed practical nurse LPN-(A) asked to R1 you're going out for a while? R1 responded yeah. Once tracker was set up LPN-A instructed R1 to put the tracker in his pocket. LPN-A and R1 discussed medication changes, however no further questions were asked to ascertain R1's mental state and about his outing (such as when he was returning). R1 was observed to be standing in a stance like position with his hands in his pocket. At start of conversation R1 was noted to be staring [NAME] ahead and not blinking or making eye contact and eyes appeared large. When discussing medication changes R1's eye pattern changed and was observed to have rapid eyes movements back and forth with his head down. Additionally, staff member did not make sure R1 had his cell phone with him, it was charged, and the ringer was on.</p> <p>During interview on 3/14/24 at 10:43 a.m., LPN-A reported the behavioral monitoring which was completed during the observation was visual. LPN-A looked at his eyes and voice appeared okay and calm and not pressured. If R1 were to have wild eyes, frightened, or like he was completely distracted and his mind was somewhere else, it would have been different, and more questions were to be asked. LPN-A did not identify concerns with R1's eye patterns.</p> <p>During interview on 3/14/24 at 11:41 a.m., social service director SSD-(A) reported R1 had a history of command voices and elopements in the facility and it was her job to monitor any changes and what the changes were. R1's care plan directed nursing staff to monitor his behaviors, whereabouts, and ask him several questions prior to him being able to leave. SSD-A indicated when R1 had an increase in voices he would leave the facility without telling staff. SSD-A reported R1 did not have any visible differences when R1 heard command voices, however had never witnessed R1 be in the moment of needing to run and escape. All facility staff were to follow the care plan, the behavior monitoring plan, and assess/monitor behaviors multiple times a day. SSD-A was unaware of any triggers for R1.</p> <p>During interview on 3/15/24 at 9:15 a.m., director of nursing (DON) identified R1 missing on 3/11/24 should have been reported to the police.</p> <p>During interview on 3/15/24 at 9:15 a.m. director of nursing (DON) indicated she was notified of R1 missing on</p> <p>3/11/24 at 7:00 p.m. and staff should have immediately initiated the missing person protocol when it was identified R1 left the facility without the tracker. Facility staff should be following the resident safety monitoring plan, the care plans, and hourly checks.</p> <p>Facility policy titled Missing Resident Reporting Procedure undated, identified the purpose is to promote a safe environment for all residents and respond appropriately when a resident is missing or overdue back from outside the facility.</p> <p>When a resident is considered missing:</p> <ul style="list-style-type: none"> -From the hours of 7 am until dark we consider a resident missing if the resident has not returned within 2 hours of the expected return time. -After dark, we consider a resident missing after 1 hour following the expected return time. -If a resident has left the facility without signing out, use the time that you discover them out of the facility as the time to start the 2-4 hour timer. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-If a resident has not returned by the expected time but has been in communication with staff, they are not considered to be missing. Staff are to update a new return time and the whereabouts of the resident and documented by putting in a progress note and updating the sign-out sheet.</p> <p>What to do when a resident is missing:</p> <p>-Elopement/wander binder is located at Nursing station</p> <p>1) verify the resident did not come back to the facility but failed to sign in.</p> <p>2) announce code white over loudspeaker</p> <p>3) staff meet at nursing station for further assignment- check inside and outside the facility and surrounding neighborhood.</p> <p>4)Inform administrator, social services and DON</p> <p>5) Try to locate the resident and an update on expected return time.</p> <p>a. Try calling the phone number listed on face-sheet or sign out sheet.</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48037</p> <p>Based on interview and document review, the facility failed to ensure appropriate services and treatment that included medication management and monitoring and failed to ensure coordination of care between mental health care providers to ensure the highest level of mental and psychosocial well being for 1 of 3 residents (R1) who had a diagnosis of schizophrenia with audible hallucinations and a court order for medication management to control symptoms of psychosis.</p> <p>Findings include:</p> <p>R1's court document dated 5/5/22 identified R1 does not have the ability to understand and use information about his mental illness, its symptoms, and treatment. Neuroleptic medications are currently prescribed for respondent (R1) by his treatment provider. They are prescribed to relieve his psychotic symptoms, including command hallucinations and paranoia. The documents included a [NAME] order (court order that gives the court the power to order administration of medication for committed person who is unwilling to take prescribed psychiatric medications). The order included, Respondent (R1) does not take prescribed neuroleptic medication voluntarily. Respondents (R1) treating physician attempted to discuss the diagnosis and proposed treatment plan including the use of neuroleptic medication with respondent. However, respondent does not have sufficient insight to understand the consequences of not taking the prescribed medications, with the result that he stops taking the prescribed medications and then decompensates. The use of neuroleptic medication will relieve the interference cause by the mental illness and allow respondent (R1) to derive increased benefit from psychosocial therapy. Respondent (R1) is not now competent and lacks the capacity to give or withhold consent for the use of neuroleptic medication.</p> <p>R1's face sheet identified R1 had diagnoses that included schizophrenia, schizoaffective disorder, other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations and other psychoactive substance dependence.</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1's cognition was not assessed. R1 had inattention behaviors that fluctuate and changed in severity, in addition to hallucinations. R1 did not display physical, verbal or other behavioral symptoms directed at others and did not have a behavior of wondering.</p> <p>R1's care plan dated 9/20/22, identified cognition, psychosis hallucinations. Resident hears command voices that tell him to do various things. He will obey commands if he doesn't take a PRN (as needed) medication to lighten the symptoms. When R1 was having hallucinations, staff are to follow interventions which included: Medications per Psychiatrist/Doctor order. Nursing will update medical doctor (MD) about any reports of increased hallucinations. Staff will ask questions to bring resident back to reality, 1) Are you having whispers, intense, or screaming voices in your head? 2) what are the voices tell you? Remind him that is not okay to take off his clothing and that he is not going to hell if he does not throw away his clothes. Staff will attempt to re-direct when hallucinations are bothering other residents. Staff will offer reality-based support and reassurance to resident when he is experiencing hallucinations.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's [NAME] order dated 12/15/23, identified order of the court filed April 17th 2023 authorized to use neuroleptic medications: Invega, Thorazine, Zyprexa and/or Haldol was granted. R1's treatment team requested his [NAME] order be amended to include the neuroleptic medication Seroquel and remove Haldol.</p> <p>R1's self-administration of medications dated 1/26/24, identified R1 was unable to identify what their medications were, was unable to tell what each medication was for, unable to tell what the most common side effect for each of their medications. R1 had not demonstrated that he/she understood their medications, what they were and why they are taking them and may not self-administer when on therapeutic leave or day pass.</p> <p>R1 physician orders included the neuroleptic or antipsychotic medications identified in R1's [NAME] order however, did not include an as needed medication for when R1 had episodes of acute psychosis or increased command voices.</p> <p>-Order dated 11/24/21, directed facility staff to ask R1 if hearing voices anxiety, psychosis, agitation give 1 unit by mouth three times a day for anxiety related to other psychoactive substance dependence, uncomplicated. Give PRN if indicated.</p> <p>-Order dated 8/14/23, identified R1 required Quetiapine Fumarate (Seroquel) oral tablet 50 milligram (MG) (antipsychotic medication) give 1 tablet by mouth three times a day for anxiety related to schizo affective disorder, unspecified.</p> <p>-Order dated 2/27/24, identified R1 required Quetiapine Fumarate oral tablet 100 milligram (mg) (quetiapine fumarate) give 100 MG orally as needed (PRN) for insomnia at bedtime. R1's record did not identify a diagnosis of insomnia nor identify R1 had problems sleeping.</p> <p>R1's behavior monitoring Point of Care (POC) documentation which asked Did the resident experience hallucinations were reviewed in conjunction with medication administration records (MAR) between 3/1/24 and 3/15/24 which prompted a response three times daily for Ask if hearing voices, anxiety, psychosis, agitation and progress notes between 2/13/24 through 3/14/24. The review indicated inconsistent documentation between POC and MAR, without further description of the behavior/hallucination/psychosis documented, and without further assessment and/or interventions when the documented responses identified the presents of the aforementioned.</p> <p>R1's MAR between 3/1/24 and 3/11/24, had recorded entries of NO for all three entries except for the evening on 3/9/24 in which the box was left blank. Responses of YES were documented on 3/12/24, for the morning and noon, and NO for the evening. On 3/13/24, the response was documented and YES.</p> <p>R1's POC documentation included one recorded entry per day which was documented primarily in the morning or mid afternoon. In response to the hallucination question; YES was documented on all days except for 3/1/24, 3/2/24, and 3/3/24.</p> <p>R1's progress note dated 2/13/24 identified R1 was seen by associated clinic of psychology (ACP) and was encouraged to use the PRN medication as needed and inform staff of this need. The note did not include the name of the PRN medication.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's ACP visit note dated 2/20/24, included R1 continued to experience emotional and behavioral symptoms that affect functioning. R1 reports his auditory hallucinations remain stable and the interventions in place are helpful. R1's sleep, mood and appetite are stable. The treatment plan included ACP to remain part of treatment plan.</p> <p>R1's progress note dated 2/23/24 at 1:30 p.m., identified R1 left the facility to visit family member at 7:30 a. m. and planned to return to the facility the next morning. Prior to leaving R1 denied exacerbation of hallucinations and denied suicidal ideations. He was provided with his medications.</p> <p>R1's ACP note dated 2/27/24, included R1 continued to experience emotional symptoms that affect functioning. R1 reports his mood, sleep, and appetite all remain stable. R1 reports his auditory hallucinations remain stable and he continues to use interventions including walks and music. R1 was reminded of his PRN medication and to alert staff if auditory hallucinations increase. Treatment included: ACP to remain part of treatment plan. The note did not include the name of the PRN medication.</p> <p>R1's progress note dated 2/27/24, at 5:22 p.m. psychiatric medical doctor (MD) indicated R1 had an appointment with multiple medication changes that included Sertraline (antidepressant) increased to 150 mg daily, Thorazine 50 mg three times a day and 150 mg at bedtime, seroquel 50 mg three times a day plus 100 mg as needed for insomnia.</p> <p>In review of R1's record it was not evident R1's psychotropic medication changes were continuously monitored for effectiveness.</p> <p>R1's associated clinic of psychology (ACP) note dated 3/5/24, identified progress toward treatment goals and continued medical necessity. Continued services are needed to maintain and improve the client's current level of functioning. Client continues to exhibit behavioral and emotional symptoms that affect functioning. R1 was reminded by treating provider of R1's PRN medication and to alert staff if auditory hallucinations increase. The name of the PRN medication was not mentioned.</p> <p>During interview on 3/13/24 at 2:20 p.m., R1 stated he enjoyed being able to leave the facility to take walks, use public transportation, go to restaurants, and visiting with his mother. He managed his own money and had a bus card. R1 recalled running away from the facility this week and was not planning on coming back. R1 explained there was two ways he would leave the facility and indicated it was dependent on the voices he heard in his head. The first way was taking his phone, going to the nurses station to sign out, and get his GPS tracker. The other way was when the voices gave him the desire to escape or the need to runaway. He would intentionally not bring his GPS tracker because he did not want staff to know he was running away, and there was nothing stopping him from leaving. R1 stated when he heard those voices he felt claustrophobic, felt like his skin was crawling, and it was almost like an attack and could feel my heart pounding. R1 stated the desire to escape came every couple of months.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Birchwood Care Home		STREET ADDRESS, CITY, STATE, ZIP CODE 715 West 31st Street Minneapolis, MN 55408	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's progress note dated 3/9/24 at 9:13 p.m. indicated at 5:15 p.m. R1 was not anywhere in the building, had not signed out, a missing person report was filed, and R1 had not returned until 12:50 a.m. on 3/10/24. R1 reported to facility staff I just was gonna run away. and only returned because it was cold outside. R1 was administered his 8:00 p.m. medications and was given PRN (name of med was not included nor reason/symptomology it was given for) Writer reminded him that he can go to myself or another nurse ect. if he feels like running away again or if the voices start telling him to leave and tell us about what's going on so that we cn give him a PRN or whatever it is that he might need. He said he would.</p> <p>R1's medication administration records reviewed between 3/1/24 through 3/15/24, identified R1 received PRN dose of Seroquel 100 MG orally as needed for insomnia at bedtime on 3/10/24 at 12:51 a.m. R1's record did not identify the indication for which the Seroquel was given and/or the effectiveness for which it was administered.</p> <p>R1's progress note dated 3/11/24, at 9:05 p.m. included staff noted the resident to be missing at 8:30 p.m., last seen between 5:30 p.m. and 6:15 p.m. per trained medication aid (TMA). Secondary note dated 3/11/24 at 9:24 p.m. identified R1 had just walked in stated the crazy thoughts are telling me to leave and can't leave me alone, had to leave for a minute, I feel better now. R1 reminded to take his tracker next time he leaves the facility or at least to let staff know.</p> <p>During interview on 3/14/24 at 10:13 a.m., trained medical aid TMA-(A) indicated on 3/11/24, she provided R1 with his medications at 3:30 p.m. and when she provided medications she was supposed monitor for behavioral symptoms. TMA-A stated she would ask R1 questions like how are you today?, is everything good?, or anything bothering you? but R1 did not typically express a lot. TMA-A did not articulate the questions outlined in the care plan. TMA-A stated R1 had never told her he was hearing the command voices and was not aware of R1's triggers and/or behaviors exhibited when R1 heard command voices. TMA-A stated the first time she had observed anything abnormal in R1's behaviors was on 3/11/24 around 5:30 p.m. He was outside walking away from the facility at a fast pace, his eyes were big, opened wide, and bulging which was abnormal.</p> <p>During interview on 3/13/24 at 3:04 p.m., licensed practical nurse LPN-(A) reported R1 had an ongoing history of elopement. LPN-A reported R1's voices have been a lot worse recently and the voices tell R1 to do things; the facility was trying to figure out why. LPN-A explained R1 heard voices all the time, however some of the voices were mean and intense; these command voices gave R1 more negative direction by telling him to do things which were uncharacteristic such as take off clothing and leaving without telling anyone. LPN-A indicated when R1 was hearing the command voices that's when he would escape from the facility. LPN-A was able to distinguish when R1 heard the negative voices because his eyes would become big and buggy, he tended to pace more, and would ask for more cigarettes. When R1 would demonstrate these behaviors she implemented more frequent checks on his whereabouts. R1's care team tried to keep R1's medication ridged as R1 decompensates very quickly. LPN-A was unaware of any sleep concerns with R1. During subsequent interview on 3/14/24 at 8:45 a.m., LPN-A reported the staff were supposed to have a PRN medication to give to R1 if they identified increased behavioral symptoms and/or command voices, however the medication (Seroquel) that would be used was specifically ordered insomnia at bedtime with no other behavioral symptoms identified for which it could be given for and therefore could not and has not been given during those episodes. LPN-A indicated she had communicated the concern with the psychiatrist (did not identify a date) with no change to the order given. LPN-A explained R1's psychiatrist made large medication changes on 2/27/24, but did not give any direction on how to monitor for the effectiveness or when to follow-up with the results.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 3/13/24 at 4:24 p.m., registered nurse (RN)-A indicated she was familiar with R1 however, was not aware of any behavioral triggers R1 displayed when he heard command voices and described him as having a flat affect (without emotion or stoic).</p> <p>During interview on 3/14/24 at 8:17 a.m., licensed graduate social worker LGSW-(A) reported to provide services through ACP (associated clinic of psychology) and had been R1's provider since may of 2023. LGSW-A had discussed with R1 and encouraged R1 to inform staff when the voices were stating to occur rather than when the voices were at their highest. LGSW-A reported R1 had a PRN medication available to assist with the increased voices but R1 needed to ask staff for medication when the voices were getting worse so that R1 received the PRN medication in time. LGSW-A was unaware R1's medications had changed on 2/27/24 and medications were not managed by ACP but through the primary provider. During subsequent interview on 3/14/24 at 3:34 p.m., LGSW-A reviewed R1's orders and identified the physician had ordered R1's PRN mediation for insomnia at night. LGSW-A reported R1 had never reported poor sleep and had always reported to LGSW-A he had been sleeping well. LGSW-A was not aware of any other mental health care provider was involved with R1's care. LGSW was under the impression R1 had a PRN medication available for when his negative auditory hallucinations increased and staff could prevent R1 from becoming manic.</p> <p>During interview on 3/15/24 at 8:48 a.m., R1's primary physician nurse practitioner NP-(A) stated she had not been notified of R1 leaving the facility without staff awareness and was not aware of the presence of command voices. NP-A indicated the command voices and management would be up to psychiatry. Psychology and psychiatry NP-A was not aware of any concerns with R1's sleep.</p> <p>During interview on 3/14/24 at 3:08 p.m., medical doctor MD-(A) reported to be R1's psychiatrist since Halloween of 2023. MD-A was unaware R1 was being provided ACP services and was unsure if it would be appropriate due to R1's need for a highly specialized provider due to R1's disorders. MD-A indicated he had not been aware of R1's complete behavioral history as a result of the command voices including when R1 had been found with no clothes on outside in cold temperatures last winter (2023). Since MD-A has been treating R1, he did not believe the command voices have led R1 to self-harm. MD-A further indicated R1's command voices could be harmful and cause emotional distress. MD-A endorsed there were medications changes on 2/27/24, including the addition of a PRN dose of Seroquel for resistant insomnia and anxiety. MD-A indicated the PRN dose was prescribed based on R1's concerns of difficulty sleeping and anxiety as the facility did not record or provide sleep logs. MD-A reported auditory hallucinations for R1 can be improved by medication and there was almost not a moment R1 should not be untouched by the frequent doses. MD-A did not address and/or instruct which of R1's medications could be administered PRN to control or manage R1's acute exacerbations of psychosis secondary to R1's command voices.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 3/14/24 at 4:31 Administrator and DON indicated R1 typically left the facility unescorted to psychiatry appointments and R1 would bring a after visit summary (AVS) from the appointment and hand deliver it to the nursing team at the facility. The document then gets uploaded into R1's electronic medical record. If facility nurses have questions or concerns, they have the ability to call R1's psychiatry care team, however all communication should be documented on a referral communication form and that would also be uploaded into R1's medical record. R1's psychology appointments were in house and if the provider had any concerns she would collaborate directly with the nursing team at the facility at the time. Administrator and DON reported R1's psychiatrist had not communicated R1 had feelings of being overwhelmed in his space or in his room. DON was not sure if R1's psychiatrist and care team members through ACP had any collaboration or communication between themselves. DON had not reached out to R1's psychiatrist as had not been aware of any issues that needed to be communicated. DON was unaware of any sleeping concerns for R1 and there was no concerns communicated to the doctor regarding sleep. The only option for medication on board to manage an acute exacerbation of the identified behavior was the Quetiapine Fumarate but that was specifically ordered as needed for sleep at bedtime. There was no medication to offer if and when the negative voices/behavior was identified during the day. Staff were to follow R1's safety monitoring plan to keep R1 safe as well as follow the missing person protocol.</p> <p>Policy and procedures for medication administration and behavioral health was requested and not received.</p> <p>Facility assessment tool dated 7/11/23 identified the facility to be able to manage residents with Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (i.e., Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that Needs Interventions with an acuity number of 60 residents. Specific care or practices include Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities.</p>		