STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southside Care Center	2644 Aldrich Avenue South Minneapolis, MN 55408

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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 - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48037 Based on interview and document review the facility failed to develop and implement individualized non-pharmacological interventions to manage behaviors for 2 of 2 residents (R1, R3) who had mental health disorders with behaviors. The facility's failures resulted in harm for R1 when she sustained burns from using hot towels to self-soothe to relieve anxiety symptoms and had multiple hospitalization for mental health stabilization. Findings include: R1's face sheet identified R1 was admitted to facility October of 2022 with diagnoses including, borderline personality disorder, generalized anxiety disorder, unspecified mood [affective] disorder, and major depressive disorder, single episode, severe without psychotic features. R1's significant change Minimum Data Set (MDS) dated [DATE], identified R1 as cognitively intact with no evidence of acute change in mental status from R1's baseline. R1 did not display behaviors. R1 was independent in mobility and activities of daily living. R1's care plan dated 6/22/23, identified R1 had delirium or an acute confusional episode due to acute disease process [Specify incomplete field] change in condition keep the resident safe from self-harm during episodes of confusion or psychosis. Resident had a history of heating up towels in the microwave and trying to burn herself. Interventions directed staff to identify themselves at each interaction. Face R1 when speaking and make eye contact. Reduce any distractions (turn off TV, radio, close doors etc.). R1 understands consistent, simple, directive sentences. Provide the resident with necessary cues stop and return if agitated. Discuss concerns about delirium with the resident/family/caregiver. Educate the resident/family/caregiver to observe for and report any signs/symptoms of delirium. Engage the resident in simple structured activities that avoid overly demanding tasks. The resident prefers (specify the activities), If resident was not redirectable, send resident 911 to HCMC Hospital for 72 hour hold and 1:1 nursing staffing to prevent self-harm. Resident had a history of trying to burn herself with hot towels from microwave. (continued on next page)

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

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F 0740 Level of Harm - Actual harm Residents Affected - Few	R1's nurse re-admission record dated 2/21/24, (no time identified) indicated R1 had returned to the facility after a hospitalization that began on 2/16/24 related to mental status changes. The note indicated R1's mental status upon return was cooperative and her anxiety had improved. Medications were adjusted in the hospital. The note indicated on 2/22/24 at 1:30 a.m. R1 up to smoke and to have a snack and beverage. R1 stated she's okand seemed less anxious that night. R1 went back to bed after smoking a cigarette, staff were to continue to monitor. R1 started saying she had anxiety at 3:30 p.m. gave her the medication PRN (as needed) medication to calm her down but she was trying to use the hot towel and scrunching herself up against the wall. At 5:30 p.m. R1 was taken to the hospital by staff. R1's behavior monitoring dated 2/22/24, identified R1 had suicidal ideations let me die, let me die due to excessive anxiety she was having. Behaviors included self-injurious heating towel in the microwave too hot to warm her back x2 occasions in the last 7 days. Crying, tearfulness x4 occurrences in the last 7 days. Nursing interventions/comments: unable to sit or stand still. Had the towel in the microwave extremely hot that could burn her skin. Staff trying to prevent her from using it on her back but she kicked staff away. Impossible to have her under control. Had to be taken to the emergency room . R1's progress note dated 2/22/24 at 5:00 p.m., identified R1 was having a lot of anxiety and crying out for help. All R1's medications were administered, but not helpful. Staff had driven R1 to the hospital and was kept for observation. R1's record did not identify non-pharmacological interventions were offered or attempted to reduce or relieve R1's anxiety. Facility reported incident (FRI) dated 2/26/24, identified on 2/22/24 during an anxiety attack, R1 accidentally self-injured her back trying to sooth herself using a heating pad that was too hot. Staff discovered the heating pad and removed it. R1 was sent to the hospital for an emergency mental health crisis- anxiety attack. R1 had a superficial skin open area on her back measuring 3 centimeters (cm) by 3 cm. R1's care plan was not updated with individualized interventions to prevent R1 from burning herself with hot towels and/or alternatives to offer R1 to use to soothe herself when she became anxious. Emergency Department (ED) discharge summery dated 2/22/24, identified R1 had a hospital visit from 2/22/24 and discharged [DATE] for the principal problem of agitation. Note identified R1 was recently in the hospital and was discharged two days prior when symptoms were similar. Recommendations for outpatient provider identified to address concerns on a follow up visit included: adherence to medications and sleeping well. R1's progress note dated 2/25/24 at 4:30 p.m., R1 was back from hospital. All medication had stayed the same from previous hospitalization . Note indicated R1 was provided with a sleep medication to help her sleep and avoid anxiety episodes during the day. R1's back was charcoal burnt black with two large open areas. Very painful to touch when assisting her to take top off. Writer had applied bacitracin (antibiotic) on gauze to the open areas. Resident strongly advised to stop heating up towels to destroy her back. Resident could have neuropathy so does not feel the excessive heat to the back but was burning her skin. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	R1's care plan dated 3/2/24, identified R1 was resistive to care due to anxiety attack brought on by episodes of insomnia. During an anxiety attack the resident will ask for help but refuse to go to the hospital. In the past the resident will only agree to go to the hospital if staff drive her in the car. R1 will not go by ambulance through 911. R1 has a history of insomnia resulting in anxiety attack. Staff are to give clear explanation of all care activities prior to and as they occur during each contact. Staff were to give one-to one attention for (individualized minutes and times each day/week field) were left blank. Praise R1 when behavior was appropriate. Provide opportunities for choice during care provision. Resident triggers for resisting care are (Specify incomplete field) were left blank. The resident's behavior was de-escalated by (Specify incomplete field) were left blank. R1's care plan lacked individualized non-pharmacological interventions to manage insomnia to prevent and/or reduce the risk of anxiety attack. The care plan continued to lack individualized non-pharmacological interventions to prevent R1 from burning herself with hot towels and other injurious behaviors to self-soothe. Additionally the care plan did not identify individualized interventions to mange insomnia nor a quanitative/qualitative assessment of R1's sleep patterns in order to develop interventions and/or assessment to determine the effectiveness of sleep medication. During interview on 10/18/24 at 9:37 a.m., R1 reported sleep was a continued factor which affected her anxiety. R1 described a good night sleep of consistent sleep of 8 to 9 hours a night and a poor night sleep would be 3 hours at night or inconsistent sleeping hours or choppy sleep. Poor sleep had been happening approximately one to two times a week while in the facility. R1 reported the first sign of anxiety was pacing and needing to go outside to go for a walk or smoke. R1 reported when the need to repetitively smoke the anxiety was probably starting to get pretty bad. Other coping strategies R1 would utilize in the facility was a hot shower and to try a heated towel from the microwave, R1 would use the hot towel to put on her back to fall asleep. R1 denied it to be an intentional self-injurious, however, reported to be pretty ramped up if using the hot packs. R1 denied ever burning self from a hot pack. R1 had been directed to request PRN medications as needed when needing to shower or use a hot pack. R1 reported she was supposed to ask when needing medications and facility staff do not anticipate R1's anxiety or encourage medication until its uncontrollable. R1 reported when begging or crying for medication it's too late and the medication does not work. R1 reported staff tend to try to talk to her, however when anxiety is too bad its too difficult to be redirected. R1's progress notes, behavior monitoring documentation, and as needed psychotropic medication administrations were reviewed between 3/19/24 through 10/12/24. The record revealed despite R1 continuing to use or attempt to use hot towels and rub her back up against walls no individualized interventions were developed or implemented to manage the behavior other than temporarily removing the microwave, no alternatives were evident including staff consistently offering PRN medications. R1's progress note dated 3/19/24, identified R1 had seen certified nurse practitioner (CNP)-A from clinical psychiatry. R1 had been stable since recent hospitalization when Belsomra (suvorexant) prescribed for bipolar insomnia diagnosis. Disrupted sleep was contributing to anxiety exasperation. Since prescription R1 was sleeping better. No concerns currently. No medication changes were proposed. R1's progress notes from 3/19/24 through 8/22/24 did not address R1's behaviors. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	R1's progress notes from 8/23/24 at 5:00 p.m., identified R1 had severe anxiety episode. R1 became restless, scratching her back against the wall. Unable to utter sensibility, heating up the towel in the microwave too hot to the back of her skin. Writer was with her most of the time to help calm her down. This time her medication at 5:00 p.m. and the HS (hours of sleep) medication helped, and she was back to normal by 11:00 p.m. R1's progress notes from 8/29/24 from a late note entry dated 8/30/24 identified R1 had severe anxiety at approx. 1:00 p.m. Writer and social worker escorted the resident to United Hospital due to anxiety attack and psychosis. Resident scratching back on doorway trying to self sooth anxiety. Unable to sit still, refusing medication, refusing to eat. 1:1 staffing required, so writer escorted R1 to an inpatient mental health unit. Emergency Department (ED) discharge summery dated 8/29/24, identified R1 had a hospital visit from 8/29/24 and discharged on [DATE]. Reason for admission was due to a concern for mania and chief complaint of anxiety. R1 required hospitalization due to potential safety risk to self or others within the last week., diagnostic clarification, decreased functioning in setting of inadequate outpatient management, need for highly structured inpatient management for stabilization of psychiatric symptoms and for psychiatric medication initiation and stabilization. R1 was stabilized and discharged . R1's progress note dated 9/6/24 at 11:00 a.m. identified R1 had high anxiety this morning and started heating up washcloth and putting on her back. Writer encouraged resident not to do too hot for washcloth to prevent skin burn. There was no indicated other than to encourage her not to use the hot pack to assist with her anxiety. R1's progress note dated 9/6/24 at 3:00 p.m., indicated R1 was a little sad because her dialysis could not be completed and had to go back to the surgical room again on Monday . Noted the presence of anxiety that make her restless. R1 started to heat up towel too hot to warm her back. Scratching her back and legs on the wall and speech not very clear. She asked for PRN medications including Seroquel and calmed her down a bit. At 8:00 p.m. staff had to monitor R1 so she does not warm the towel in the microwave too hot to put on her skin. Given meds at 9:00p.m. R1's progress note dated 9/7/24 at 1:00 p.m., writer had got report from night nurse that R1 used hot towel on her back during night shift. Night nurse took the microwave downstairs. Resident went downstairs and got microwave and started heating up towel too hot. Writer encouraged resident not to do too hot towel. Resident refused and started heating up too hot. Writer removed microwave. R1's progress note dated 9/7/24 4:15p.m., identified R1 took a shower this morning and came out with a towel wrapped around her and writer noticed how badly her back looked. It looked like a lizard skin. Has black (dark) and looked like somebody burned patient all over with cigarette. R1 was starting to wet towels and put them in the microwave for 4 minutes. Writer had to tell her she was endangering herself and burning her back, but patient ignored staff. Writer had to call manager and remove microwave and place it downstairs, hoping it stopped patient from burning her back. R1's progress note dated 9/7/24 at 9:00 p.m., identified resident had been unable to eat all day. Instead, she had been jerking, scratching her back against the wall and unable to sit still. When she sits her preference was to sit on the table and not the chair. Took all medications at 8:00 p.m., but at 9:00 p.m. not the slightest improvement. R1 looked too miserable to be here so writer called and sent resident back to hospital. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Emergency Department (ED) discharge summery dated 9/7/24, identified R1 had a hospital visit from 9/7/24 and discharged on [DATE]. The reason for continued admission was due to decompensated mental illness conditions. Stabilization was required prior to transferring R1 back to facility R1's progress notes identified R1 was readmitted to facility from hospital 10/4/24 at 4:00 p.m., and R1 had a follow up outpatient psychology appointment on 10/8/24. R1's PRN medication administration record (MAR) for October 2024 identified the following physician orders: -Order date 10/4/24 Quetiapine (Seroquel) 50 milligram. Take one tablet by mouth every six hours as needed for agitation (not further defined) identified two doses administrated on 10/11/24 at 10:00 p.m. and 10/12/24 at 10:40 a.m. -Order date of 9/5/24 hydroxyzine pamoate 50 mg capsule (Vistaril) 1 cap by mouth every six hours as needed for anxiety (not further defined). Signed on 10/11/24, however time was not noted. R1's progress note dated 10/11/24 identified R1 came out of room reported feeling very anxious and wanted to heat some towels in the microwave. Nurse informed R1 that would not be beneficial and redirected R1 to take a PRN hydroxyzine. R1 agreed and went back to room. While writer was in restroom, R1 used the dining room microwave to heat up wash cloths in a plastic bag. Resident perplexed it helps. Education provided on the dangers of hot towels on skin. Resident reported no its fine. Removed microwave for safety reasons. Besides removing the microwave there was no indication if other interventions were used to address R1 anxiety. R1's document titled behavior sheet dated 10/11/24, identified the following: R1 resists cares does her own plan ignores staff x 2 occurrences in the last seven days. Self-injurious goes out after curfew to smoke x2 occurrences in the last seven days. Delusions x 3 occurrences in the last seven days believes she can take care of herself. Inappropriate smoking behaviors x3 occurrences in the last seven days chain smokes. Nursing interventions/additional comments: Resident believes she can live in her own apartment and take care of herself; staff have to watch her when she is anxious, she will heat towels too hot and burn herself. R1's weekly progress note/care plan review dated 10/11/24, identified R1 rarely requests PRN's during the night shift, she remains intact with bruises and scar tissue, she sleeps well some nights, she goes out after curfew to smoke. R1's progress note dated 10/12/24 at 4:00 a.m., identified writer arrived on shift and immediately R1 went to take shower. It was a long shower. After that asked nurse to warm up towels, nurse replied she was not allowed to do that. R1 continued to ask writer said no again. R1 went to room to sleep. Around 4:00 a.m. R1 tried to teat up towels in kitchen. Writer told her it was not allowed and removed both microwaves due to R1 heating up towels so hot and placing them on her back. R1's back is scarred. R1's progress note dated 10/12/24 at 7:00 a.m., identified R1 was restless all night and was reporting anxiety. R1 received all PRN medication, Resident was undirectable [sic] to any cues. Resident was crying. Writer called 9-1-1 and sent to hospital. Resident was taking hot showers and rubbing against doorways. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 10/12/24 3:00 p.m., identified resident from when she left until 3:00 p.m. did not sleep. Resident smoked 2-6 cigarettes to keep busy. Resident kept begging staff to get the microwaves out. Resident was crying and rocking back and forth. Called EMS and returned to emergency room . Emergency Department (ED) discharge summery dated 10/12/24, identified R1 had a hospital visit from 10/12/24- Current. R1 was admitted for the chief complaint of anxiety and high blood sugar. R1 arrived by emergency medical services from R1's facility. R1 had reported having an anxiety attack for the last 23 hours and started throwing up and reporting severe abdominal pain. There was no indication in the medical record the the facility had completed a comprehensive assessment to determine triggers, or any specific behaviors pattern or trends that could be addressed by medication management or interventions to reduce or prevent her anxiety that resulted in several hospitalization s. During interview on 10/18/24 at 12:21 p.m., family member (FM)-A reported R1 had a long-standing history of anxiety prior to admitting to the facility. FM-A reported concerns regarding R1's sleep and when FM-A received late-night phone calls to be very worried about R1's anxiety for the next day. If R1's sleep was out of control it would be a trigger for behaviors to get worse. FM-A reported historically R1 had a weighted blanket but was unsure where it had gone. FM-A reported PRN medications were for the facility to provide prior to R1 not sleeping and prior to R1 reporting she needed it. FM-A reported R1 was to receive the PRN's from facility staff based of how R1 was acting or how her behaviors were. During interview on 10/18/24 at 10:15 a.m., licensed practical nurse (LPN)-A reported R1 did fine on her good days, however had times with a lot of anxiety and scratching her back on the walls. LPN-A reported staff were to calm her down by providing R1 with an as needed medication if it was available (Seroquel). LPN-A recalled providing R1 an as needed medication in the month of October as R1 was acting up and having one of her episodes. LPN-A described this behavior as R1 scratching her back on walls, warming up wash cloths and when she starts to beg/cry to know R1 needed her as need medication. LPN-A reported had needed to hide the microwave as R1 was attempting to warm up towels too hot. R1 was independent and able to do so without assistance, but staff do not condone it. LPN-A reported R1 did not display signs of anxiety until R1 was scratching her back. Staff were only able to give her the as needed medication and there is nothing else staff can do. R1 was able to report anxiety and tell staff it's getting worse, but once she's gone, she's gone. LPN-A reported R1 may needed more medication to cope with the anxiety and more psychological help. During interview on 10/22/24 at 10:45 a.m., registered nurse (RN)-B reported R1 was in the facility for medication management and was independent in most of her cares. RN-B reported R1 had anxiety and R1's anxiety presents when she was crying and starts acting like she needs medication. RN-B further described this behavior as crying, taking multiple showers, and warming towels. In most cases R1 would ask for the medication and the PRN medication was for when R1's anxiety was bad. RN-B was unaware of any non-pharmacological options that were successful for R1. RN-B reported when R1's anxiety comes the facility staff cannot control it and was unsure why her medication was not working. RN-B reported staff were unable to provide R1 with PRN medications unless R1 requests it. RN-B would not give PRN medication to prevent anxiety such as going to a dialysis appointment and only provide it if R1 requests it. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	During interview on 10/18/24 at 2:38 p.m., RN-A recalled being the RN who needed to send R1 to the hospital on the morning of 10/12/24. R1 was noted to be anxious and walking back and forth. When asking about R1's anxiety R1 reported I just can't. R1 was attempting to warm towels with the use of the microwave and education provided for safety. RN-A educated R1 on heating packs that do not get as hot can be sold at Walgreens, however, the facility did not have any alternatives to offer R1. RN-A reported R1 was not allowing RN-A to heat the hot pack for R1, as R1 wanted to heat it longer than 2 minutes. RN-A was attempting to redirect R1 by talking to her. RN-A reported giving all PRN medications available, and R1 wanted to shower when night shift had arrived. RN-A had asked the overnight staff if R1 was able to get any sleep. R1 had not, however, was water seeking and trying to get hot water or to heat towels. LPN-A had removed one of the microwaves. RN-A was worried as R1 had not slept and was rubbing her back on the sides of doorways. RN-A had contacted 911 around 7:00 a.m. RN-A reported only giving a PRN medication if R1 asks for it. During interview with administrator on 10/23/24 at 9:56 a.m., Administrator/director of nursing reported R1 had stress related triggers such as going to multiple medical appointments and inability to sleep. Staff should be giving PRN medication prior to R1 having an episode of crying, using hot packs and the inability to self-regulate/self sooth. Administrator reported the facility could have done a better job offering the PRN medications. Administrator reported R1's sleep could impact her stress tolerance and the facility had been tracking the hours of sleep, however not monitoring the quality of sleep. The facility had a sleep disturbance evaluation tool which could have benefited R1. Additionally, Administrator reported R1's care plan was not individualized and did not have all of R1's triggers nor individualized interventions identified. R1's target behaviors were not being monitored. During interview on 10/22/24 at 3:32 p.m., certified nurse practitioner (CNP)-A reported to be a board-certified nurse practitioner specializing in psychiatry who had worked with R1 for [AGE] years working together on an outpatient bases and consulting as needed while she was inpatient. CNP-A reported seeing R1 about monthly, however due to inpatient hospitalization s outpatient services would be delayed. CNP-A reported seeing R1 in December and then not again until March, May and then June. July got delayed until October due to frequent hospitalization s. During that time CNP-A had contact with impatient psychiatry team. CNP-A reported R1 was on a PRN Seroquel for agitation. R1 should be asking for medications ideally, but the facility should also be offering when they are seeing some key futures of R1's agitation such as pacing or frequently smoking. R1 was described as a very vulnerable adult who may not always present as such due to age and appeared functional. CNP-A reported R1's anxiety presents as very restless and agitated. If R1's behaviors present past that, R1 would either do healthy coping or unhealthy coping such as using hot towels and burn her back. Using hot towels had been a long-standing coping strategy described as an intentional and self-inflicted relief such as cutting/burning/punching self. R1 was known to intentionally attempt this method to self-regulate, not attempting to kill herself. R1's sleep was reported as intermittently terrible and waxes and wanes. R1's sleep was known to affect the way R1 could respond to anxiety or stress. CNP-A reported it was an indicator R1 could be kind of destabilizing and was currently R1's biggest complaints. Non-pharmacological interventions that are successful include some movement with activity, crafting and reported R1 had limited tools and was one of the reasons they were initiating dialectical behavior therapy (DBT) since this recent hospitalization . R3's face sheet printed identified R3 was admitted with diagnoses including, schizoaffective disorder, depressive type, other psychoactive substance use, unspecified with psychoactive substance- induced mood disorder and unspecified mental disorder due to known physiological condition. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	R3's quarterly change Minimum Data Set (MDS) dated , 7/27/24 identified R3 as cognitively intact with no behaviors. R3 was independent in mobility and activities of daily living. R3's care plan dated, 2/6/2021 identified R3 had alteration in neurological status of paranoid delusions people are out to get her due to schizoaffective disorder. R3 was to be assessed for effects of psychotropic medications, dystnoia, akithesia, akinesia, rigidity, tremors, etc. R3 required cueing reorientation as needed. Staff were to give medication as ordered. Monitor/document for side effects and effectiveness. Staff were to provide main management as needed. See medical doctor (MD) orders. Provide alternative comfort measures as needed. Staff were to give PRN analgesics and monitor effectiveness. Report new onset of pain to MD. R3's medical record lacked individualized behavior interventions for target behaviors. R3's behavior monitoring sheet requested and not received. During an interview on 10/23/24 at 3:33 p.m. DON/administrator stated we have identified target behaviors for our residents but have not gone the extra step to include personalized interventions for target behaviors. During interview on 10/23/24 at 4:13 p.m., DON/administrator reported the facility did not have any policy or procedure related to mental health/behavioral management/psychiatric or mental health care needs.