STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265001	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Athene Nursing and Rehabilitation	13995 Clayton Road Town and Country, MO 63017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40865 Based on observation, interview and record review, the facility failed to ensure four of six sampled residents were free from physical abuse. The residents' right to be free from physical abuse were violated when during two separate incidents a resident (Resident #2) hit four residents (Resident #5, Resident #6, Resident #3 and #4) in the face and stomach. The census was 92. On 7/1/24 at 5:00 P.M., the Administrator was notified of the past noncompliance, which occurred on 6/28/24. On 6/28/24, the Administrator was notified by staff of the incident and an investigation was started. The facility immediately took steps to protect the residents and set interventions in place to prevent further abuse. The alleged violation was reported within the required timeframe. Facility staff received education on the facility's Abuse and Neglect Policy. Resident #2 was discharged to the hospital and is not expected to return. Appropriate corrective actions were taken. The deficiency was corrected on 6/30/24. Review of the facility's Abuse, Neglect and Exploitation policy, revised 8/22/22, showed: -Definitions: --Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation of an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology; --Physical abuse includes but is not limited to hitting, slapping, punching, biting and kicking; -Policy Explanation and Compliance Guidelines: --The facility will develop and implement written policies and procedures that: --- Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	---Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention; --The facility will provide ongoing oversight and supervision of staff to assure that its policies are implemented as written; -Prevention of Abuse, Neglect, and Exploitation: --The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that includes: ---Identifying, correcting and intervening in situations in which abuse, neglect, exploitation and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; ---The identification, ongoing assessment, care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict or neglect; ---Addressing features of the physical environment that may make abuse, neglect, exploitation and misappropriation of resident property more likely to occur; ---Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors; -Identification of Abuse, Neglect and Exploitation: -The facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations; -Possible indicators of abuse include, but are not limited to: --Physical marks such as bruises or patterned appearances such as a hand print, bell or ring mark on a resident's body; --Physical abuse of a resident observed; --Verbal abuse of a resident overheard; --Psychological abuse of a resident observed; -Protection of the resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Responding immediately to protect the alleged victim and integrity of the investigation; --Increased supervision of the alleged victim and residents. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/25/24, showed: -Severely cognitively impaired; -Diagnoses included dementia, heart failure, Alzheimer's disease, restlessness and agitation, cognitive communication deficit and other abnormalities of gait and mobility. Review of the resident's progress notes, showed: -On 3/30/24 at 8:45 P.M., the nurse observed the resident being combative with staff and trying to go into other resident rooms. Staff were able to redirect him/her after 15 minutes; -On 5/5/24 at 4:43 P.M., the resident was not following directions and was acting inappropriately. He/She blockaded the staff from leaving the station and was moving his/her hands around swinging at staff. He/She was swearing at residents and staff. Staff spoke with the resident's family member and recommended sending him/her to the hospital after consulting with his/her physician for evaluation; -On 5/17/24 at 9:52 P.M., staff observed the resident being physically abusive toward staff members and attempting to be physically abusive towards residents on the unit. The resident was not easily redirected. The resident had an open area to his/her forearm which reopened and when the nurse tried to clean the area, the resident balled up his/her right fist and hit him/her in the stomach. The resident attempted to swing on staff when they were trying to toilet him/her. He/She propelled down the hall entering other resident rooms. He/She picked up a water pitcher and threw water on staff and residents by the desk. Staff continued to redirect and were not successful. Staff sent the resident to the hospital for evaluation; -On 6/13/24 at 6:55 P.M., the resident exited his/her room and charged towards a resident and punched him/her in the stomach. The resident then turned towards staff and grabbed their clothing, punching and swinging uncontrollably. The resident then turned towards another resident and punched him/her in the head and slung him/her to the floor. The resident then attacked the Assistant Director of Nursing and another floor nurse who attempted to assist staff. Staff were unable to redirect the resident. The nurse called 911 and sent the resident to the emergency room ; -On 6/13/24 at 8:14 P.M., the resident was up in his/her wheelchair and displayed physical aggression towards a peer. Staff were unable to redirect the resident verbally. The resident became combative with staff. Staff escorted peers in the dining room away from the resident so he/she could not harm them. Staff notified the resident's physician who ordered him/her sent out to the hospital for psych/behaviors due to being harmful to others and him/herself. The resident continued his/her combative behavior by swinging and propelling fast towards staff. Staff stayed with the resident until the police and paramedics arrived. The resident became calm once the police stood next to him/her. The resident had a skin tear on his/her left forearm which was bleeding. He/She allowed the Assistant Director of Nursing to clean and place a bandage on it before leaving with the paramedics. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's admission MDS, dated [DATE], showed: -Mildly cognitively impaired; -Diagnoses included aphasia (a disorder that affects how you communicate) after stroke, paranoid personality disorder (a mental health condition marked by a pattern of distrust and suspicion of others without adequate reason to be suspicious), dementia, bipolar disorder (a chronic mood disorder that causes intense shifts in mood, energy levels and behavior) and muscle weakness. Review of Resident #6's quarterly MDS, dated [DATE], showed: -Severely cognitively impaired; -Diagnoses included dementia, high blood pressure, major depressive disorder, encephalopathy (damage or disease that affects the brain), unspecified lack of coordination and cognitive communication deficit. Review of a handwritten statement by Certified Nurse's Aide (CNA) L, dated 6/13/24, showed: -The staff member witnessed Resident #2 punch Resident # 5 in the stomach and was trying to fight him/her; -When the staff tried to stop him/her, the resident attacked them; -The resident then walked up to Resident #6 and pulled him/her by the hair, punched him/her in the head and pulled him/her to the ground; -The resident was still trying to fight staff as they were pulling the residents apart. Review of the investigation provided by the facility dated 6/13/24, showed: -At approximately 7:15 P.M., the resident exited his/her room and propelled his/her wheelchair and charged towards a resident in the hallway and punched him/her in the abdomen; -He/She then turned towards staff grabbing staff clothing, punching and swinging uncontrollably while staff attempted to redirect him/her and maintain a safe environment for him/her and all the others on the unit; -While staff were attempting to calm and redirect his/her behaviors, the resident charged towards another resident while he/she was walking in the hallway outside his/her room and punched him/her in the head and pushed him/her to the floor; -Staff were able to separate the two residents and remove all other residents from the area during the incident preventing any other residents from being struck by the resident; -The resident continued to display aggressive and combative behaviors with the staff who were attempting to deescalate his/her behaviors and calm him/her down; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff called emergency services due to their inability to calm the resident or redirect his/her behavior and in an effort to maintain the safety of all other residents and staff on the unit; -On 6/21/24 the resident returned to the facility and the following interventions were put in place: -Family called and reviewed plan of care for behaviors; -Care plan meeting scheduled; -Resident placed on hour rounds for 24 hours to monitor behaviors and aggression; -Medication orders received for behavior management from hospital; -Resident evaluated by physician upon return from hospital and orders placed. Review of the hospital discharge paperwork provided by the facility, showed the following: -The resident presented from the skilled nursing facility on 6/13/24, for agitation, combative, aggressive behaviors. He/She reportedly injured two staff members; -The resident was aggressive with emergency department staff and required chemical sedation and restraints overnight; -The resident's family member said this is the third time in six months the resident was sent to the hospital for aggressive behaviors, and he/she feels helpless to stop the cycle for the resident coming to the hospital and returning to the nursing home without any changes or improvement; -The hospital staff contacted the facility staff who reported the resident was sent to the hospital because he/she assaulted a resident and one of their staff. He/She knocked down one of the residents who has dementia and punched one of the staff in the face. They had to stop him/her from using a wheelchair. The facility was unlikely to take him/her back and requested a 72 hour hold to make sure his/her behavior was stable before coming there again; -The treatment options and alternatives, including medications and their side effects were reviewed: -Close observations for safety; -The treatment team will develop a comprehensive plan, including pharmacological and psychological approaches; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Social work consult to establish outpatient psychiatric and medical follow up care. Review of the resident's care plan, dated 6/13/24, showed: -Focus: The resident resides on the memory care unit; -Interventions: Monitor the resident per protocol to ensure safety; -Focus: Resident has a behavior problem (date initiated 5/13/24, revision on 5/26/24); -Interventions: Administer medications as ordered; -Interventions: Anticipate and meet the resident's needs; -Interventions: Caregivers to provide opportunity for positive interaction, attention. Stop and talk to him/her; -Interventions: Explain all procedures to him/her before starting and allow resident time to process the information (revision on 5/26/24) -Interventions: Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternative location as needed; -Interventions: Monitor behavior and episodes and attempt to determine underlying cause. Document behavior and potential causes (all interventions initiated on 5/13/24); -No new documented behavioral interventions after 5/26/24 prior to the 6/28/24 assault. Review of the resident's progress notes, showed: -On 6/22/24 at 4:39 A.M., the resident had to be redirected several times during the evening for going in and out of resident rooms and being verbally abusive; -On 6/28/24 at 11:13 A.M., the staff notified the nurse the resident was in the dining room attempting to take another resident's breakfast tray. When the other resident refused to give up his/her tray, the resident became physically aggressive towards the resident. Staff quickly intervened removing the resident from the dining room, away from other residents. The resident was in the hallway propelling him/herself towards staff with his/her arm in the air and hands balled up into a fist. The staff observed the resident attempting to charge at another staff member. The nurse was unable to redirect the resident. Staff administered an as needed medication. It was ineffective. The resident continued to refuse care and help. Staff notified the resident's physician and sent the resident to the hospital. Staff sent the bed hold policy and a copy of an immediate discharge with the resident to the hospital. Review of Resident #3's quarterly MDS, dated [DATE], showed: -Severely cognitively impaired; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included unspecified dementia, history of falling, macular degeneration (eye disease), delusional disorders (an unshakable belief in something that's untrue) and cognitive communication deficit. Review of the facility's investigation, dated 6/27/24, showed: -On the morning of 6/28/24, on the Memory Care Floor, Resident #2 and Resident #3 were seated in the dining room; -Resident #2 attempted to take Resident #3's food while he/she was eating and he/she pulled his/her plate back; -Resident #2 then hit Resident #3 in the face; -Resident #4 was standing nearby and saw Resident #2 hit Resident #3 and asked why he/she would hit him/her; -Resident #2 then got aggressive towards Resident #4 and hit him/her in the stomach; -Staff quickly intervened and separated the residents; -Staff called for Emergency Medical Services (EMS) to take Resident #2 out for aggressive behavior; -Staff notified the residents' families and physicians; -Staff completed skin and pain assessments on the residents. Observation on 7/1/24 at 1:20 P.M., showed Resident #3 sat at a table in his/her wheelchair in the dining room, on the secured memory care unit. He/She was small in stature and only spoke in garbled speech. He/She had slight reddening to the right side of his/her face. Observation and interview on 7/1/24 at 1:25 P.M., showed Resident #4 sat at the table in the dining room on the secured memory care hall and said he/she did not know why Resident #2 hit him/her. He/She could not remember the entire incident but did remember being hit. All he/she did was ask the resident, Why did you do that? and the resident hit him/her. He/She was not afraid of the resident but was glad he/she was not at the facility. During an interview on 7/1/24 at 1:00 P.M., Certified Medication Technician (CMT) M said the resident could be aggressive with members of the opposite sex. He/She had been told to stay close to him/her and watch him/her for triggers, but the problem was you never knew what was going to trigger him/her. The resident could be perfectly fine and then would strike out. It might be okay if there were enough staff to deal with him/her, but if they were short staffed or there were only females working, it might be a problem. He/She did not feel like they could keep the other residents safe from him/her because he/she was so unpredictable. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/1/24 at 1:15 P.M., Licensed Practical Nurse (LPN) F said he/she was here on 6/28/24 when the resident assaulted the two other residents in the dining room. They immediately removed the other residents from the dining room, but he/she followed them out into the hall. They would think he/she was calm, and then he/she would get agitated again. He/She got more and more combative, and they ended up taking him/her to another floor to calm him/her down. He/She could not assess him/her because he/she was so combative. A male CNA came to the floor to help get him/her off the hall. The resident had been aggressive before and had attacked another resident. It was getting bad. They had been told to remove the parties from the situation and try to redirect the resident, but he/she was hard to redirect. Once his/her trigger was pulled, there was nothing you could do. During an interview on 7/1/24 at 1:45 P.M., CNA N said the resident and Resident #3 were seated by each other and the resident took his/her plate of food. When Resident #3 went to take it back, the resident hit him/her in the face. You could hear the loud smack where he/she hit him/her. Resident #4 asked Resident #2 why he/she hit Resident #3, and the resident turned around and started attacking Resident #4. The CNA and another staff member pulled Resident #2 away, but he/she kept trying to attack Resident #4. Resident #2 hit Resident #4 in the arm as he/she went by him/her. They were finally able to get some more nurses and a male CNA down to calm the resident down and take him/her off the floor. The resident had been aggressive like that before. He/She had tried to slap CNA N before also, but he/she had been able to redirect him/her. If you did not approach him/her in the right manner, it could be a problem. He/She believed Resident #2 could be a danger to the other residents due to his/her size and unpredictability. During interviews on 7/1/24 at 9:15 A.M. and at 5:10 P.M., the Administrator said they put interventions in place after the assaults on 6/13/24. The family did not want the resident to be too medicated. They sent the resident out immediately after the assault on 6/28/24. He thought they did everything they could do. MO00238273

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40865 Based on interview and record review, the facility failed to ensure pre-admission screenings were completed timely and failed to incorporate the recommendations from the Pre-admission screening and resident review (PASARR) Level II determination and the PASARR evaluation report for one of six sampled resident's (Resident #1's) plan of care. The census was 92. Review of the facility's Resident Assessment-Coordination with PASARR Program policy, revised on 9/1/21, showed: -This facility coordinates assessments with the PASARR program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs; -All applicants to the facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening; a. PASARR Level 1- initial pre-screening that is completed prior to admission; -Positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission; b. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has mental disorder (MD), intellectual disability (ID), or related condition, determines the appropriate setting for the individual and recommends any specialized services and/or rehabilitation services the individual needs; -The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission; -The social services director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority; -Recommendations such as any specialized services from a PASARR Level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning and transitions of care; -Any Level II resident who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional resident review. Examples include: *A resident who demonstrates increased behavioral, psychiatric, or mood related symptoms; (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*A resident with behavioral, psychiatric or mood related symptoms that have not responded to ongoing treatment. Review of the facility's Comprehensive Care Plan policy revised on 9/1/21, showed: -It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment: -Person centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives; -The comprehensive care plan will describe, at a minimum, the following: -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; -Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment; -Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations; -The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented as needed; -The facility will document alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative. Review of the Missouri Long-Term Care Information Update, dated 2/17/23, showed the following: -With the recent announcement from the [NAME] House regarding the official end of the Public Health Emergency on May 11, 2023, the waiver that allowed nursing homes to admit new residents who have not received PASARR Level I screenings and Level II evaluations will terminate on May 11, 2023. -That date is beyond the 60 day notice that Centers for Medicare and Medicaid Services (CMS) has previously said would be given to allow states to unwind any COVID related changes to their PASARR program. As such, CMS will expect states to resume the completion of PASARR activities prior to admission as of May 12, 2023. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The PASARR process requires that all applicants admitting to Medicaid-certified nursing facilities be screened for possible serious mental disorders or intellectual disabilities and related conditions. This initial pre-screening is referred to as PASARR Level I, and is completed prior to admission to a nursing facility. A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. A positive Level 1 screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR Level II, which must be conducted prior to admission to a nursing facility. Review of Resident #1's medical record, showed: -admitted [DATE]; -Diagnoses of chronic kidney disease, diabetes, unspecified mood disorder, schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), acute kidney failure, unspecified psychosis (mental disorder with symptoms that happen when a person is disconnected from reality and cognitive communication deficit). Review of the PASARR Level I screening, referral completion date 5/30/24, showed the following: -Does the individual have any area of impairment due to serious mental illness: Yes; -Does the individual have a suspected diagnosis or history of an intellectual disability/related condition: Yes; -admitted to nursing facility 5/30/24. Review of the resident's PASARR/Level II Evaluation, dated 6/19/24, showed: -Reason for nursing facility application, admission or continued stay: -Assistance needed to completed activities of daily living (ADLs; eating, dressing, grooming, bathing, incontinence care); -Assistance needed for transfers, ambulation, fall prevention; -Behavioral difficulties and/or mental illness symptoms requiring 24 hr monitoring/management; -List all documented historical and current psychiatric and intellectual disability/developmental disability diagnoses: Paranoid Schizophrenia; -List all medical conditions that could exacerbate, mimic to be related to mental illness symptoms or be considered developmental disability related condition: Chronic kidney disease, high blood pressure and diabetes; (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Describe historical symptoms of behavioral symptoms indicating a psychiatric disorder: Hospital discharge summary: 5/29/24: Patient with intermittent tangential speech and reported history of schizophrenia and requested to see psychiatry. During current admission, there has been documentation he/she has been sexually inappropriate to female staff. He/She has been facetiming with people with other residents without their consents. On 6/10/24 he/she called the police after a misunderstanding regarding medication; -Describe any previous psychiatric treatment: Resident has had multiple inpatient admissions; -Describe previous medications used to treat mental illness including current or recent use of medications that could mask or mimic mental illness symptoms: Thorazine (antipsychotic - used to treat behavioral disorders)/Cymbalta (antidepressant - used to treat depression) -started while inpatient; -Mental status examination: Unable or unwilling to participate; -Affective behavioral observations: Unable to asses; -Does the individual have a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders including schizophrenic, mood, paranoid, panic or other severe anxiety disorder, other psychotic disorder or another mental disorder that may lead to a chronic disability: Yes: Schizophrenia; -As a result of the previously indicated major mental disorder, has the individual experienced functional impairment which has substantially affected one or more major life activities (including ADLs or functioning in social, family and academic or vocational contexts) or would have caused functional impairment without the benefit of treatment or other support services? Yes: Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interactions; agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations; self-injurious, self-mutilation, suicidal; physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability or requires intervention by mental health or judicial system; -Concentration, Persistence and Pace: The individual has serious difficulty in sustaining focused attention for long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings; difficulties in concentration; inability to complete simple tasks within an established time period; makes frequent errors or requires assistance in the completion of these tasks, or has impairment of ADLs; -As a result of the previously indicated major mental disorder, has the individual required intensive mental health services (more intensive than routine follow up care) provided by mental health professional to stabilize or maintain a person experiencing a significant disruption of their major mental disorder in the last two years? Yes: Psychiatric consultation of other services by mental health professionals, community mental health services, mental health the primary reason for nursing facility (NF) admission or continued stay; -Is the level of support for ADLs and other identified needs such that the individual's total care needs could be met in a nursing facility? Yes; (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Could alternatives to nursing facility services be considered at this time: No; The resident was previously living at home and unable to take care of him/herself. He/She was noncompliant with medications and basic daily needs. He/She has a limited support system who is unable to ensure he/she is taking his/her medication and assist with his/her ADLs. He/She requires assistance with ADLs, medications administration and meal preparation. Also, while in the current skilled nursing facility, he/she has had sexually inappropriate behaviors which could put him/her at risk if alone in the community; -The individual needs or continues to need the following supports and services: -Provision of specific services to address the individual's mental health and behavioral needs; -Monitoring of behavioral symptoms; -Medication therapy and monitoring symptoms; -Monitoring of therapeutic effects in managing mental health symptoms including labs as indicated; -Provision of a structured environment:; -Maintain environment with low stimulation; -Provide instructions at the individual's level of understanding; -Assess and plan for the level of supervision required to prevent harm to self or others; -Provide for sensory supports; -Provide schedule of daily tasks/activities; -Implementation of ADL program to increase independence and self-determination:; -Assess and plan a program for the development and maintenance of necessary living skills including: -Grooming/dressing; -Personal hygiene; -Toileting/bowel/bladder; -Bathing; -Maintenance of own living environment; -Development of personal supports: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Assess and plan for meaningful socialization and recreational activities to diminish tendencies toward isolation, withdrawal, etc; -Assess, plan and develop appropriate personal support network through community and social connections; -Assess and plan for discharge, transition to less restrictive environment. The client will work with the facility to determine if the client is able to transition to a less restrictive environment. Review of the resident's PASARR determination dated 6/21/24, showed: -PASARR related disability: Yes; -Specify: Does have serious mental illness; -You indicated during the evaluation that you are interested in the possibility of returning to the community; -The PASARR Level II Evaluation indicated the following supports and services are to be provided by the facility: -Behavioral support plan; -Structured environment; -Personal support network; -Medication therapy; -ADL program. Review of the resident's care plan, dated 6/26/24, showed: -Focus: Resident wishes to stay here for long-term; -Focus: Resident has a full code status; -Focus: Resident requires assist with activities of daily living related to deconditioning; -Interventions: Encourage resident to participate to the fullest extent possible with each interaction; -Interventions: Encourage resident to use bell to call for assistance; -Interventions: Resident requires supervision/set up assistance with self care and functional mobility; -Interventions: Monitor for changes in status, notify interdisciplinary team as needed; (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Requires supervision with walker/wheelchair mobility; -Focus: Resident is physically and verbally aggressive towards staff and residents; -Interventions: 6/26/24 - Emergency Medical Services (EMS)/police present; resident refused to be transported to the hospital for psychiatric evaluation; -Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness; -Interventions: Anticipate and meet the resident's needs; -Interventions: Explain all procedures to the resident before starting and allow the resident time to process; -Interventions: If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident; -Focus: Resident is at risk for falls; -Interventions: Anticipate and meet the resident's needs; -Interventions: Be sure resident's call light is within reach and encourage the resident to use it for assistance when needed. The resident needs prompt response to all requests for assistance; -Focus: The resident uses psychotropic medications related to schizophrenia; -Interventions: Administer medications as ordered. Monitor for side effects and effectiveness; -Interventions: Monitor/document/Report any adverse reactions; -Focus: Resident has potential for impairment to skin; -No documentation of a behavioral support plan until 6/26/24 after the resident's behavior escalated; -No documentation of assessing and planning for meaningful socialization and recreational activities to diminish tendencies toward isolation, withdrawal, etc; -No documentation of development of personal supports to prevent isolation in the community; -No documentation of assessing, planning and developing appropriate personal support networks through community and social connections including community based psychiatric treatment and supports, behaviors supports/supervision and individual counseling and psychotherapy. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/1/24 at 1:30 P.M., Licensed Practical Nurse (LPN) F said the resident was hard to work with because he/she was institutionalized. He/She had been in prison for so many years, he/she still acted like an inmate. He/She was very rigid in his/her thinking and would write everything down. If things did not go the way he/she wanted, he/she would get angry. He/She kept a meticulous room but wanted to drink water from the toilet because this is how he/she used to get water. The nurse had to sit down and educate him/her about infection control and tell him/her it was safe to get water from the pitcher. The resident would continually argue with the staff regarding the medication and wanted to know about each pill. The nurse would have to come to the unit and explain what each pill was before the resident would agree to take it. The resident did have a rapport with some of the staff. He/She was usually fine during the day, but they would start getting phone calls from the staff in the evenings. The resident would use profanity and call the staff out of their names. He/She was not very social and would isolate in the television room. During an interview on 7/1/24 at 1:45 P.M., LPN K said the resident had different behavior on different shifts. He/She usually did not have a problem with the staff on his/her day shifts, but he/she had heard the resident had a problem on other shifts. Staff had not been given any direction on how to deal with his/her behavior, but he/she needed an understanding approach. The resident liked things a certain way, like his/her food, and if they were not done that way, there was going to be a problem. He/She liked attention and if the staff spent some time talking to him/her, the resident responded well to it. During an interview on 7/1/24 at 2:10 PM, the Social Services Director said she makes the referral for the PASARR for the resident, and then they have a company who assesses the resident and determines whether he/she meets the qualifications. If he/she does, they list the services the facility will need to provide. It was hard to provide services to the resident because he/she would not talk to them or participate in any activities. She knew the resident had a long history of incarceration and trauma and this setting might be too confining for him/her. The Minimum Data Set (MDS) coordinator was the person who developed and added the information to the care plan. The services listed on the PASARR should have been in the care plan. During an interview on 7/1/24 at 4:00 P.M., the MDS coordinator said she was responsible for completing the resident's care plan. She would have liked to have seen it be more detailed. She was aware of the resident's history of trauma and incarceration and knew he/she was screened for services on the PASARR II. She thought all of this information had been added to the care plan. It was an oversight on her part. She had only started working at the facility in March and was trying to get caught up on all of the care plans. During interviews on 7/1/24 at 9:00 A.M. and at 5:15 P.M., the Administrator said the resident was screened for the PASARR services on 6/21/24 and he/she did not start displaying disruptive behaviors until 6/26/24. They added the behavior monitoring on 6/27/24. The resident was having behavioral problems before 6/27/24. He/She had called the sheriff's office and the Governor's office to report various grievances he/she felt were being perpetrated on him/her by staff. The staff would try to reason with him/her, but the resident continued to make baseless claims. These behaviors probably should have been added to the care plan, but everything happened so fast they were just trying to control the situation. The Administrator was aware the resident had been incarcerated for over [AGE] years, but he/she had not displayed any behaviors during the screening process and they were just trying to do the right thing for him/her. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00238156

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40865 Based on interview and record review, the facility failed to provide necessary behavioral health care services for a resident's psychosocial well-being when staff did not address the resident's behaviors, which included verbal aggression, for one sampled resident (Resident #1) out of six sampled residents. The facility failed to inform staff how to handle the resident's escalating behaviors. The facility census was 92 residents. Review of the facility's Comprehensive Care Plan policy revised on 9/1/21, showed: -It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment: -Person centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives; -The comprehensive care plan will describe, at a minimum, the following: -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; -Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment; -Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of pre-admission screening and resident review (PASARR) recommendations; -The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented as needed; -The facility will document alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative. Review of Resident #1's medical record, showed: -admitted [DATE]; -Diagnoses of chronic kidney disease, diabetes, unspecified mood disorder, schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), acute kidney failure, unspecified psychosis (mental disorder with symptoms that happen when a person is disconnected from reality and cognitive communication deficit). (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 the admission screening, effective 5/30/24, showed: -admitted from hospital; -Oriented to person, place, time and situation; -Cognition: Intact; -Mood/Behavior: Hallucinations; Delusions; Anxiety; -Musculoskeletal: Wheelchair; Walker; -Medication review: -Were there any of the following Clinically Significant medication issues identified: No issues identified; -High Risk Medications: -Medication reconciliation has been completed with the medical profession in which any clinical significant medication issues have been identified and addressed; -Psychotropic Medication: -Focus: The resident uses psychotropic medications: Not checked; -Goal: The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date: Not checked. Review of the resident's psychosocial assessment, effective 5/30/24, showed: -Adequate hearing and vision; -Usually understood and understands others; -Inattention-Behavior not present; -Disorganized thinking-Behavior not present; -Altered level of consciousness-Behavior not present; (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Was responsible staff or provider informed that there is a potential for resident self harm? - No; -Behaviors: None of the above; -Social service plan: Monitor for social service; -Progress notes: Social services will follow up with any concerns. Review of the resident's progress notes, showed: -On 6/2/24 at 7:22 P.M., no inappropriate behaviors toward staff noted; -On 6/7/24 at 3:51 P.M., the wound nurse informed social services staff, the resident was talking sexually inappropriately to the female nursing staff and facetiming with other residents without their consent. Staff educated him/her on talking sexually to the female nurses or residents. The staff also educated him/her on not having other residents on his/her facetime when talking to his/her family. The resident said he/she was sorry and would not do it again; -On 6/10/24 at 5:30 P.M., staff redirected the resident after a misunderstanding over his/her medications. The resident called the police. The resident assured the police he/she was safe and did not feel any harm but wanted the sheriff. Staff notified his/her physician. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 6/26/24 at 12:10 A.M., staff notified the nurse the resident displayed agitation towards him/her. He/She jumped out of his/her wheelchair and lunged at him/her after he/she asked him/her to keep the noise level down. The nurse went down to talk to the resident regarding his/her agitation. The resident was upset, cursing and using racial slurs. The nurse attempted to redirect the resident and de-escalate the situation. The resident then became agitated and jumped out of his/her wheelchair and lunged towards the nurse. The nurse called 911. The resident also called 911 numerous times alleging he/she was abused, attacked, beat and spat on by the nurse and certified nurse's aide (CNA). The resident then sat on the floor near the nurse's station and stated, I am going to sit right here. I am not moving. They are gonna have to pick me up and move me. The police were present in the facility and spoke with the resident. The resident stated, I want them arrested. I was abused. I am injured and hurting all over. I want them arrested right now. The resident also called the nurse and CNA, Dogs, crack heads, things, monsters and whores. The police contacted ambulance services per the resident's request. The ambulance arrived at the facility and assessed the resident. He/She stated he/she did not want to go to the emergency room . The police and emergency medical technicians (EMTs) noted no injuries on the resident. The EMTs encouraged the resident to go to the hospital due to his/her elevated blood pressure and increased agitation. The resident continued to refuse to go. The nurse and floor two charge nurse encouraged the resident to stay on floor two for the night but the resident refused. The resident refused to sign a refusal to send to the emergency room (ER) by the EMTs. The police and EMTs left the facility. The resident sat at the nurse's station recording staff on his/her cellular phone. He/She continued to use derogatory names and racial slurs toward staff while recording with his/her phone. At 11:22 A.M., the resident became aggressive with CNAs, accusing them of spitting on them, then took out his/her phone and began to record staff members working with other residents. The resident stated he/she was going to post the video on social media. The nurse asked the resident not to record staff members and other surrounding residents in the hall but the resident continued to yell and curse at staff in a threatening manner. Staff heard a commotion a the desk on the three hall while passing medications to residents and came over to inquire what was going on. The resident was very aggressive, cursing and yelling. He/She was not easily redirected. The staff member asked him/her what was wrong and he/she stated the CNAs were calling him/her names. The staff member did not hear the CNAs respond to the resident at all, other than asking him/her not to record them. The resident continued to record the staff member. He/She asked the resident to please go to his/her room and close the door and after medication pass, he/she would come in and listen to the resident's side of the story. The resident failed to comply with this request and remained in the hallway, yelling and causing a disturbance which upset the residents. Staff asked the resident several times to calm down and go to his/her room, but he/she refused. The CNAs said they were calling the supervisor to inform him/her of the residents behavior. The supervisor came in the building to deal with the situation, which had escalated. At 10:18 P.M., the resident displayed behaviors this shift. The resident noted being verbally aggressive toward other residents. Resident called another resident a derogatory, racial slur. Resident also noted threatening other residents with physical violence. Resident noted verbalizing homicidal ideations towards staff. Resident stated, I got six, and counting. Resident continues to state he/she murdered six people and is looking for number seven. The resident then made physical contact with CNA/Certified Medication Technician (CMT) by using his/her arm to elbow, forcefully pushed him/her in the back as he/she walked past him/her. Staff contacted 911 due to the resident's unpredictable behavior. The resident refused to go to the hospital. The resident stated he/she is willing to sign him/herself out against medical advice (AMA) but will not go to the hospital. Emergency medical services (EMS) made the nurse aware they were unable to transport the resident at the time due to his/her mental status and refusal. EMS departed the building. The resident was now walking through the building with his/her cane attempting to provoke and intimidate staff and other residents. Staff contacted the Director of Nursing (DON) and made her aware; (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 6/27/24 at 12:50 A.M., staff contacted the resident's physician and made him aware of the resident's behaviors. The physician sent a new order that staff may send the resident to the ER for a Psychiatric hold/evaluation due to physical and verbal aggression towards residents and staff. During an interview on 7/1/24 at 3:00 P.M., CNA I said he/she came back from break on the morning of 6/26/24, and the resident was on the phone talking really loud. He/She was clapping his/her hands and talking very loudly, and the CNA was worried the resident would wake the other residents. The CNA asked the resident could he/she talk a little quieter, and the resident stood up from his/her wheelchair and started yelling at him/her. It really startled him/her because the resident had never gotten out of the wheelchair and walked for him/her before and they had a pretty good relationship before this. The resident was cursing at him/her and calling him/her a honky. The CNA started to get scared and walked away. Then the resident sat back down in his/her wheelchair and yelled he/she was going to call the police. The CNA walked off the hall and to the nurse's station around the corner to get away from the resident. The resident wheeled down to where he/she was sitting and continued to threaten him/her. He/She was accusing the CNA of hitting and spitting at him/her. When the police got there, the resident told them the CNA beat him/her all over his/her body. The nurse and the police checked out the resident and did not see any marks. He/She refused to go anywhere near him/her the rest of the night. The CNA had heard the resident called the police on other staff when he/she did not like what they did or said, but this is the first time he/she did it to him/her. No one told him/her what to do with the resident or how to handle his/her behavior. It happened so fast and was so scary. He/She could not get the resident to calm down. The next night, the CNA asked the nurse to check on him/her all night so he/she would not have to deal with him/her. The resident was always cursing people and calling them out of their names. No one told him/her how to manage or prevent these behaviors. During an interview on 7/8/24 at 1:00 P.M., CNA C said he/she was working on the day the resident came onto the other hall to yell at CNA I. The resident was very agitated and he/she sat on the floor and said, Call the police. Try and get me off the floor. I am not going anywhere. The resident wanted the CNA locked up. This was the first time he/she saw the resident like that. Usually he/she was so calm and cool. He/She did not even know he/she could walk. The resident looked threatening and out of control. He/She did not calm down for a long time after the police and EMS staff left. No one gave the CNA any instructions on how to manage or prevent the resident's behaviors. During an interview on 7/8/24 at 2:30 P.M., CNA J said he/she was working evenings on 6/26/24 and was walking with another CNA when the resident got off the elevator. The resident heard another CNA say something and immediately started yelling the CNA had said something about him/her. The resident pulled out his/her cell phone and started recording the staff at the nurse's station and backed CNA J into a corner. He/She asked the resident to back up so he/she would not be in the corner and he/she stood up from his/her wheelchair. The CNA immediately felt threatened as the resident refused to back up and continued to verbally curse at him/her. This frightened the CNA because he/she had never seen the resident walk before and he/she was so threatening. He/She tried to get past the resident but he/she blocked the way, so he/she called out to the nurse on the other hall. The resident then moved his/her wheelchair to the middle of the hallway and elbowed another CNA as he/she tried to walk past him/her. The CNA had never had a problem with the resident before but he/she heard the resident had problems with the staff the night before and had threatened the staff then too. He/She knew the resident cursed other staff, but the resident had never directed his/her anger at the CNA before. No one told him/her how to manage or prevent the resident's behaviors. (continued on next page)

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	265001	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Athene Nursing and Rehabilitation	13995 Clayton Road Town and Country, MO 63017

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a written statement by Nursing Supervisor G provided by the facility, dated 6/26/24, showed: -He/She saw the resident calling another resident a derogatory racial slur and threatened he/she would Beat his/her ass; -When another staff member tried to deescalate the situation, the resident became verbally aggressive towards him/her; -The resident then began walking around the facility threatening staff and other residents saying, he/she killed six people and was looking for number seven; -The resident then pushed a staff member forcefully in the back with his/her arm and elbow; -The nursing supervisor called 911 due to the resident's unpredictable behavior and homicidal ideations; -After EMS and the police left, the resident continued to ambulate around the facility attempting to provoke and intimidate staff and residents; -The nursing supervisor was concerned about the safety of the staff and residents. Review of the resident's care plan, dated 6/27/24, showed: -Focus: The resident required assistance with Activities of Daily Living (ADL) related to deconditioning; -Interventions: The resident requires supervision/set up assistance with self care and functional mobility; -Interventions: Patient requires supervision with walker/wheelchair mobility; -Focus: The resident is physically and verbally aggressive towards staff and residents; -Interventions: 6/26 - EMS/Police present; Patient refused to be transported to the hospital for psych evaluation; -Administer medications as ordered. Monitor/document for side effects and effectiveness; -Anticipate and meet the resident's needs; -Explain all procedures to the resident before starting and allow the resident time to process; -If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident; -Focus: The resident is on psychotropic medications; (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Think the behavior is intentional because he/she knows when to do it and when not to do it. Daytime easy to redirect. Nights going above and beyond. Staff are afraid. Review of an email from the facility to the Department of Health and Senior Services on 6/28/24 at 12:24 P.M. , showed: -This morning at 9:45 A.M., the resident signed him/herself out on the resident sign out sheet and stated to the receptionist and Director of Nursing, he/she was not returning and was going to find a hospital and get checked out. The DON offered to assist him/her with a ride to the hospital and appropriate discharge planning and/or AMA paperwork. All were refused by the resident; -Staff notified 911 so they can follow up with him/her and make sure he/she is safe; -Staff notified the local Ombudsman as well; -Staff observed 911 intervening with the resident on the road; -The police came to the facility to gather more information and informed them the resident refused to come back to the facility or be taken to the hospital for EMS evaluation. Review of hospital admission paperwork dated 7/1/24, showed: -Patient was referred by Police Department and transported via EMS; -Affidavit from Police Department showed: -Police department dispatched to nursing home for resident leaving in his/her wheelchair; -Since at the at the facility, the resident assaulted staff and showed erratic violent behavior; -The resident told staff he/she was not returning to the facility but refused to sign the necessary forms to discharge him/her as a patient; -The resident identified him/herself as a [NAME] citizen and does not recognize police or EMS as authorities; -The resident served a long incarceration and is still on parole; -The resident refused assistance from the police and said he/she was walking to the hospital; -From 10:00 A.M. - 3:00 P.M., the police received approximately 40 phone calls to check on his/her welfare; -The resident refused to ride on the sidewalk and walked his/her wheelchair on the right side of the roadway; -Around 3:00 P.M., he/she began walking down the middle of the roadway and was non-compliant; (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 7/1/24 at 2:00 P.M., the Social Services Director said she did not address the resident's behavioral issues because the resident did not have any until his/her last week there. The resident refused to talk to them so it was hard to assess him/her or provide any services or activities. She addressed his/her behaviors when he/she acted out sexually inappropriately with the staff and and he/she agreed not to do it again so she thought it was done. They monitored his/her behavior regularly and made checks on him/her. She knew the resident had been incarcerated for a number of years, and people who have been in jail sometimes have a certain mindset. The resident also had a long history of trauma. She did not know if he would be able to handle the confines of the facility well. This information might have been helpful in the care plan for staff to develop interventions for recognizing and/or preventing behaviors. She thought the resident had seen psychiatric services but was unable to locate the notes or a referral for it. During an interview on 7/1/24 at 4:00 P.M., the Minimum Data Set coordinator said she was responsible for completing the resident's care plan. She would have liked to have seen it be more detailed. She was aware of the resident's history of trauma and incarceration. The resident had an incident of sexually inappropriate behavior and facetiming other residents without their consent. All of this should have been on the care plan. It was an oversight on her part. She had only started working at the facility in March and was trying to get caught up on all of the care plans. During interviews on 7/1/24 at 9:00 A.M. and at 5:15 P.M., the Administrator said the resident was screened for the PASARR services on 6/21/24, and he/she did not start displaying disruptive behaviors until 6/26/24. They added the behavior monitoring on 6/27/24. The resident was having behavioral problems before 6/27/24. He/She had called the sheriff's office and the Governor's office to report various grievances he/she felt were being perpetrated on him/her by staff. The staff would try to reason with him/her but the resident continued to make baseless claims. These behaviors probably should have been added to the care plan but everything happened so fast they were just trying to control the situation. The Administrator was aware the resident had been incarcerated for over [AGE] years, but he/she had not displayed any behaviors during the screening process and they were just trying to do the right thing for him/her. MO00238156