STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265255	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Healthcare and Rehabilitation Center	1009 East Ohio Clinton, MO 64735

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 35690 Based on interview and record review, the facility failed to implement an effective grievance process when staff failed to ensure all grievances included documentation of a full investigation, of a final decision, and of follow-up regarding findings with the resident who filed the grievance. Review of the facility policy Grievances/Complaints, Recording and Investigating, dated 2021, showed the following: -The administrator has assigned the responsibility of investigating grievances and complaints to the grievance officer. -The investigation and report will include the circumstances surrounding the alleged incident, the names of any witnesses and their accounts of the alleged incident, the resident's account of the alleged incident, and recommendations for corrective action. 1. Review of the Grievance/Complaint Report, dated 04/29/24, showed the following: -Resident stated the night shift Certified Nurse Aide (CNA) 4 was rough when doing cares and transfers. -Staff spoke to CNA 4 about his/her behavior and educated him/her on customer service. CNA 4 with issues at home. Explained that home problems must be left at the door. CNA 4 verbally agreed that he/she understood the education given. Staff will continue to monitor CNA 4 behavior with residents. (Staff did not document a full investigation, the final decision, or the follow-up with the resident who filed the grievance.) 2. Review of the Grievance/Complaint Report, dated 05/03/24, showed the following: -Resident stated that staff member, CNA 4, was rude and hateful on night shift. -Staff spoke to CNA 4 and reminded him/her that resident can often recognize and feel when they are rushed and have personal frustrations. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Staff did not document a full investigation, the final decision, or the follow-up with the resident who filed the grievance.) 3. Review of the Grievance/Complaint Report, dated 07/11/24, showed the following: -Resident stated that night shift CNA 4 was rude and rough and he/she did not want him/her in his/her room or providing cares for him/her. (Staff did not document a full investigation, the final decision, or the follow-up with the resident who filed the grievance.) 4. Review of the Grievance/Complaint Report, dated 08/09/24, showed the following: -Resident stated staff member CNA 4 was very rough when doing cares. -Director of Nursing (DON) educated staff on proper customer service and transferring technique when doing cares. (Staff did not document a full investigation, the final decision, or the follow-up with the resident who filed the grievance.) 5. Review of the Grievance/Complaint Report, dated 08/09/24, showed the following: -Resident stated staff (CNA 4) was very rough. Resident said he/she just jerks me around. Resident also stated that employee was rude and hateful. -Staff educated employee to announce to resident before he/she starts any cares and to practice good customer service skills. (Staff did not document a full investigation, the final decision, or the follow-up with the resident who filed the grievance.) 6. During an interview on 09/03/24, at 3:15 PM, the Regional Operations Director (ROD), Regional Nurse Consultant (RNC) 2 and the Administrator reviewed the grievance forms related to CNA 4. The Administrator said when education was completed it was completed verbally and nothing was documented. The RNC agreed the current documentation was not enough to ensure the grievance was resolved.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690 Based on interview and record review, the facility failed to ensure all residents, or resident representatives, received written notice of transfer when staff failed to provide a written notice of discharge to one resident (Resident #56), of one sampled resident, or his/her representative, for a facility initiated emergent hospital transfers. Review of the facility's Discharge Policy, dated 2021, showed the policy did not address written transfers notice. 1. Review of Resident #56's face sheet, located in the electronic medical record (EMR) under the Resident tab, showed the following: -admitted [DATE]; -Diagnoses included chronic respiratory failure with hypoxia (low oxygen levels). Review of the resident's Progress Note, located in the EMR under the Progress Note tab, showed the following: -The resident was sent to the emergency room for increased anxiety, complaints of extreme back pain, and difficulty with breathing. -The resident was admitted to the Intensive Care Unit (ICU) for chronic obstructive pulmonary disease (COPD - a common lung disease causing restricted airflow and breathing problems). -Staff did document regarding, or have a copy of, a written transfer provided to the resident and/or representative. During an interview on 09/04/24, at 6:53 A.M., Licensed Practical Nurse (LPN) 5 said he/she did not complete a transfer/discharge summary to provide to the resident and/or representative when a resident discharges to the hospital. During an interview on 09/05/24, at 4:30 P.M., the Administrator agreed a transfer/discharge summary should be provided to all residents upon discharge. She confirmed the resident and/or the representative did not receive a transfer/discharge summary when she was sent to the hospital.

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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** 40902 Based on record review and interview, the facility failed to ensure that a new Preadmission Screening and Resident Review (PASARR) Level I assessment was submitted after a new mental illness diagnosis for two (Resident #20 and #42) out of five residents reviewed for PASARR. 1. Review of Resident #20's Face Sheet, located in the Profile tab of the electronic medical record (EMR), showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included unspecified mood affective disorder (mental disorder characterized by dramatic changes or extremes of mood) and major depressive disorder. Review of the resident's PASARR Level I, located under the Diagnosis tab in the EMR and dated 05/14/20, showed no mental illness diagnosis. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an assessment reference date (ARD) of 05/01/24 and located under the MDS tab of the EMR, showed the resident had no cognitive impairment and an active diagnosis of psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions.) and depression. Review of of the resident's Care Plan, located under the Care Plan tab of the EMR and dated 01/23/23, showed staff care planned regarding the resident being verbally aggressive to staff members. Review of the resident's Diagnosis List, located under the Diagnosis tab in the EMR, showed unspecified mood affective disorder was diagnosed on [DATE] and major depressive disorder was diagnosed on [DATE]. Review of of the resident's Initial Psychiatric Evaluation, located under the Diagnosis tab in the EMR and dated 06/01/23, showed the resident's physician requested an evaluation due to resident's increased paranoia. A new diagnosis of mood disorder was added. Review of the resident's Physician Orders, located under the Orders tab in the EMR dated 08/01/24, showed an order for olanzapine (an antipsychotic medication) 0.5 milligrams (mg) tab once daily for psychotic disorder. Staff did not have a copy of, or document completion of, a new Level I PASSAR was with the mental health diagnoses. 2. Review of Resident #42's Face Sheet, located in the Profile tab of the EMR, showed the following: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-admitted [DATE]; -Readmitted [DATE]; -Diagnoses included major depressive disorder, generalized anxiety disorder, panic disorder, bipolar II disorder (defined by a pattern of depressive episodes and hypomanic episodes), alcohol abuse, and opioid dependence. Review of the resident's PASARR Level I, located under the Diagnosis tab in the EMR dated 08/30/20, showed no mental illness diagnosis. Review of the resident's Psychiatric Follow-up, located under the Diagnosis tab in the EMR dated 05/04/23, showed the resident reported a suicide attempt and had a new diagnosis of bipolar disorder. Review of the resident's annual MDS, with an ARD of 09/18/23 and located under the MDS tab of the EMR, showed no cognitive impairment and active diagnoses of anxiety, bipolar disease, and depression. Review of the resident's Care Plan, located under the Care Plan tab of the EMR and dated 03/29/24, showed staff care planned related to self-destructive behaviors due to alcohol abuse. Review of the resident's Diagnosis List, located under the Diagnosis tab in the EMR, showed the following: -Bipolar was diagnosed on [DATE]; -Major depressive disorder, generalized anxiety disorder, and panic disorder were diagnoses on 07/14/23. Review of the resident's Physician Orders, located under the Orders tab in the EMR dated 08/01/24, showed an order for fluoxetine, an antidepressant medication, 40 mg tab once daily. Staff did not have a copy of, or document completion of, a new Level I PASSAR was with the mental health diagnoses. 3. During an interview on 09/05/24, at 10:14 A.M., Licensed Practical Nurse (LPN) 2 said the following: -His/her understanding was that a new PASARR level I only needed to be completed when a resident discharged , or there was a major change in the resident like a new psychiatric diagnosis, or a major decline. -Whenever staff got the new diagnosis for the resident they would have communicated that to him/her, but there was not a process in place to monitor for new mental illness diagnosis. -He/she has never completed a new PASARR level I for any resident. -He/she never received training in PASARR, and that he/she had just winged it. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During an interview on 09/05/24, at 12:46 P.M., the Director of Nursing (DON) said she knew that a PASARR level I was completed on admission or with any significant change in status. She did not know another one needed to be done after a new diagnosis.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690 Based on interview and record review, the facility failed to ensure a baseline complete care plan was developed and provided for one resident (Resident #123), of 27 sampled residents, when the facility failed to care plan for the resident's diagnosis of schizophrenia (a mental health condition that affects how people think, feel and behave). Review of the facility's policy titled, Care Plans - Baseline, revised 03/2022, showed the following: -A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission; -The baseline care plan included instructions needed to provide effective, person -centered care of the resident and must include the minimum healthcare information necessary to properly care for the resident including physician orders. 1. Review of Resident #123's Face Sheet, located in the electronic medical record (EMR) under the Resident tab, showed the following: -admitted [DATE]; -Diagnoses of included schizophrenia. Review of the resident's medical record showed staff did not document, or have copy of, a base line care plan or a comprehensive care plan completed within 48 hours of admission related to the resident's diagnosis of schizophrenia. During an interview on 09/04/24, at 3:15 PM, the Director of Nursing (DON) said that all diagnoses a resident had upon admission should be included in the baseline care plan and the resident's diagnosis of schizophrenia was not included. During an interview on 09/05/24, at 4:30 PM, the Administrator said that the baseline care plan should have included the resident's admitting diagnosis of schizophrenia.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observation, interview, and record review, interview, the facility failed to develop and implement complete and accurate care plans for all residents when staff failed to ensure five residents' (Resident #36, #42, #3, #1, and #4), of 27 residents reviewed, care plans addressed all appropriate care areas. Review of the facility's policy Care Plans, Comprehensive Person-Centered, dated 03/2022, showed the following: -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. -The comprehensive person-centered care plan included measurable objectives and timeframes, resident's stated goals upon admission, and desired outcome. 1. Review of Resident #36's Face Sheet, located in the Profile tab of the electronic medical record (EMR), showed the following: -admitted [DATE]; -Diagnoses included anxiety disorder and major depressive disorder. Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an assessment reference date (ARD) of 07/04/24 and located under the MDS tab of the EMR, showed the following: -The resident had no cognitive impairment; -The resident received antidepressant and antipsychotics on a routine basis. Review of the resident's current Physician Orders, located under the Orders tab in the EMR and dated 08/12/24, showed the following: -An active order for buspirone (an antidepressant medication) 15 milligrams (mg) tab, three times daily for anxiety disorder; -An active order for quetiapine (an antipsychotic medication) 50 mg, once daily for major depressive disorder. Review of the resident's Care Plan, located under the Care Plan tab of the EMR dated 03/14/24, showed staff did not care plan related to the resident's psychotropic medication use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/05/24, at 12:35 P.M., the MDS Coordinator (MDSC)/Director of Nursing (DON) said the resident's medications should have been care planned. She said any type of psychotropic medication should have their own care plan with interventions. 2. Review of Resident #42's Face Sheet, located in the Profile tab of the EMR, showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included major depressive disorder, generalized anxiety disorder, panic disorder, bipolar II disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), alcohol abuse, and opioid dependence. Review of the resident's annual MDS, with an ARD of 09/18/23 and located under the MDS tab of the EMR, showed the following: -Resident had no cognitive impairment; -Resident received antidepressant and antianxiety medication on a routine basis. Review of the resident's current Physician Orders, located under the Orders tab in the EMR, showed an active order for fluoxetine (an antidepressant medication) 40 mg tab, once daily. Review of the resident's Care Plan, located under the Care Plan tab of the EMR and dated 03/14/24, showed staff did not care plan related to the resident's psychotropic medication use. During an interview on 09/05/24, at 12:35 P.M., the MDSC/DON said the resident's medications should have been care planned. She said any type of psychotropic medication should have their own care plan with interventions. 35690 3. Review of Resident #3's Admission Record, located in the EMR under the Profile tab, showed the following: -admitted [DATE]; -Diagnoses included major depressive disorder, anxiety disorder, and Alzheimer's Disease. Review of the resident's MDS, with an ARD of 06/24/24, located in the EMR under the MDS tab, showed the following: -The resident was severely cognitively impaired; -The resident received antidepressant and antipsychotic medication for seven of seven days during the look back review period. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Medication Administration Record (MAR), dated 09/2024, located in the EMR under the Orders tab, showed the following: -The resident received citalopram (an antidepressant) 10 mg, daily for major depressive disorder; -The resident received olanzapine (an antipsychotic) 2.5 mg, daily for an anxiety disorder. Review of the resident's comprehensive Care Plan, updated 08/17/24, showed the following: -Staff did not care plan related to the resident's diagnoses of major depressive disorder, anxiety, or Alzheimer's Disease; -Staff did not care plan related to the resident's use of an antidepressant. During an interview on 09/04/24, at 12:42 PM, the DON/MDSC said there should be a care plan for each psychotropic medication and each diagnosis the resident had. The DON agreed that the resident did not have a care plan for the use of an antidepressant, a major depression diagnosis, a diagnosis of Alzheimer's Disease, or a diagnosis of anxiety. 36246 4. Review of Resident #1's Admission Record, in the EMR under the Profile tab, showed the following: -admitted [DATE]; -Diagnoses included of chronic allergic conjunctivitis (inflammation of the conjunctiva from infection or allergies). Review of the resident's Progress Note, dated 04/16/24 found in the EMR under the Progress Note tab, showed the resident had left side effect from previous CVA (cerebral vascular accident or stroke) that limited his/her range of motion (ROM) to his/her upper extremity. Review of the resident's quarterly MDS, with an ARD of 06/05/24, showed the resident had limited ROM to the upper and lower extremities on one side. Review of the resident's Physician's Orders, in the EMR under the Orders tab, showed the following: -An order, dated 07/29/24, for Pataday Ophthalmic Solution 0.1 % (olopatadine HCl), instill one drop in both eyes one time a day for chronic allergic conjunctivitis. Observation and interview on 09/02/24, at 4:14 P.M., showed the resident had a contracture of the left wrist. The resident said it was the result of a stroke. Review of the the resident's current Care Plan, in the EMR under the Care Plan tab showed staff did not care plan related to the resident's chronic allergic conjunctivitis or his left wrist contracture. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/04/24, at 4:37 P.M., the DON/MDSC said confirmed staff did not care plan the above concerns for the resident. 5. Review Resident #4's Admission Record, in the EMR under the Profile tab, showed the following: -admitted [DATE]; -Diagnoses included of glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of the eye called the optic nerve) and dry eye syndrome. Review of the resident's annual MDS, with an ARD of 05/30/24 found in the EMR under the MDS tab, showed the following: -The resident had moderate difficulty with her hearing and was moderately impaired for her vision. -The resident received anti-anxiety and anti-depressant medications. During an interview on 09/02/24, at 4:08 P.M., the resident said he/she had a detached retina in the right eye making him/her blind in that eye and he/she was hard of hearing in the left ear. Review of the resident's Care Plan, in the EMR under the Care Plan tab, showed staff did not care plan related to the resident's hearing, vision, or for the use of anti-anxiety and anti-depressant medications. During an interview on 09/04/24, at 4:37 P.M., the DON/MDSC said confirmed staff did not care plan the above concerns for the resident. 6. During an interview on 09/05/24, at 12:35 P.M., the MDSC/DON said staff would let her know after a new care area was identified or if they noticed that something was not on the care plan. 7. During an interview on 09/05/24, at 3:57 P.M., the Administrator said that all regulations should be followed. She said the care plan should be specific to the needs of the residents and updated timely.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36246 Based on observation, interview, and record review, the facility failed to ensure all residents received respiratory care by standards of practice when staff failed to change one resident's (Resident # 4), out of 27 sampled residents, nebulizer tubing as ordered. 1. Review of the Resident #4's Admission Record, found in the electronic medical record (EMR) under the Profile tab, showed the following: -admitted [DATE]; -Diagnoses included COPD (chronic obstructive pulmonary disease - a common lung disease causing restricted airflow and breathing problems), asthma, and allergic rhinitis. Review of the resident's Respiratory Care Plan, in the EMR under the Care Plan tab, dated 03/14/24, showed the following interventions: -Administer respiratory medication as ordered. -The resident did not like to keep nebulizer mask in plastic bag and will often take it out and sit it on top of the machine. Review of the resident's Physician's Order, dated 07/27/24, and in the EMR under the Orders tab, showed the following: -An order, dated 08/23/24, for nebulizer tubing to be changed weekly, every night shift, every Sunday night and place tubing in bag when not in use. Review of the resident's Treatment Administration Record (TAR), dated for September 2024, in the EMR under the Orders tab, showed the following: -An order, dated 08/23/24, for nebulizer tubing changed weekly, every night shift, every Sunday night, place tubing in bag when not in use; -Staff had not signed off as completing the order on the night of 09/01/24 (Sunday). During an observation on 09/02/24, at 3:39 P.M., and again on 09/03/24, at 10:29 A.M., the resident's nebulizer machine was on the shelf in her room. The tubing was undated tubing. During an observation and interview on 09/03/24, at 10:30 A.M., Registered Nurse (RN) #1 the nebulizer tubing should have had a date on it to indicate when it was changed. She said that oxygen and nebulizer tubing are supposed to be changed every Sunday night.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690 Based on record review and interview, the facility failed to provide effective pain management for all residents when the facility failed to ensure four of four residents (Resident #57, #32, #18 and #7) had pain medication available to be administered as ordered at all times. Review of the facility policy titled, Pharmacy and Medication Administration, undated, showed the following: -The emergency medication kit is refilled by the pharmacy; -The facility will have a clear practice about reordering of medication. If the medication nurse or CMT (Certified Medication Tech) does not pull the labels to reorder the medications during their med pass, they may not be available when needed. Review of the facility policy titled, Emergency Kit System/With Controlled Substances (E-Kit), dated March 2015, showed the following: -The E-kit will be replaced after it has been opened and the pharmacy notified. -Replacement of the entire E-Kit will be done on the next scheduled delivery. -Remove the item/s needed. Remove enough of the medication to last until the order is filled and can be delivered. -If for some reason the E-Kit is not exchanged at the next delivery, again call the pharmacy during regular business hours. -The facility is responsible to notify the pharmacy if the E-Kit is not delivered as expected. 1. Review of Resident #57's Admission Record, located in the electronic medical record (EMR) under the Profile tab, showed the following: -admitted [DATE]; -Diagnoses included pain and fibromyalgia (musculoskeletal pain). Review of the resident's Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 05/15/24, located in the EMR under the MDS tab, showed the following: -The resident had no cognitive impairment. -The resident received scheduled and PRN (as needed) pain medications during the five day look back period, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident had occasional pain frequency and pain occasionally affected her sleep. -The resident rated the pain as a seven out of 10 (with one being no pain and 10 being the worse pain). Review of the resident's pain Care Plan, updated 11/11/23, showed the following: -Resident was experiencing the presence of occasional pain; -Interventions included teaching distraction techniques, resting after receiving pain medication, monitoring worsening of pain symptoms, notifying physician of changes, and assessing pain daily using the 1 to 10 scale. Review of the resident's August 2024 Medication Administration Record (MAR), located in the EMR under the Orders tab, showed the following: -A current order for tramadol (an opioid pain medication) 50 mg (milligrams), three times a day for pain; -A current order for acetaminophen 325 mg, two tablets every four hours as needed for general discomfort; -A current order to assessed for pain every shift. -The resident did not receive his/her tramadol or acetaminophen on 08/31/24 during the evening medication administration. The resident rated his/hr pain as a seven. Review of the resident's Progress Notes, located in the EMR under the Progress Notes tab, dated 08/27/24, showed Licensed Practical Nurse (LPN) 1 notified the physician by voice mail that the resident was out of tramadol. Review of the resident's Progress Notes, located in the EMR under the Progress Notes tab, dated 08/28/24, showed LPN 1 contacted the pharmacy to follow-up on the resident's tramadol. The LPN was informed the pharmacy was waiting for the order from the physician. Review of the resident's September 2024 MAR, located in the EMR under the Orders tab, showed the following: -The resident did not receive his/her tramadol on 09/01/24 during the evening medication administration. The resident rated his/her pain as a seven at 6:00 PM. -The resident did not receive all three doses of tramadol on 09/02/24. The resident rated his/her pain as an eight. -The resident did not received all three doses of tramadol on 09/03/24. The resident rated his/her pain as a seven. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility E-kit forms showed four tramadol 50 mg were removed for the resident on 08/27/24. Two tramadol were removed for the resident 08/28/24 and 08/30/24. The pharmacy was noted to have been sent a fax on 08/31/24. During an interview on 09/02/24, at 2:58 P.M., the resident the resident said he/she had not received his/her tramadol over the weekend because the facility ran out. The facility had called the doctor, but they had not received it yet. He/she had been taking Tylenol (acetaminophen) and gabapentin (can be used to treat neuropathic pain) which was somewhat effective. The resident said he/she noticed the difference between tramadol and Tylenol and he/she was hurting more without the tramadol. During an interview on 09/04/24, at 3:14 PM, LPN 5 said he/she would order medication when the medication card indicated the resident had seven days of medication left. At this time the physician should be notified. If he/she didn't get any results the day after calling the physician, he/she would call the next day. LPN 5 said medication was delivered at night, so nurses knew they needed to call by 4:00 P.M. to have it delivered that day. On 09/01/24, there was no tramadol on the medication cart or in the E-kit. There was also no one to call to receive more medication. He/she thought there was a backup pharmacy for the facility, but he/she was not sure who it was. He/she confirmed he/she had not called the physician to see if she could give the resident something else for pain. 2. Review of Resident #32's Admission Record, located in the EMR under the Profile tab, showed the following: -admitted [DATE]; -Diagnosis included chronic pain. Review of the resident's quarterly MDS, with ARD of 06/24/24, located in the EMR under the MDS tab, showed the following: -The resident was severely cognitively impaired. -The resident received scheduled and PRN pain medications during the five day look back period. Review of the resident's Progress Notes, located in the EMR under the Progress Notes tab, showed the resident had an active order for tramadol 50 mg, two tablets two times a day for chronic pain syndrome. Review of the facility's E-kit forms provided showed four tramadol 50 mg were removed for the resident on 08/27/24. Four tramadol 50 mg were removed for the resident on 08/31/24. The pharmacy was noted to have been sent a fax on 08/31/24. Review of the resident's Progress Notes, located in the EMR under the Progress Notes tab, showed the following: -The resident had an active order for tramadol 50 mg, two tablets two times a day for chronic pain syndrome; -The resident missed his/her medication twice on 09/01/24, once on 09/02/24, and twice on 09/03/24; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff did not document notification of the resident's physician about the resident being out of tramadol, or of any non-pharmacological interventions were attempted. 3. Review of Resident #18's Admission Record, located in the EMR under the Profile tab, showed the following: -admitted [DATE]; -Diagnoses included of chronic pain syndrome. Review of the resident's quarterly MDS, with ARD of 06/19/24, located in the EMR under the MDS tab, showed the following : -The resident was moderately cognitively impaired. -The resident received scheduled pain medications during the five day look back period. -A pain assessment interview should be conducted and the resident had pain constantly. The resident rated his/her pain as a eight out of 10. Review of the resident's Progress Notes, located in the EMR under the Progress Notes tab, showed the following: -The resident had an order for ordered Norco (narcotic pain medication) 5-325 mg, one tablet six times per day for pain; -The resident missed his/her medication twice on 08/31/24, six times on 09/03/24, and twice on 09/02/24; -Staff did not document notification of the physician that the resident was out of medication or that any non-pharmacological interventions were attempted. 4. Review of Resident #7's Admission Record, located in the EMR under the Profile tab, showed the following: -admitted [DATE]; -Diagnoses included pain. Review of the resident's quarterly MDS, with ARD of 07/03/24, located in the EMR under the MDS tab, showed the following: -The resident was moderately cognitively impaired. -The resident received scheduled and PRN pain medications during the five day look back period. -The resident reported his/her pain was frequent and affected his/her sleep occasionally. The resident's pain intensity was seven out of 10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Progress Notes, located in the EMR under the Progress Notes tab, showed the following: -The resident has an order for hydrocodone-acetaminophen (narcotic pain medication) tablet 5-325 mg, one tablet three times a day for pain. -The resident missed his/her medication once on 09/01/24, once on 09/02/24, and all three times on 09/03/24. -Staff did not document notification of the physician that the resident was out of medication or that non-pharmacological interventions were attempted. 5. During an interview on 09/04/24, at 2:38 P.M., Licensed Practical Nurse (LPN) 1 said if the medication was out on the medication cart then medication should be pulled from the E-kit. There was no tramadol in the E-kit on 09/02/24 and 09/03/24. He/she knew that Resident #57 and Resident #32 had run out of medication. He/she confirmed he/she had contacted the physician on 08/27/24 to order more medication and the pharmacy was contacted on 08/28/24 and they said they were waiting for the orders from the physician. This was the only time the physician and the pharmacy were contacted. He/she was not sure if the facility had a backup pharmacy, but it was difficult to obtain medication from the pharmacy or orders from the physician during a holiday weekend. 6. During an interview on 09/04/24, at 3:04 P.M., the Regional Nurse Consultant (RNC) 1 said the EMR System interfaced through the pharmacy and medication should automatically be reordered and delivered in timely manner. If the medication was not available, nurses should use the medication in the E-kit. The physician should be called daily. The pharmacy manager should be called to find out why the E-kit was not stocked. Since the facility ran out of pain medication, nurses should have asked the physician if there was another medication that was available that could be administered and non-pharmacological approaches for pain should have been attempted. Additionally, the backup pharmacy should have been called. 7. During an interview on 09/05/24, at 9:24 A.M., Registered Nurse (RN) 1 said if the medication card indicated the resident had seven days worth of medication, it would be time to notify the physician to reorder the medication. They should call sooner if a resident was running out of a narcotic for pain. They could also get medication from the E-kit and if the E-kit was out of medication they would call the pharmacy to determine when the medication would be delivered. RN 1 said there were risks if a resident did not receive their medication which included the potential for withdrawal. The physician should be notified every time a resident missed their medication. A nurse should also ask the physician if they could give the resident something else for pain and try non-pharmacological interventions. Occasionally a physician will not respond to the request then the Administrator, Director of Nursing (DON), and the Medical Director should be notified to get assistance to obtain the unavailable medication. He/she knew that Resident #57 had run out of tramadol and there was no tramadol in the E-kit. He/she also knew Resident #18 had run out of Norco. It was important that nurses always think ahead to ensure a residents' medication was ordered to ensure they did not run out. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. During an interview on 09/05/24, at 9:39 A.M., the Regional Operations Director (ROD) 1 and Regional Nurse Consultant (RNC) 2 agreed that more should have been done to obtain the medication for the residents RNC 2 said that the physician should have been notified daily about the missing medication for each resident and should have been asked if there was another medication that could be provided in place of the missing medication. Residents should have also been offered and provided non-pharmacological interventions to assist with managing their pain. 9. During an interview on 09/05/24, at 9:54 AM, the Administrator said the physician should have been called to see if something else could have been given to the resident.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on interview and record review, the facility failed to ensure dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) services were provided per standards of practice and resident's care plan when staff failed to have ongoing pre and post dialysis communication for one resident (Resident #38) who received dialysis. 1. Review of Resident #38's Face Sheet, located in the Profile tab of the electronic medical record (EMR), showed the following : -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included end stage renal disease (ESRD). Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an assessment reference date (ARD) of 07/23/24, located under the MDS tab of the EMR, showed the following: -The resident had severe cognitive impairment. -The resident received hemodialysis treatment (a machine filters wastes, salts and fluid from the blood when the kidneys are no longer healthy enough to do this work adequately). Review of the resident's Physician Orders, located under the Orders tab in the EMR, dated 07/16/24, showed an order for dialysis Monday, Wednesday, and Friday. Review of the resident's Care Plan, located under the Care Plan tab of the EMR, dated 07/19/24, showed the resident required dialysis three times weekly. Intervention in place included to ensure staff coordinate with dialysis team to provide best care for resident. Review of the resident's Dialysis Communication Record, located under the Misc tab in the EMR for the months of July, August and September of 2024 , showed the forms were only completed for the dates of 07/22/24, 07/26/24, and 08/19/24. During an interview on 09/05/24, at 9:06 A.M., Registered Nurse (RN) 1 said after they switched the resident's dialysis time to 5:00 A.M., staff have not been completing the pre and post dialysis communication form. The night shift was supposed to send it with the resident to dialysis and day shift was supposed to make sure it came back with the resident after he/she returned from dialysis. He/she knew it had not been done in the last few weeks. He/she was the nurse in the hall yesterday and the resident did not come back from dialysis with one. He/she had not reported that to anyone. He/she assumed if there was an issue the dialysis center would call the facility to make them aware. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/05/24, at 9:46 A.M., Licensed Practical Nurse (LPN)1 said the dialysis communication should be completed before and after dialysis. If the form was not being completed by the dialysis center staff should call the dialysis center to get the information and document that in a progress notes and let the Administrator know. During an interview on 9/05/24, at 12:46 P.M., the Director of Nursing (DON) said nurses had the dialysis communication form and it should have been filled out and sent with the resident to dialysis and the dialysis center should have completed their portion and it sent it back with the resident. If staff knew the dialysis center was not filling out their portion they need to let her or the Administrator know and make the dialysis center aware. She expected it to be completed each and every time and if dialysis wasn't completing their portion they need to be calling the dialysis center and getting that information.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 36246 Based on record review and interview, the facility failed to ensure a system was in place to account for all controlled drugs and that allowed for accurate reconciliation when staff failed to routinely complete a documented narcotic count for each change of shift. 1. Review of the 200 Hall Narcotic Record Books, reviewed with Licensed Practical Nurse (LPN) 5 and Medical Records, showed there were missing signatures for the following: -On 08/17/24 for 6:00 P.M. outgoing; -On 08/21/24 for 6:00 P.M. outgoing; -On 08/26/24 for 6:00 P.M. outgoing; -On 08/27/24 for 6:00 P.M. outgoing; -On 09/01/24 for 6:00 A.M. incoming; -On 09/01/24 for 6:00 P.M. outgoing. Review of the medication tech 100 Hall Narcotic Record Books, reviewed with LPN 5 and Medical Records, showed there were missing signatures for the following: -On 08/17/24 for 6:00 P.M. outgoing; -On 08/20/24 for 6:00 A.M. incoming; -On 08/22/24 for 6:00 A.M. incoming; -On 08/22/24 for 6:00 P.M. outgoing; -On 08/26/24 for 10:00 A.M. incoming; -On 08/26/24 for 10:00 P.M. outgoing; -On 08/27/24 for 6:00 A.M. incoming; -On 08/27/24 for 6:00 P.M. outgoing; -On 08/30/24 for 6:15 A.M. incoming; -On 08/30/24 for 6:00 P.M. outgoing; -On 09/01/24 for 11:00 P.M. outgoing; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 09/02/24 for 6:00 P.M. outgoing. Review of the nurse 100 Hall Narcotic Record Books, reviewed with LPN 5 and Medical Records, showed there were missing signatures for the following: -On 08/17/24 for 6:00 A.M. incoming; -On 08/17/24 for 6:00 P.M. outgoing; -On 08/19/24 for 10:00 P.M. incoming; -On 08/20/24 for 6:00 P.M. outgoing; -On 08/21/24 for 6:00 A.M. incoming and outgoing; -On 08/21/24 for 7:00 P.M. outgoing; -On 08/22/24 for 6:00 A.M. incoming; -On 08/22/24 for 6:00 P.M. outgoing; -On 08/26/24 for 10:00 P.M. outgoing; -On 08/27/24 for 6:00 A.M. incoming; -On 08/27/24 for 6:00 P.M. outgoing; -On 08/30/24 for 6:15 A.M. incoming; -On 08/30/24 for 6:00 P.M. outgoing; -On 08/31/24 for 6:00 A.M. incoming; -On 08/31/24 for 6:00 P.M. outgoing; -On 09/01/24 for 6:00 A.M. outgoing; -On 09/04/24 for 6:00 A.M. incoming. Review of the medication tech 200 Hall Narcotic Record Books, reviewed with Registered Nurse (RN) 1, was missing signatures for: -On 08/20/24 for 6:00 A.M. incoming; -On 08/20/24 for 6:00 P.M. outgoing; -On 09/03/24 for 6:00 A.M. incoming; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 09/03/24 for 6:00 P.M. outgoing; -On 09/05/24 for 6:00 A.M. incoming. During an interview on 09/05/24, at 8:49 A.M., RN 1 reviewed the results of the review of the four Narcotic Record Books and confirmed the missing signatures. The RN said the Narcotic Record Books were supposed to be signed by the oncoming and outgoing staff, at the change of every shift, after the narcotics are counted by those two staff, acknowledging that the narcotic count was done and correct. During an interview on 09/05/24 at 11:19 A.M., the Administrator said the Narcotic Record Books contained empty signature areas indicating staff was not signing consistently at every change of shift, after the narcotic count was done.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on interview and record review, the facility failed to have a system in place to monitor for side effects and targeted behaviors for five of five sampled residents (Resident #48, #36, #42, #4, and #3) reviewed for unnecessary medications who received psychotropic medications. Review of the facility's Psychotropic Medication Use policy, dated 7/2022, showed the following: -Psychotropic medication management included .adequate monitoring for efficacy and adverse consequences and preventing, identifying, and responding to adverse consequences. 1. Review of Resident #48's Face Sheet, located in the Profile tab of the electronic medical record (EMR), showed the following: -admitted [DATE]; -Diagnoses included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), anxiety disorder, schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania), and major depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an assessment reference date (ARD) of 09/18/23 and located under the MDS tab of the EMR, showed the following: -The resident had severe cognitive impairment. -The resident received antipsychotics on a routine basis. Review of the resident's current Physician Orders, located under the Orders tab in the EMR, showed the following: -A current order for fluphenazine (an antipsychotic medication) 5 milligram (mg) tablet, twice daily for schizoaffective disorder; -A current order for risperidone (an antipsychotic medication) 1 mg, twice daily for schizoaffective disorder. Review of the resident's Medication Administration Record (MAR), dated 08/01/24 through 09/05/24, found in the EMR under the Orders tab, showed staff did not document monitoring of side effects of the resident's psychotropic medication or specific behaviors associated with the administration of the resident's psychotropic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Progress Notes, dated 08/01/24 through 09/05/24, showed staff did not document monitoring of side effects of the resident's psychotropic medication or specific behaviors associated with the administration of the resident's psychotropic medications. During an interview on 09/05/24, at 9:06 A.M., Registered Nurse (RN) 1 reviewed the resident's Treatment Administration Records (TAR) and MARs and verified there was nothing that indicated behavior monitoring completed by staff. During an interview on 09/05/24, at 12:13 P.M., the Regional Nurse Consultant (RNC) verified there was no behavior monitoring for the resident. 2. Review of Resident #36's Face Sheet, located in the Profile tab of the EMR, showed the following: -admitted [DATE]; -Diagnoses included anxiety disorder and major depressive disorder. Review of the resident's significant change MDS, with an ARD of 07/04/24 and located under the MDS tab of the EMR, showed the following : -The resident had no cognitive impairment; -The resident received antidepressant and antipsychotics on a routine basis. Review of of the resident's current Physician Orders, located under the Orders tab in the EMR, showed the following: -A current order for buspirone (an antidepressant medication) 15 mg tab, three times daily for anxiety disorder; -A current order for quetiapine (an antipsychotic medication) 50 mg, once daily for major depressive disorder. Review of the resident's MAR, dated 08/01/24 through 09/05/24 and found in the EMR under the Orders tab, showed staff did not document monitoring of side effects of the resident's psychotropic medication or specific behaviors associated with the administration of the resident's psychotropic medications. Review of the resident's Progress Notes, dated 08/01/24 through 09/05/24, showed staff did not document monitoring of side effects of the resident's psychotropic medication or specific behaviors associated with the administration of the resident's psychotropic medications. During an interview on 09/05/24, at 9:06 A.M., RN 1 reviewed the resident's TARs and MARs and verified there was nothing that indicated behavior monitoring completed by staff. During an interview on 09/05/24, at 12:13 P.M., the RNC verified there was no behavior monitoring for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265255	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Healthcare and Rehabilitation Center	1009 East Ohio Clinton, MO 64735

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #42's Face Sheet, located in the Profile tab of the EMR, showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included major depressive disorder, generalized anxiety disorder, panic disorder, bipolar II disorder, alcohol abuse, and opioid dependence. Review of the resident's annual MDS, with an ARD of 09/18/23 and located under the MDS tab of the EMR, showed the following: -The resident had no cognitive impairment; -The resident received antidepressant and antianxiety medication on a routine basis. Review of the resident's Physician Orders, located under the Orders tab in the EMR, showed a current order for fluoxetine (an antidepressant medication) 40 mg tablet, once daily. Review of the resident's MAR, dated 08/01/24 through 09/05/24, found in the EMR under the Orders tab, showed staff did not document monitoring of side effects of the resident's psychotropic medication or specific behaviors associated with the administration of the resident's psychotropic medications. Review of the resident's Progress Notes, dated 08/01/24 through 09/05/24, showed staff did not document monitoring of side effects of the resident's psychotropic medication or specific behaviors associated with the administration of the resident's psychotropic medications. During an interview on 09/05/24, at 9:06 A.M., RN 1 reviewed the resident's TARs and MARs and verified there was nothing that indicated behavior monitoring completed by staff. During an interview on 09/05/24, at 12:13 P.M., the RNC verified there was no behavior monitoring for the resident. 4. Review of Resident #4's Admission Record, found the EMR under the Profile tab, showed the following; ' -admitted [DATE]; -Diagnoses included anxiety disorder and depression. Review of the resident's annual MDS, with an ARD of 05/30/24 and found in the EMR under the MDS tab, showed the resident was on anti-anxiety and anti-depressant medication. Review of the resident's Physician Orders, found in the EMR under the Orders tab, showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265255	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Healthcare and Rehabilitation Center	1009 East Ohio Clinton, MO 64735

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A current order for lorazepam (anti-anxiety medication) oral tablet one mg, give one tablet by mouth at bedtime for anxiety; -A current order for paroxetine HCL (antidepressant medication) 20 mg, give one tablet by mouth in the afternoon for depression. Review of the resident's medical record showed staff did not document monitoring of side effects of the resident's psychotropic medication or specific behaviors associated with the administration of the resident's psychotropic medications. During an interview on 09/05/24, at 10:12 AM, RN 1 said behavior monitoring or side effect monitoring for these medications should be listed on a resident's Medication Administration Record (MAR) or the Treatment Administration Record (TAR). RN 1 confirmed this was not being completed for the resident. During an interview on 09/04/24, at 4:35 P.M., the Director of Nursing (DON) confirmed there was no behavior or side effect monitoring being completed for the resident's use of the anti-anxiety or anti-depressant medications. 5. Review of Resident #3's Admission Record, located in the electronic medical record (EMR) under the Profile tab, showed the following; -admitted [DATE]; -Diagnoses included major depressive disorder, Alzheimer's Disease, and anxiety disorder. Review of the resident's MDS, with an ARD of 06/24/24, located in the EMR under the MDS tab, showed the following: -The resident had severe cognitive impairment; -The resident received antidepressant and antipsychotic medication for seven of seven days during the look back review period. Review of the resident's comprehensive Care Plan, updated 08/17/24, showed the following: -The resident was at risk for side effects of antipsychotic drug use; -Intervention included monitoring patterns of target behaviors. Review of the resident's MAR, dated 09/2024, located in the EMR under the Orders tab, showed the following: -A current order for citalopram (an antidepressant) 10 mg, daily for major depressive disorder; -A current order for olanzapine (an antipsychotic) 2.5 mg, daily for an anxiety disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265255	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Healthcare and Rehabilitation Center	1009 East Ohio Clinton, MO 64735

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed staff did not document monitoring of side effects of the resident's psychotropic medication or specific behaviors associated with the administration of the resident's psychotropic medications. 6. During an interview on 09/05/24, at 9:06 A.M., Registered Nurse (RN) 1 said most of the residents on antipsychotic medications had a question on the Treatment Administration Record (TAR) that asked about behaviors. 7. During an interview on 09/05/24, at 12:13 P.M., the RNC verified said they were unaware there needed to be behavior monitoring for psychotropic medications because they have never monitored for anything other than anti-psychotic medications. 8. During an interview on 09/05/24, at 12:46 P.M. and 1:15 P.M., the DON said as a nurse she knew to look for and monitor for any change in a resident's condition that was on psychotropic medications. She agreed that if behavior monitoring was not on the MAR/TAR that not all staff would know what to look for or ensure they were monitoring for specific behaviors and there would not be any consistency in monitoring. Specific targeted behavior and potential side effects should be monitored for all psychotropic medications. 9. During an interview on 09/05/24, at 3:57 P.M., the Administrator said that all regulations should be followed, including behavior monitoring and monitoring side effects for anti-depressants and anti-psychotics. 35690 36246