STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand River Health Care	118 Trenton Road Chillicothe, MO 64601

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 44395 Based on interview and record review the facility failed to ensure one resident (Resident #1), of three sampled residents, was free from the use of physical restraint when staff members used their bodies to wrap their arms around the resident to entrap the resident's arms down to his/her side, not allowing movement from the resident, while the nurse administered an intramuscular (IM) injection to the resident for aggressive behaviors towards staff. The facility census was 29. Review of the facility policy Behavioral Interventions Catastrophic Reactions (an overreaction or inappropriate behavior associated with a resident who has dementia (a progressive condition that causes a decline in thinking, remembering, and reasoning, that interferes with daily life,)) from the Special Care Unit Manual, Section 6, dated April 2006 showed staff should do the following: -Allow a resident who is experiencing a catastrophic reaction to move freely, except when acting violently to another person. Don't restrain a resident. -Do not restrain the resident or use physical force. Review of the facility provided policy Injection (Intramuscular) dated March 2015 directed staff to place the resident in a safe and comfortable position compatible with the resident's physical condition. Review of the facility provided policy Restraints, Physical, dated March 2015 showed: -Physical restraints are defined as any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. -Assess the resident's need for restraint use. -Obtain a physician's order for restraint. -Use other nursing measures, diversion programs, activity programs and supervision to control behavior whenever possible. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Restraints shall only be used upon the written order of a physician and after informing the resident and/or the legal representative. Review of Resident #1's Quarterly Minimum Data Set (MDS: a facility assessment completed by facility staff) dated 6/26/24 showed: -Brief Interview of Mental Status (BIMS) of 13 indicated minimal cognitive loss -Supervision of staff with Activities of Daily Living (ADLs: tasks completed in a day to care for oneself) -Verbal behaviors directed at others (such as yelling out and cursing)one to three days of a week -Daily wandering (aimless movement throughout an area) -Diagnoses of: Bipolar Disorder (a mental illness that causes extreme shifts in mood, energy, and activity levels), history of falling, unsteadiness on feet, need for assistance with personal care, conversion disorder (a condition in which a person experiences physical and sensory problems, such as paralysis, numbness, blindness, deafness or seizures, with no underlying medical condition), psychosis (a set of symptoms that cause a person to lose touch with reality and have difficulty distinguishing what is real and what is not), major depressive disorder (a serious mental disorder that can affect how someone feels, thinks, and acts; characterized by a depressed mood and loss of interest in activities), Pseudobulbar affect (disorder that causes uncontrollable episodes of laughing or crying that are inappropriate for the situation), anxiety (feelings of fear, dread or uneasiness),and dementia (memory loss that effects your ability to care for yourself). Review of the resident's comprehensive care plan dated 6/4/24 showed: -He/She had confusion, paranoia (an irrational fear or distrust of others, often believing that they are being harmed or deceived) and forgetfulness. -Demonstrate that the resident is accepted. -Encourage daily activities that increase self-esteem. -Encourage participation in diversional activities. -Explain all treatments and procedures before beginning or carrying through for the resident. -Staff were to allow ample time to express emotions. -Staff were to offer reassurance to the resident during times of increased emotions. Review of the resident's progress notes showed: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 8/20/24 at approximately 7:00 P.M. the resident was in the living room area; being loud and disruptive to other residents. The resident was asked by staff, several times to lower his/her voice so as not to disturb other residents. The resident continued to yell profanities at staff passing by. The resident went to his/her room and slammed the door. The resident slept for a few hours, got up, and was slamming his/her door and yelling. Staff went to the resident's room, told him/her to lower their voice, and the resident returned to bed. -At approximately 4:30 A.M. The resident's call light was on. The resident was found sitting upright on the floor, with the call light in his/her hand. The resident said he/she needed assistance up and needed to use the bathroom. His/her walker was upright, sitting behind the resident. This nurse asked two aides to assist the resident up and onto the bed. The resident denied pain and again said he/she needed to go to the bathroom. During a physical assessment the resident yelled out he/she needed to go to the bathroom and staff were not letting him/her. The nurse asked the resident to lower his/her voice and staff would assist him/her. The walker was placed in front of the resident; he/she began shuffling to the bathroom yelling he/she could walk alone. The resident flung his/her walker aside and continued to walk. The nurse asked the resident to lower his/her voice and reminded the resident he/she needed to use the walker. The resident yelled he/she wanted to go the bathroom and staff would not allow it. Staff placed the walker in front of the resident, and the nurse asked the resident to slow down for safety. The resident flung his/her walker at staff, sat down on the bed, and yelled he/she wanted his/her clothes, didn't want to be there, wanted to go to the hospital, and wanted to call his/her sibling. The resident then called staff a profanity. The nurse asked the resident to lower his/her voice and told him/her to stop cursing. The resident said he/she would hit staff with his/her walker. The nurse told the resident his/her screaming may disturb other residents and violence towards staff or other residents would not be tolerated. The resident flung his/her hands up and said everyone hates him/her, and he/she wanted to go to the living room. The resident was handed clothing and told to get dressed. The resident then slapped the aide in the arm. The resident was told that slapping staff was inappropriate. The resident denied hitting the staff and said staff hated him/her. The resident got dressed and continued to yell while in his/her room. He/she walked to the living room and continued to yell out at staff. The nurse asked the resident to return to his/her room, until he/she was calm, and cursing at staff was inappropriate. The resident said he/she didn't curse at staff. The resident went to his/her room, screamed out, cried, and slammed the door shut. At approximately 5:15 A.M. the nurse called the psychiatric Nurse Practitioner and discussed the resident's behaviors. Orders were received for Depakote 500 milligrams (mg) twice a day and Haldol solution (a medication used to manage the symptoms of schizophrenia, including hallucinations and delusions) 5 mg intramuscular (IM given into the muscle) one time for behaviors. The resident went to the nurse's desk and asked staff if he/she got more medication. The staff told the resident of the Nurse Practitioner's orders. The resident walked rapidly to his/her room and slammed the door while screaming. Registered Nurse A, Certified Nurse Aide A and B went to the resident's room. The resident was screaming and crying, saying he/she didn't do anything. Staff reminded the resident of his/her behaviors and told him/her of the NP orders. The resident began swatting at staff and screaming. Staff assisted the resident to a sitting position on the bed. The resident was screaming and slapping at staff. One aide hugged the resident, while the other aide held his/her hands. The IM injection was given in the left deltoid (common shoulder muscle). The staff released the hug and hand hold. As the RN was exited the room, the resident slapped CNA B in the face. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/10/24 at 11:12 A.M the resident said: -He/she did not mean to yell. -No staff were mean to him/her. -He/she is not scared. -He/she likes hugs but not tight ones. -He/she does not like to go to his/her room. During an interview on 9/10/24 at 3:59 P.M the Medical Director said: -He would not expect a resident to be held tightly to give an injection. -It is a form of restraint to hold a resident down or against their will. -He would not approve for a resident's arms to be held down to give an injection. During an interview on 9/10/24 at 3:53 P.M. the Psychiatric Nurse Practitioner said: -She does not give orders for medications to be given no matter what. -If an injectable medication is ordered it would be a dire need for the resident. -Treatment for resident #1 is difficult as the resident had learning disability. -Resident #1 behaviors are not always a side effect of his/her psychosis, but a true behavior disorder. During an interview on 9/10/24 at 4:09 P.M. CNA B said: -On 8/20/24 about 5:15 A.M. the Charge Nurse asked him/her and CNA A to assist with an injection for Resident #1. -He/she and CNA A sat on each side of Resident #1, and sandwiched the resident between them. -Resident #1's arms were placed down to his/her sides. -He/she hugged the resident so the resident could not hit or push the needle away and to hold his/her arms down. -He/she does not remember if the charge nurse told him/her to hold the resident's arms down. -He/she thought CNA A had his/her arms around the resident also. During an interview on 9/10/24 at 4:32 P.M. RN A said: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 8/20/24 Resident #1 was smacking at staff, smacking staff arms, and screaming in the hallway. -Resident #1 did not make any attempts to hit other residents. -He/she notified the Psychiatric Nurse Practitioner for orders. -If he/she does not pay attention to Resident #1 his/her behaviors will escalate. -To administer the injection, one CNA gave the resident a tight hug and the other CNA held the resident's hands, so the resident could not mover or slap at staff. He/she is unsure which CNA hugged the resident and which CNA held the resident's hands. -He/she has not had any training on restraints, behavior modification, or de-escalation. During an interview on 9/10/24 at 4:47 P.M. the Administrator said: -During education over this event staff were told residents cannot be held down to administer medications. -Resident #1 is easily redirectable. -Staff have been told previously to call the Director of Nursing if a resident is having uncontrolled behaviors. -Staff have not had formal training on de-escalation. MO240852

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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. 44395 Based on observation, interview, and record review, the facility failed to provide adequate behavioral health interventions for one resident (Residents #1) who exhibited behaviors that escalated to a catastrophic reaction, culminating in the use of an antipsychotic (previously known as major tranquilizers: are a class of medication primarily used to manage psychosis: a mental disorder characterized by a disconnection from reality.)medication injection. The facility census was 29. Review of the facility provided policy Behavioral Interventions, dated April 2006 showed: -Catastrophic reaction is the over reactive or inappropriate behavior associated with the resident. This behavior occurs when the resident misunderstands or cannot cope with a distressing physical or environmental situation. A catastrophic reaction can occur when a resident becomes overwhelmed. -Angry and agitated behaviors are part of a brain syndrome and are not deliberate -Do not overwhelm a resident. Usually a calm, private and reassuring show of support will help manage a difficult situation. -Always try to speak in positive terms, rephrasing negative terms such as don't and no into neutral statements. -Food and activities are excellent distraction techniques; use music, massage and quiet readings -Rule out physical problems (i.e. pain, fever, so on) -Anger and fear should be acknowledged, these represent a loss of control -Never remind a resident of an outburst -Gentle and supportive approach is more successful than a command or an attempt to perform reality orientation -Behavior charting must include:behavior on anxiety exhibited, what possibly caused the incident, non-drug interventions used to reduce anxiety and outcome. -No psychoactive drug will be initiated without first being approved by the Behavior Management Committee. -Alternative interventions must be implemented and recorded prior to the use of an as needed medication. Review of the facility provided Behavior Management Program, dated April 2006 showed: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Each resident will have an individualized plan of care, incorporating both proactive and reactive approaches. Review of Resident #1's Quarterly Minimum Data Set (MDS: a facility assessment completed by facility staff) dated 6/26/24 showed: -Brief Interview of Mental Status (BIMS) of 13 indicated minimal cognitive loss -Supervision of staff with Activities of Daily Living (ADLs: tasks completed in a day to care for oneself) -Verbal behaviors directed at others (such as yelling out and cursing)one to three days of a week -Daily wandering (aimless movement throughout an area) -Diagnoses of: Bipolar Disorder (a mental illness that causes extreme shifts in mood, energy, and activity levels), history of falling, unsteadiness on feet, need for assistance with personal care, conversion disorder (a condition in which a person experiences physical and sensory problems, such as paralysis, numbness, blindness, deafness or seizures, with no underlying medical condition), psychosis (a set of symptoms that cause a person to lose touch with reality and have difficulty distinguishing what is real and what is not), major depressive disorder (a serious mental disorder that can affect how someone feels, thinks, and acts; characterized by a depressed mood and loss of interest in activities), Pseudobulbar affect (disorder that causes uncontrollable episodes of laughing or crying that are inappropriate for the situation), anxiety (feelings of fear, dread or uneasiness),and dementia (memory loss that effects your ability to care for yourself). Review of the resident's comprehensive care plan dated 6/4/24 showed: -He/She had confusion, paranoia (an irrational fear or distrust of others, often believing that they are being harmed or deceived) and forgetfulness. -Demonstrate that the resident is accepted. -Encourage daily activities that increase self esteem. -Encourage participation in diversional activities. -Explain all treatments and procedures before beginning or carrying through for the resident. -Staff were to allow ample time to express emotions. -Staff were to offer reassurance to the resident during times of increased emotions. Review of the resident's progress notes showed: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 8/20/24 at approximately 7:00 P.M. the resident was in the living room area; being loud and disruptive to other residents. The resident was asked by staff, several times to lower his/her voice so as not to disturb other residents. The resident continued to yell profanities at staff passing by. The resident went to his/her room and slammed the door. The resident slept for a few hours, got up, and was slamming his/her door and yelling. Staff went to the resident's room, told him/her to lower their voice, and the resident returned to bed. -At approximately 4:30 A.M. The resident's call light was on. The resident was found sitting upright on the floor, with the call light in his/her hand. The resident said he/she needed assistance up and needed to use the bathroom. His/her walker was upright, sitting behind the resident. This nurse asked two aides to assist the resident up and onto the bed. The resident denied pain and again said he/she needed to go to the bathroom. During a physical assessment the resident yelled out he/she needed to go to the bathroom and staff were not letting him/her. The nurse asked the resident to lower his/her voice and staff would assist him/her. The walker was placed in front of the resident; he/she began shuffling to the bathroom yelling he/she could walk alone. The resident flung his/her walker aside and continued to walk. The nurse asked the resident to lower his/her voice, and reminded the resident he/she needed to use the walker. The resident yelled he/she wanted to go the bathroom and staff would not allow it. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff placed the walker in front of the resident, and the nurse asked the resident to slow down for safety. The resident flung his/her walker at staff, sat down on the bed, and yelled he/she wanted his/her clothes, didn't want to be there, wanted to go to the hospital, and wanted to call his/her sibling. The resident then called staff a profanity. The nurse asked the resident to lower his/her voice and told him/her to stop cursing. The resident said he/she would hit staff with his/her walker. The nurse told the resident his/her screaming may disturb other residents and violence towards staff or other residents would not be tolerated. The resident flung his/her hands up and said everyone hates him/her, and he/she wanted to go to the living room. The resident was handed clothing, and told to get dressed. The resident then slapped the aide in the arm. The resident was told that slapping staff was inappropriate. The resident denied hitting the staff and said staff hated him/her. The resident got dressed and continued to yell while in his/her room. He/she walked to the living room and continued to yell out at staff. The nurse asked the resident to return to his/her room, until he/she was calm, and cursing at staff was inappropriate. The resident said he/she didn't curse at staff. The resident went to his/her room, screamed out, cried, and slammed the door shut. At approximately 5:15 A.M. the nurse called the psychiatric Nurse Practitioner and discussed the resident's behaviors. Orders were received for Depakote 500 milligrams (mg) twice a day and Haldol solution (a medication used to manage the symptoms of schizophrenia, including hallucinations and delusions) 5 mg intramuscularly (IM given into the muscle) one time for behaviors. The resident went to the nurse's desk and asked staff if he/she got more medication. The staff told the resident of the Nurse Practitioner's orders. The resident walked rapidly to his/her room and slammed the door while screaming. Registered Nurse A, Certified Nurse Aide A and B went to the resident's room. The resident was screaming and crying, saying he/she didn't do anything. Staff reminded the resident of his/her behaviors and told him/her of the NP orders . The resident began swatting at staff and screaming. Staff assisted the resident to a sitting position on the bed. The resident was screaming and slapping at staff. One aide hugged the resident, while the other aide held his/her hands. The IM injection was given in the left deltoid (common shoulder muscle). The staff released the hug and hand hold. As the RN was exited the room, the resident slapped CNA B in the face. Review of the facility initiated investigation dated 8/22/24 showed all staff were educated on resident rights, resident behaviors, and approach of residents on 8/22/24. During an interview on 9/10/24 at 11:12 A.M the resident said: -He/she did not mean to yell. -No staff were mean to him/her. -He/she is not scared. -He/she likes hugs but not tight ones. -He/she does not like to go to his/her room. During an interview on 9/10/24 at 2:32 P.M. Certified Nurse Aide (CNA) C said: -He/She was working on 8/20/24 -He/she had some training for outburst behaviors, no other training. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When behaviors occur he/she would try to calm the resident, talk to the resident, or give them time to calm down. -When talking or giving the resident time is not effective he/she would get the Charge Nurse or Director of Nursing (DON). -Resident #1 may lash out when upset, hitting or saying things that are not true. -When resident #1 lashed out or hit, staff had to give her time alone. During an interview on 9/10/24 at 4:09 P.M. CNA B said: -He/She had no training from the facility for behaviors and what to do. -He/She worked in other facilities before and had some training there. -He/She would do what the Charge Nurse asked him/her to do when a resident was having behaviors. During an interview on 9/10/24 at 4:32 P.M. Registered Nurse (RN) A said: -He/She tried to take Resident #1 to his/her room and explain to him/her not to have behaviors -Staff put their finger to their lips to tell the resident to be quiet when he/she was yelling out. -He/She has had no training on restraints or behavior modification. During an interview on 9/11/24 at 11:00 A.M. the Administrator said: -Staff have not had formal education about behavior modification. -Staff are advised, when a resident had uncontrollable behavior, to call the DON. MO240852