STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265598	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Health Care Center	721 West Harrison St Brunswick, MO 65236

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 36185 Based on interview and record review, the facility failed to ensure one resident (Resident #1), of 11 sampled residents, remained free from sexual abuse, when another resident with inappropriate sexual behaviors (Resident #2), sexually abused the resident in Resident #1's room. The facility census was 21. On 4/15/25 at 5:05 P.M., the administrator was notified of the immediate jeopardy (IJ) past non-compliance that occurred on 3/29/25. Corrective measures and an investigation began immediately. Resident #1's family and physician were notified of the allegation of abuse and the resident was placed one on one for safety until emergency medical services arrived to transport the resident to the hospital for assessment and evaluation. Resident #2 was placed on one on one supervision until local law enforcement arrived. Education on Sexual Harassment and Sexual Abuse policies was provided to all staff. The IJ was corrected on 3/31/25. Review of the facility's policy, Abuse and Neglect, revised on 6/12/24, showed the following: -It is the policy of this facility to report allegations of abuse/neglect/exploitation, or mistreatment, including injuries of unknown sources and misappropriation of property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations with prescribed time frames; -Sexual abuse is non-consensual contact of any type with a resident. Sexual abuse includes, but is not limited to the following: -Unwanted intimate touching of any kind especially of breasts or perineal area; -All types of sexual assault or battery, such as rape, sodomy and coerced nudity; -This also includes failure to intervene or attempt to stop or prevent non-consensual sexual activity or performance between residents. 1. Review of Resident #1's Face Sheet, undated, showed the following: -The resident's original admitted was 8/7/24; (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident was his/her own responsible party. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 2/15/25 showed the following: -Cognitively intact; -Disorganized thinking continuously present and does not fluctuate; -No behavioral symptoms directed towards others exhibited (including hitting, kicking, pushing, grabbing or abusing others sexually); -Other behavioral symptoms not directed towards others (including public sexual acts) not exhibited; -The resident required substantial assistance with positioning in bed; -The resident was dependent on staff with transfers from bed to chair; -The resident had a urinary catheter; -Diagnoses included Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior), cerebral palsy (a disorder that affects movement, balance and posture), epilepsy, Parkinson's disease (a brain disorder that causes movement problems, like shaking, stiffness and difficulty with standing), anxiety disorder and depression. Review of the resident's Grievance Report, dated 3/13/25, showed the following: -Date complaint/grievance occurred: 3/8/25 to 3/13/25; -Resident #2 was always touching Resident #1 on the shoulder. Resident #2 asked Resident #1 to go on a date with him/her and Resident #1 did not want to; -Resident #1 had to ask Resident #2 to stay out of his/her room. Resident #2 made him/her feel scared; -Form completed by Registered Nurse (RN) B; -Grievance follow up: Tried talking to Resident #2. He/She apologized and walked away. Review of the resident's Progress Note, dated 3/29/25 at 6:01 P.M., showed the following: -The resident just reported to an aide that Resident #2 came into his/her room earlier today. The charge nurse on the off going shift, Licensed Practical Nurse (LPN) A, and the oncoming shift nurse, LPN F, talked to the resident. The resident reported at 3:00 P.M., Resident #2 came into his/her room and put his/her fingers inside the resident's genitalia. Resident #1 told Resident #2, No, but the resident continued and said he/she (Resident #2) had permission to be in Resident #1's room, which the resident did not; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #1 complained of pain in the genital area after the incident. The Assistant Director of Nursing (ADON) was notified to report the incident. LPN F made an emergency call to 911 and Emergency Medical Services (EMS). Review of the resident's Care Plan, revised on 3/31/25, showed the following: -The resident had a potential behavior problem related to inappropriate sexual comments. Anticipate and meet the resident's needs (date initiated 7/8/24); -Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner divert attention and remove from situation and take to alternate location as needed; -The resident required assistance of two staff to turn and reposition him/her in bed every two hours and as necessary; -The resident was totally dependent on two staff for dressing; -On 3/29/25, the resident reported another resident came into his/her room earlier that day. The incident happened around 3:00 P.M., and the other resident put his/her fingers inside the resident's genitalia. Resident #1 told him/her, no but the resident continued and said he/she had permission to be in the resident's room; -The resident complained of pain between his/her legs, initiate post-incident psychosocial assessment. Completing every shift for three days and then daily for seven days; -Notified the physician, ADON, the Director of Nursing (DON), Administration, reported to the state agency and law enforcement; -Order received to send the resident to the emergency room for evaluation and treatment; -The resident was immediately placed one on one for oversight and kept away from the other resident. Review of the resident's Police Report, Sodomy or Attempted Sodomy/ Supplemental Narrative Report, dated 4/5/25 at 10:24 A.M., showed the following: -On 4/5/25 the resident was asked what happened last Saturday, 3/29/25; -Resident #1 said Resident #2 came in to his/her room at 3:00 A.M. while he/she was sleeping and kissed Resident #1 on the lips and lifted up his/her gown; -Resident #2 put his/her fingers inside the resident's genitalia and pushed deeper and deeper inside. Resident #1 said he/she told Resident #2 no, and to stop several times before he/she stopped; -Resident #1 was questioned about his/her relationship with Resident #2 and Resident #1 said Resident #2 just hooked onto him/her, they were not friends, and he/she didn't know him/her; -Resident #1 said Resident #2 had asked if he/she wanted to date and Resident #1 told him/her, no; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #1 said the hospital did an exam of him/her and there was tearing and bleeding between his/her legs; -The resident was asked if he/she wanted to press charges and he/she said, yes. During an interview on 4/3/25 at 11:05 A.M. and 4/7/25 at 12:15 P.M., Resident #1 said the following: -At first, he/she enjoyed spending time with Resident #2. Resident #2 acted like he/she cared for him/her; -Resident #2 would touch him/her on the arm or shoulder, it made him/her feel good and Resident #2 sat with him/her during meals; -He/She and Resident #2 had watched movies in the facility sunroom. Resident #2 had kissed him/her and Resident #1 was fine with that; -On Saturday, in the night, around 3:00 A.M., he/she (Resident #1) was asleep in bed, and was awakened by Resident #2 kissing him/her on the lips; -Resident #2 pulled up his/her gown and put his/her fingers inside the resident's genitalia. Resident #1 was scared and stunned it happened so fast, he/she yelled for Resident #2 to stop, stop, stop, but he/she wouldn't; -Resident #2 was rough, and it hurt. He/She was afraid of Resident #2 now. 2. Review of Resident #2's Face Sheet, undated, showed the following: -admitted [DATE]; -The resident was his/her own responsible party. Review of the resident's admission MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -No behavioral symptoms exhibited including physical behaviors (e.g., hitting, kicking, scratching or abusing others sexually), verbal behaviors or behaviors not directed towards others (physical symptoms such as hitting, scratching, pacing rummaging or sexual acts in public); -No wandering exhibited; -Independent with mobility; -No mobility device utilized. Review of the resident's Progress Note, dated 3/9/25 at 3:58 P.M., showed the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #2 was at a table playing a game with Certified Nurse Assistant (CNA) E and another resident (Resident #1); -Resident #2 asked if he/she could take people out on dates and how he/she could go about it, the resident was directed to ask social services, but that it would have to be agreed upon; -Resident #2 asked a question about bringing someone into his/her room and told the staff member he/she was hot and attractive, and his/her body looked sculpted; -The staff member educated the resident and told him/her it was not appropriate to talk about staff members that way. Review of the resident's Progress Note, dated 3/18/25 at 6:30 P.M., showed Dietary Aide D said the resident came into the kitchen doorway and told him/her that he/she had a banging body and he/she wanted to kidnap him/her. Review of a Grievance Form, dated 3/18/25, untimed, completed by Dietary Aide D, showed the following: -Resident #2 said he/she had a banging body along with he/she would fuck him/her and that he/she looked at his/her ass; -Resident #2 also made a comment about kidnapping Dietary Aide D. Review of the resident's Medication Review report dated 3/30/25 showed the following: -Diagnoses included homeless, bipolar disorder, current episode depressed, mild (a mental health condition characterized by both periods of elevated mood, mania or hypomania) and periods of depression, with the current episode being a mild form of depression), adjustment disorder (an excessive emotional or behavioral reaction to a stressful life event or change) and anxiety; -Progesterone (can be used to reduce inappropriate sexual behaviors) for sexual disinhibition (loss of normal restraints or controls on sexual thoughts, impulses or behaviors) 100 milligrams (mg) one capsule at bedtime for sexual disinhibition (order date 3/11/25). Review of recorded facility camera footage, dated 3/29/25, showed the following: -At 3:03 P.M., Resident #2 walked down the hall and entered Resident #1's room and shut the door. No staff members were observed in the area at the time; -At 3:33 P.M., Resident #2 exited Resident #1's room. Review of the local law enforcement report, dated 3/29/25 at 6:24 P.M., showed the following: -On 3/29/24 at about 6:24 P.M., a report came into dispatch about a sexual assault that occurred at the facility. Staff at the facility advised to stay with the victim (Resident #1) and keep him/her separated from the suspect (Resident #2); (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Arrived on scene at 7:53 P.M., was advised the victim had been transported to the hospital for a sexual assault exam. Questioned staff about Resident #1's mental status and was told he/she was alert and oriented to person, place, and time with occasional confusion; -Resident #1 gave a verbal statement that was written by Licensed Practical Nurse (LPN) A which included that around 3:00 P.M., Resident #2 went into Resident #1's room when he/she was asleep. He/She (Resident #2) gave the resident a kiss and put his/her fingers inside the resident's genitalia, it was hard, and Resident #1 told Resident #2 to stop, and he/she didn't. -Resident #1 told Resident #2 to stop again. Resident #2 kept going on and on. Resident #1 finally yelled stop, and Resident #2 finally stopped; Resident #2 wouldn't leave. Review of the resident's Care Plan, revised 3/31/25, showed the following: -The resident told a staff member that he/she was hot, attractive, and his/her body looked sculpted (date initiated 3/10/25); -The resident was educated on appropriate conversations that occur with staff and started on progesterone; -The resident had a problem with being verbally sexually inappropriate (date initiated 3/10/25); -Intervene as necessary to protect the rights and safety of other residents, divert attention. Remove from situation and take to alternate location as needed; -The resident was independent with activities of daily living (ADL); -The resident was a wanderer and significantly intruded on the privacy and activities of other residents (dated initiated 3/24/25); -Advised the resident he/she couldn't go down other hallways where he/she didn't live, the resident didn't verbalize an understanding and stated he/she would walk all the hallways, and he/she wasn't going into other rooms; -If wandering occurs attempt to offer favorite snacks; -Another resident (Resident #1) reported that the resident had entered his/her room and touched him/her (Resident #1) inappropriately (date initiated 3/30/25); -Local county law enforcement agency was called and notified to come to the facility; -The resident was placed on one-on-one supervision to ensure he/she was not found around the other resident (Resident #1); -The resident was taken with law enforcement for questioning over the incident. During an interview on 4/7/25 at 9:25 A.M. CNA E said the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Recently he/she was playing a game at a table in the dining room with Resident #1 and Resident #2; -Resident #2 made a comment about him/her (CNA E) being pretty and his/her body being sculpted. Resident #2 asked how residents could go about going on dates, CNA E wasn't sure if Resident #2 meant with residents or staff, he/she redirected Resident #2 and reported the incident to Registered Nurse (RN) B; -Resident #1 and Resident #2 sat together during meals, Resident #2 would pat Resident #1's shoulder or leg. Resident #1 didn't act like he/she liked it or didn't like it; -The week before the incident, Resident #1 asked to sit at another table, instead of sitting with Resident #2; -A few days later he/she asked to sit with Resident #2 again during meals; -He/She questioned Resident #1 about the seating arrangement and Resident #1 said he/she liked to sit with Resident #2. During an interview on 4/4/25 at 8:50 A.M. and 4/8/25 at 11:45 A.M. the Social Service Designee (SSD) said the following: -Resident #2 sat with Resident #1 at meals and would put his/her (Resident #1's) clothing protector on; -Resident #1 made a grievance against Resident #2 entering his/her room uninvited. SSD thought maybe Resident #2 wanted to visit, as many residents do in the facility, or because Resident #1 was aware Resident #2 had taken items from other residents, and Resident #1 didn't want him/her in his/her room; -He/She explained to Resident #1, Resident #2 could not enter his/her room uninvited, and he/she had to give him/her permission to do so; -He/She instructed Resident #1 to call for help or let staff know if there was an issue otherwise staff wouldn't know there was a problem; -He/She didn't ask Resident #1 why Resident #2 made him/her feel scared, as he/she (Resident #1) indicated on the grievance submitted to the SSD; -Resident #2 made inappropriate sexual comments towards staff regarding their appearance; -He/She had several grievances against Resident #2 for stealing other residents' items or going in their rooms; -He/She educated Resident #2 on not going in other resident's rooms or taking items that didn't belong to him/her. During an interview on 4/4/25 at 9:15 A.M. RN B said the following : (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #2 made a sexually inappropriate comment towards Dietary Aide D, the physician was notified and received an order for progesterone; -The physician followed up on medication effectiveness and RN B told the physician it was helping as he/she didn't notice any inappropriate sexual behaviors after being on the medication. During an interview on 4/7/25 at 11:45 A.M. and 4/8/25 at 2:04 P.M., the Director of Nursing (DON) said the following: -The facility did not know a lot about Resident #2 when he/she admitted to the facility; -Resident #2 was started on progesterone for inappropriate sexual comments made towards staff; -Resident #1 and Resident #2 sat together during meals and spent time together in the common area; -When Resident #1 told Resident #2 to stop and he/she didn't, that was considered sexual abuse/sexual assault. During an interview on 4/8/25 at 2:30 P.M. the Administrator said the following: -Resident #2 made inappropriate sexual comments towards staff and he/she was educated on this behavior not being appropriate; -The physician was notified and Resident #2 was started on progesterone; -She didn't have concerns with Resident #2 being sexually inappropriate with residents, it seemed directed towards the staff; -Resident #1 and Resident #2 sat together during meals and spent time together in the common area; -On 3/29/25, Resident #1 reported Resident #2 sexually assaulted him/her in his/her room; -She considered what Resident #2 did to Resident #1 was sexual assault and sexual abuse. MO251962 MO251922

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36185 Based on interview and record review, the facility failed to ensure staff were employed with the appropriate competencies and skill sets to provide nursing care and related services to assure resident safety and attain the highest practicable mental and psychosocial well-being for their resident population when the facility accepted residents for admission with behavioral health needs that staff were not trained to care for. The facility census was 21. Review of the facility's Behavioral Health Services Policy, revised 10/31/24, showed the following: -Affected Personnel: All facility employees; -It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning; -All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the staff member and resident needs identified through the facility assessment. Review of the facility's policy, Resident Referral Review Process, dated 12/1/22, showed the following: -When the facility receives a resident referral for admission, the Admission Coordinator will convene an Admission Team meeting immediately. This meeting will convene within 15 minutes of receiving the referral; -The members of the team must stop what they are doing and immediately attend the admission team meeting to review the referral; -The admissions coordinator will contact the referral sources and inform them of Admission Team's (Admissions Coordinator, Social Service Designee, Business Office Manager, Director of Nursing (DON) and Administrator) decision as rather to admit or not to admit the potential resident; -Referral decisions for medical referrals should be made in 15 minutes of the meeting; -Referrals for behavioral referrals should be made in two hours of receiving the referral, unless additional information was needed to make the decision; no longer than 24 hours after; -If the admissions team feels they cannot meet the resident's needs or the facility had no available bed for the referral, the admission coordinator will contact the referral source and inform them of the admissions team's decision to not admit; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The final decision as to whether to admit or not to admit the referral will be made by the Administrator. Review of the Facility's Assessment, dated 1/1/24 through 4/16/24, showed the following: -Average daily census was 31; -Diagnoses included psychiatric/mood disorders: alcohol abuse, alcohol dependence, anorexia, anxiety, bipolar disorder (a mental health condition characterized by both periods of elevated mood, mania or hypomania), hallucinations, insomnia, major depressive disorder, mood disorder (a mental health disorder affecting one's mental state), panic disorder, paranoid schizophrenia (mental health condition that can affect how a person thinks, feels and behaves), post-traumatic stress disorder (a mental health condition that develops after a traumatic event), psychiatric disorder with delusions (false beliefs); -When the facility received a referral for the care of a resident that staff are less familiar or when a resident develops a new diagnosis, condition or symptom that staff have not previously exposed to, the Interdisciplinary Team will immediately inform the DON, notify the Medical Director, review the company clinical library for related policy and procedures, utilize the regional nurse, utilize evidence based resources, utilize medical director for training, utilize vendors for training as needed, educate all involved staff and perform required competency related to new condition or procedure and consult company executive clinical leadership team as needed; -Average number of residents with special treatments/ acuity showed behavioral health needs was one; -Average number of residents with active or current substance use disorders was none; -Services and care offered based on our residents' needs included mental health and behavior, manage the medical conditions and medication related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, other psychiatric diagnoses, psychology and psychiatry by third party, psychosocial support by Social Worker (SW); -Staff training/education and competencies included providing a yearly calendar of educational experiences that cover pertinent and mandatory topics for the support and care needed for the resident population; -Nursing department required competency included person centered care and behavior management. Review of the list of residents admitted in the last 60 days with mental health diagnoses, provided by the facility, dated 4/8/25, showed the following: -Resident #3 admitted to the facility on [DATE]. Diagnoses included paranoid schizophrenia and paranoid personality disorder (a mental health disorder characterized by persistent pattern of mistrust and suspicion of others); (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #2 admitted the facility on 2/21/25. Diagnoses included bipolar disorder and adjustment disorder; -Resident #4 admitted to the facility on [DATE]. Diagnoses included bipolar disorder and anxiety disorder; -Resident #11 admitted to the facility on [DATE]. Diagnoses included unspecified psychosis not due to a substance or known physiological condition (a state where person's ability to distinguish between real and unreal experiences is impaired, leading to hallucinations (seeing or hearing things that aren't there) and delusions; -Resident #9 admitted to the facility on [DATE]. Diagnoses included delirium due to known psychological condition (a person's mental state, typically marked by confusion and disorientation, is caused by a preexisting mental health issue); -Resident #8 admitted to the facility on [DATE]. Diagnoses included undifferentiated schizophrenia (a diagnosis used when a person experiences of schizophrenia but don't fit into a clear specific subtype), other specified depressive disorders, social exclusion and rejection, major depressive disorder, bipolar disorder, current episode manic without psychosis features and delusional disorders (a state where an individual experiences a manic episode, characterized by elevated mood, energy and activity but doesn't experience delusions or hallucinations); -Resident #10 admitted to the facility on [DATE]. Diagnoses included paranoid schizophrenia, personal history of traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), paranoid personality disorder, major depressive disorder, delusional disorder (a mental illness characterized by persistent, false beliefs, called delusions, that last for at least a month) and anxiety disorder. During an interview on 4/8/25 at 1:00 P.M. Certified Nurse Assistant (CNA) F said he/she had no formal training on caring for residents with mental health conditions. During an interview on 4/4/25 at 10:15 A.M. Licensed Practical Nurse (LPN) A said the following: -The facility was a basic long-term care facility, and recently they had admitted several residents with mental health conditions; -LPN A had not received formal training on caring for residents with mental health issues; -If the facility continued to admit residents with mental health issues, staff should have additional training, resources and education to care for those residents. During an interview on 4/8/25 at 1:00 P.M., the Activity Director said he/she had not received any formal training to care for mental health residents. During an interview 4/3/25 at 3:07 P.M. and 4/7/25 at 3:50 P.M. the Social Service Director (SSD) said the following: -She became the SSD in December 2024; (continued on next page)

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	265598	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Health Care Center	721 West Harrison St Brunswick, MO 65236

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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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She had not received any formal mental health training; -The facility had admitted several residents with mental health conditions and she was not sure if she was doing the right thing to help residents with mental health issues; -Resident #2 was recently admitted to the facility. The resident was homeless and was basically dropped off at the facility by a ride-sharing service; -The facility knew very little about the resident and was unaware of his/her mental health conditions; -Resident #2 would steal and go in other rooms without permission, corporate staff told facility staff to educate the resident; -Staff attempted to educate Resident #2 and he/she would just walk away or ignore staff; -When staff tried to redirect Resident #2 he/she would retaliate by making a mess in another room or emptying his/her colostomy bag (bag that collects feces after a surgical procedure called a colostomy) in the sink or disconnecting the toilet; -There needed to be a better screening process before admitting residents to the facility. During an interview on 4/7/25 at 11:05 A.M., the Assistant Director of Nursing (ADON)/Admission Coordinator said the following: -He/She had not received any formal training on mental health; -The facility had admitted several residents with mental health diagnoses; -When he/she reviewed Resident #2's referral paperwork he/she missed the resident's mental health diagnoses, he/she basically reviewed the high points of the paperwork; -If he/she would have been aware of the resident's mental health diagnoses and that no medications were prescribed for symptom management, he/she would have questioned the resident's admission to the facility; -Corporate staff expected admission referrals be reviewed in 15 minutes and a prompt response on whether the facility would admit the resident; -Resident #3 continually made comments about wanting or needing to leave the facility. During an interview on 4/7/25 at 10:45 A.M. and 11:45 A.M. the Director of Nursing (DON) said the following: -She started working at the facility in December of 2024; -She had been a nurse for less than a year; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She had not received any formal training at the facility regarding mental health conditions; -She had concerns with the recent admission of residents with mental health conditions and the facility's ability to care for some of those residents due to the lack of training; -Corporate staff sent new admission referrals to the facility and the facility's administrative staff were to review the information and respond in 15 minutes whether they would accept the resident as an admission; -Resident #2's mental health diagnoses were missed when reviewing the information. The resident was not on any medications to manage his/her bipolar disorder. If that had been known, the facility would have questioned symptom management prior to accepting the resident; -Resident #2 had stolen clothing from other residents, stolen food from his/her roommate, used profanity towards staff when they tried to redirect him/her and was very manipulative; -She reached out to corporate staff and was adamant the resident needed to be transferred and was told to educate the resident on appropriate behavior and come up with interventions; -Resident #3's Level II screening (a process used to determine if an individual has a mental illness or intellectual disability and if a nursing facility is the most appropriate placement for them) indicated the resident needed a secured/behavioral unit, which the facility did not have. During an interview on 4/7/25 at 10:30 A.M. and 4/8/25 at 10:10 A.M. and 2:30 P.M., the Administrator said the following: -She had not received any formal mental health training; -The facility had admitted several residents recently with mental health conditions; -Facility staff had not received any formal mental health training; -Corporate staff sent all new admission referrals to the facility. The expectation was for referrals to be reviewed in 15 minutes and a decision made whether the facility would accept the resident as an admission; -Resident #2's mental health diagnoses got missed due to the rushed process of reviewing the referral information. The facility had limited information on him/her; -When she spoke with corporate staff about the resident's behaviors and what should be done to address those behaviors, she was told to educate the resident and document it.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36185 Based on observation, interview and record review, the facility failed to ensure two residents (Resident #2 and #3), of 11 sampled residents with mental disorders, received individualized treatment and services to meet their needs. Residents displayed verbal, manipulative and aggressive behaviors on multiple occasions. The facility failed to adequately develop and implement meaningful interventions, including non-pharmacological interventions, alternate strategies, or to ensure the residents received timely and appropriate treatment or services to address the residents' psychosocial well-being. The facility census was 21. Review of the facility's Behavioral Health Services Policy, revised 10/31/24, showed the following: -Affected Personnel: All facility employees; -Purpose: It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning; -All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the staff member and resident needs identified through the facility assessment; -Mental Disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities; -Background: Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders; -The facility will consider the acuity of the resident population. This includes residents with mental disorders, psychosocial disorders, or substance use disorders (SUDs), and those with a history of trauma and/or post traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), as reflected in the facility assessment; -A facility must ensure behavioral health services are provided: The facility will ensure necessary behavioral health services are person centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety; -Behavioral Health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person centered-care; -The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice and safety; -Complete PASARR (Pre-admission screening for serious mental disorders or intellectual disabilities and related conditions), screening, obtain history from records; -Obtain history from medical records, the resident, and as appropriate resident's family and friends, regarding mental, psychosocial, and emotional health; -Assess and develop a person-centered care plan for concerns identified in the resident's assessment; -Share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes, including differential diagnosis; -Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record; -Ensure appropriate follow-up assessment, if needed; -Discuss potential modifications to the care plan; -Evaluate resident and care plan routinely to ensure the approaches are meeting the needs of the resident; -The care plan shall have interventions that are person centered, evidence based, culturally competent, trauma-informed, and in accordance with professional standards of practice, reflect the resident's goals for care; -Use pharmacological interventions only when nonpharmacological interventions are ineffective or when clinically indicated; -Address any other individualized needs the resident may have related to the mental disorder or the substance abuse disorder; -The resident's care plan shall be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition. 1. Review of Resident #2's Face Sheet, undated, showed the following: -admitted was 2/21/25; -The resident was his/her own responsible party. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Progress Note, dated 2/23/25 at 9:38 A.M., showed the following: -The nurse went to administer morning medication to the resident in his/her room. The resident had cigarettes that had been used in a cup of water. The resident's room didn't smell like smoke, and there wasn't smoke in the room at the time; -The nurse asked the resident if he/she had been smoking in his/her room as residents couldn't smoke in the facility and the resident said go fuck with someone else and to leave him/her the fuck alone; -The nurse explained it was his/her job to keep him/her and other residents safe in the facility. The resident wasn't receptive to the information. Review of the resident's PASARR Level I Screening, dated 2/24/25, showed the following: -Previous address was homeless/shelter; -The resident didn't show any symptoms of a major mental illness, suspected or history of a major mental illness or an impairment due to a serious mental illness; -Within the last two years the resident had not experienced one psychiatric treatment episode that was more intensive than routine follow-up care or due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community or intervention by housing or law enforcement officials; -The resident did not have a substance related disorder; -No behavioral symptoms. Review of the resident's Progress Note, dated 2/24/25 at 5:10 P.M., showed the following: -Staff alerted the nurse the resident had smoke coming from his/her mouth and tracheostomy (a surgical procedure, where an opening was created in the trachea, when a person has difficulty breathing through the mouth for some reason) when he/she entered the room and there was a cigarette smoke smell in the hallway; -The resident was informed the facility was a non-smoking facility, and residents could not smoke cigarettes or vapes inside the facility; -The resident shook his/her head up and down as a response. Review of the resident's Progress Note, dated 2/25/25 at 12:40 A.M., showed the following: -The resident got upset with the nurse when he/she told the resident that he/she could not have an ice-cream shake with peanut butter. The resident demanded he/she wanted one; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse said the resident could have a snack that was already prepared. The resident became angry and said that staff could make him/her a shake, but that staff didn't want to. Staff gave the resident a bowl of ice-cream and a spoonful of peanut butter. The resident said if staff could do that, they could make him/her a shake; -The resident came out of his/her room and said he/she wanted to buy a pack of cigarettes. Explained to the resident the nurse didn't smoke and he/she didn't have a pack of cigarettes; -The resident went outside and looked through the can of cigarette butts and went back to his/her room. Review of the resident's Progress Note, dated 2/25/25 at 8:39 A.M. showed the following: -It was passed on in report this morning from the night charge nurse the resident had been in other resident rooms looking for cigarettes and things to take. When the resident was redirected, the resident said to the nurse, lose your fucking attitude; -The resident was pleasant this morning but taking cigarettes from outside and bringing them inside and putting them on a tray in the dining room. When the resident was informed by the kitchen staff that this was not allowed, the resident rolled his/her eyes. The resident was not easily directed at this time. Review of the resident's Progress Note dated 2/25/25 at 8:48 A.M. showed a cigarette butt was found on the resident's tray in the dining room. Explained to the resident that cigarette butts weren't to be left on food trays. The resident rolled his/her eyes and walked away. Review of the resident's Progress Note, dated 2/25/25 at 9:30 A.M., showed the Social Service Designee (SSD), Director of Nursing (DON) and Unit Manager educated the resident on not smoking in his/her room, and the resident wasn't to enter other resident rooms unless asked to come in. The resident was also educated that he/she wasn't to take cigarettes etc. from any resident, if the resident needed something to ask staff. Review of the resident's Progress Note, dated 2/26/25 at 2:05 A.M., showed the resident picked up anything left on tables or in the kitchen. Review of the resident's Progress Note, dated 2/26/25 at 11:00 A.M,. showed the DON and Dietary Manager educated the resident that he/she could not empty his/her colostomy bag on the tray his/her food was delivered on and everything would need to be thrown away that stool was emptied on. Review of the resident's Behavior Note, dated 2/26/25 at 11:40 A.M. showed the resident had emptied his/her colostomy bag on dinner tray on multiple occasions. Education was provided to empty bag using a graduate container and to empty contents into the stool. Review of the resident's admission Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff). dated 2/27/25, showed the following: -Moderate cognitive impairment; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No behavioral symptoms exhibited including physical behaviors (e.g., hitting, kicking, scratching or abusing others sexually), verbal behaviors or behaviors not directed towards others (physical symptoms such as hitting, scratching, pacing rummaging or sexual acts in public); -There was no evidence of an acute change in mental status from the resident's baseline; -Signs and symptoms of delirium, for example, being distractible or having difficulty keeping on track of what was said and disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) was present and this showed inattention, behavior fluctuated (comes and goes and changes in severity); -No wandering exhibited; -Independent with mobility; -No mobility device utilized. Review of the resident's Progress Note, dated 3/1/25 at 3:02 P.M., showed the resident requested the sign out book so he/she could leave and walk to the convenience store. Explained to the resident the nurse needed to call the Administrator and DON for approval. Instructed the resident to sign against medical advice (AMA) papers in case the resident didn't return. The resident became aggravated, explained to the resident if something happened to him/her it would protect the facility. The resident agreed to sign the paperwork and left the facility. The resident is his/her own responsible party per the face sheet. Review of the resident's Progress Note, dated 3/1/25 at 3:18 P.M., showed the resident had walked to an employee's home when out of the facility. The resident was brought back to the facility by the employee and the employees family member after the resident was told he/she could not be at an employee's home. Review of the resident's Behavior Note, dated 3/2/25 at 8:45 A.M., showed the resident came to nurse's station and said he/she was calling 911 and was going to have Emergency Medical Services (EMS) take him/her to the hospital for ostomy supplies. The nurse asked the resident what supplies the resident needed and if he/she could look for the supplies the resident needed. The resident agreed if he/she could have breakfast in his/her room, a cup of coffee, and ice cream right now. Staff accommodated the resident's wishes. The resident said receiving his/her pain pill every eight hours was way to long and it needed shortened. Staff said they would reach out to the physician. Review of the resident's Progress Note, dated 3/3/25 at 6:35 A.M., showed over the weekend maintenance had to come to the facility and spend six hours due to flooding in the resident's room as well as sink repairs. The float and a connecting arm were completely removed from the toilet tank. This allowed water to continuously flow onto the floor in the resident's room. Maintenance removed 80 gallons of water from the resident's floor, hallway and two adjoining rooms. Maintenance reported there was no way for the float from the back of the toilet tank to be missing unless removed. Also, cigarette butts were in the bowl of the toilet. Review of the resident's Progress Note, dated 3/9/25 at 3:58 P.M., showed the following: (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #2 was at a table playing a game with Certified Nurse Assistant (CNA) E and another resident (Resident #1); -Resident #2 asked if he/she could take people out on dates and how he/she could go about it, the resident was directed to ask social services, but that it would have to be agreed upon; -Resident #2 asked a question about bringing someone into his/her room and told the staff member he/she was hot and attractive, and his/her body looked sculpted; -The staff member educated the resident and told him/her it was not appropriate to talk about staff members that way. Review of the Grievance Report, made by Resident #1 regarding Resident #2, dated 3/13/25, showed the following: -Date complaint/grievance occurred: 3/8/25 to 3/13/25; -Resident #2 was always touching Resident #1 on the shoulder. Resident #2 asked Resident #1 to go on a date with him/her and Resident #1 did not want to; -Resident #1 had to ask Resident #2 to stay out of his/her room. Resident #2 made him/her feel scared; -Form completed by Registered Nurse (RN) B; -Grievance follow up: Tried talking to Resident #2. He/She apologized and walked away. Review of the resident's Social Service Progress Note, dated 3/14/25 at 9:09 A.M., showed the following: -Received several grievances from residents regarding Resident #2's behavior. The resident continued to act out if things didn't go his/her way. The resident continued to curse at staff and could be threatening; -Tried several times to talk to the resident about his/her behavior and the resident would apologize and continue to repeat the behavior. Will continue to monitor the resident. Review of the resident's Progress Note, dated 3/18/25 at 6:30 P.M., Dietary Staff D said the resident came into the kitchen doorway and told him/her that he/she had a banging body and he/she wanted to kidnap him/her. Grievance form filled out. Review of a Grievance Form, dated 3/18/25, untimed, completed by Dietary Aide D, showed the following: -Resident #2 said he/she had a banging body along with he/she would fuck him/her and that he/she looked at his/her ass; -Resident #2 also made a comment about kidnapping Dietary Aide D; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Follow-up: Talked to the resident about making inappropriate remarks to staff. Resident #2 said he/she would leave the staff member alone; -Date resolved was 3/19/25, dietary staff were educated to keep the kitchen door locked, so the resident could not enter the kitchen. Review of the resident's Medication Review Report, dated 3/30/25, showed the following: -Diagnoses included homeless, bipolar disorder (current episode depressed, mild (a mental health condition characterized by both periods of elevated mood, mania or hypomania) and periods of depression, with the current episode being a mild form of depression), adjustment disorder (an excessive emotional or behavioral reaction to a stressful life event or change) and anxiety; -Progesterone (can be used to reduce inappropriate sexual behaviors) for sexual disinhibition (loss of normal restraints or controls on sexual thoughts, impulses or behaviors) 100 milligrams (mg) one capsule at bedtime for sexual disinhibition (order date 3/11/25). Review of the resident's PASARR Level One Screening, dated 3/30/25, showed the following: -The resident showed signs and symptoms of a major mental illness. Signs/symptoms included sexually inappropriate, verbally aggressive and stealing; -Diagnoses included bipolar disorder, major depressive disorder, anxiety disorder, adjustment disorder and personal history of mental behavioral disorder; -Adaption to change: The individual had serious difficulty 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 (ideation, gestures, threats, or attempts) physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability, or requires intervention by health health or judicial system; -Due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community or interventions by housing or law enforcement officials; -The resident had a substance related disorder. The most recent substance abuse was unknown; -Upon review of cyber access, the resident had psychiatric diagnoses that had not been documented; -Being withdrawn/depressed: minimal symptoms noted; -Suspicious/paranoid/ aggressive (physical/verbal) behaviors: moderate symptoms noted; -Wandering, abnormal thought process and sexually inappropriate behaviors: maximal symptoms noted; -The resident had not been at the facility long enough to see a psychiatric provider. No psychiatric evaluation available; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Unstable mental condition monitored by a physician or mental health professional at least monthly or behavior symptoms are currently exhibited, or psychiatric conditions are recently exhibited; -Level of supervision: Every two-hour check; -No issues with cognition. During an interview on 4/3/25 at 1:30 P.M., Resident #11 said the following: -Resident #2 was his/her roommate for awhile; -Resident #2 stole his/her soda, popcorn and other items. Resident #2 was constantly making a mess with feces all over the room; -Resident #2 would always rub other resident's shoulders and heads, he/she thought it was inappropriate. Resident #2 touched the residents when staff weren't around; -He/She complained about Resident #2 and they moved him/her (Resident #2) to another room. During an interview on 4/3/25 at 11:05 A.M. and 4/7/25 at 12:15 P.M., Resident #1 said the following: -At first, he/she enjoyed spending time with Resident #2. Resident #2 acted like he/she cared for him/her; -Resident #2 would touch him/her on the arm or shoulder, it made him/her feel good and Resident #2 sat with him/her during meals; -He/She and Resident #2 had watched movies in the facility sunroom. Resident #2 had kissed him/her and Resident #1 was fine with that; -On Saturday, in the night, around 3:00 A.M., he/she (Resident #1) was asleep in bed, and he/she awakened by Resident #2 kissing him/her on the lips; -Resident #2 pulled up his/her gown and put his/her fingers inside the resident's genitalia. Resident #1 was scared and stunned it happened so fast, he/she yelled for Resident #2 to stop, stop, stop, but he/she wouldn't; -Resident #2 was rough, and it hurt. He/She was afraid of Resident #2 now; -Resident #2 told staff and he/she was sent out to the hospital. Review of the resident's Care Plan, revised 3/31/25, showed the following: -Staff alerted the charge nurse that the resident had smoke coming from mouth and trach. The resident was educated the facility was non smoking facility (date initiated 2/24/25); (continued on next page)

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	265598	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Health Care Center	721 West Harrison St Brunswick, MO 65236

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

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Removal of connecting arm from float in toilet tank causing 80 gallons of water to be removed from the resident's floor as well as two adjoining room. Education was provided to the resident that if there was a problem with the toilet to alert staff so maintenance could be notified (date initiated 2/28/25); -The resident walked to an employees' residence. The resident was told by employees' family member to leave (date initiated 3/1/25); -Smoking a vape in the dining room. Reeducation on smoking policy (date initiated 3/9/25); -The resident told a staff member that he/she was hot, attractive, and his/her body looked sculpted. Staff member told the resident it was not appropriate to talk about staff members that way. Resident said, I am just saying and walked away. The resident was educated on appropriate conversations that occur with staff and started on Progesterone (date initiated 3/10/25); -The resident was a wanderer related to it's his/her right and significantly intruded on the privacy and activities of other residents. Educated not to go into therapy room without therapy personal related to safety, the resident verbalized understanding. (date initiated 3/24/25); -The resident doesn't verbalize understanding, the resident stated he/she was going to walk all the halls, he/she was not going into rooms (date initiated 3/28/25); -Another resident (Resident #1) reported the resident had entered his/her room and touched him/her (Resident #1) inappropriately. Local county law enforcement agency was called and notified to come to the facility. The resident was placed on one-on-one supervision to ensure he/she was not found around the other resident (Resident #1). The resident was taken with law enforcement for questioning over the incident (date initiated 3/30/25); -Advised the resident he/she couldn't go down other hallways where he/she didn't live; -The resident didn't verbalize an understanding and stated he/she would walk all the hallways, and he/she wasn't going into other rooms (revised 3/28/25); -If wandering occurs attempt to offer favorite snacks (dated initiated 3/31/25); -The resident had a problem with contraband in his/her possession, being verbally aggressive, being verbally sexually inappropriate, taking items that didn't belong to him/her related to diagnoses of bipolar and adjustment disorder (initiated 3/10/25 and revised on 3/31/25); -Administer medications as ordered, monitor/document for side effects and effectiveness. Anticipate and meet the resident's needs. Assist the resident with developing appropriate methods of coping and interacting to include setting boundaries, redirection, and encouraging the resident to express feelings appropriately. Intervene as necessary to protect the rights and safety of other residents, divert attention. Remove from situation and take to alternate location as needed (date initiated 3/30/25). Review of the resident's medical record showed no evidence the resident was receiving psychiatric services and no additional monitoring was put in place. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 4/3/25 at 3:07 P.M. and 4/7/25 at 3:50 P.M. the Social Service Designee (SSD) said the following: -She became the SSD in December 2024; -She had not received any formal mental health training; -The facility had admitted several residents with mental health conditions and she was not sure if she was doing the right thing to help residents with mental health issues; -Resident #2 was recently admitted to the facility. The resident was homeless and was basically dropped off by a ride-sharing service; -The facility knew very little about the resident and was unaware of his/her mental health conditions; -Resident #2 would steal and go in other rooms without permission, corporate told us to just educate him/her; -Staff attempted to educate Resident #2 and he/she would just walk away or ignore staff; -When staff tried to redirect Resident #2 he/she would retaliate by making a mess in another room or emptying his/her colostomy bag (bag that collects stool after a surgical procedure called a colostomy) in the sink or disconnecting the toilet; -The facility did not put any increased supervision of Resident #2 in place after his/her behaviors. The facility was not familiar with residents or situations like this; -There needed to be a better screening process before admitting residents to the facility; -She wasn't sure if the facility had psychiatric services available for the residents at the facility. 2. Review of Resident #3's PASARR Level II Evaluation, dated 1/31/25, showed the following: -Psychiatric evaluation 1/24/25, paranoid type delusional disorder (a mental illness characterized by the persistent belief that someone is being persecuted, harassed, or followed by others, even when there is no evidence to support these beliefs); rule out bipolar illness, mixed, with psychotic features (both manic and depressive symptoms are present and involves hallucinations (sensory experiences that appear real but are not actually present) or delusions (a false belief that persists despite evidence to the contrary) alongside the typical mood swings of bipolar disorder); -Psychiatric records, 2014: substance induced mood disorder, depression, Opioid dependency; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Historical symptoms or behaviors indicating a psychiatric disorder and time of onset: the resident was incarcerated which occurred in 2023. The resident was uncooperative, oppositional, disorganized in thought/behavior throughout his/her time in jail. The resident was agitated, yelling, and cursing at other inmates and jail staff. The resident was involved in physical altercations with others who were incarcerated on the mental health unit. The resident was unable to understand the charges due to his/her acute psychosis. He/She was committed to Department of Mental Health (DMH) for competency evaluation. The resident remained in jail from 9/11/23 to 1/23/25; -On 1/23/25 the resident received court ordered psychiatric treatment. Guardianship ad litem (a court appointed individual who represents the best interest of a incapacitated adult's well-being) was granted by the court on 1/31/25. Since admission the resident remained verbally abusive, cursing, yelling/screaming at staff for short periods of time, then will stop until the next staff member presents information the resident doesn't wish to hear; -Current psychiatric support/services included inpatient psychiatric treatment, medication administration/management/monitoring, secured behavioral unit, close observation/check every 15 minutes and group therapy/counseling; -The resident has memory impairment, difficulty with daily activities due to cognitive confusion/disorientation, however his/her delusional thought content and medication non-compliance issues are the primary issues in treatment currently; -Reason for nursing facility application or continued stay included assistance with activities of daily living (ADLs), medical treatment and/or monitoring, behavioral difficulties and/or mental illness symptoms requiring 24-hour monitoring or management, inadequate community/family support and required 24 nursing care and supervision; -Overt behaviors: refuses medications, frequent continuous yelling, intrusive, impatient/demanding, wandering, verbally abusive, verbally threatening, uncooperative with medical/nursing care or treatments, cursing/swearing, and being suspicious of others; -The individual's needs could be met in a nursing facility at this time; -The resident will require further stabilization on medications to address delusional and disorganized thinking. After found stable to transition from inpatient psychiatric setting, will require 24 hour a day nursing supervision and oversight to assure he/she and others are safe, to assure basic needs are met, and to ensure he/she had consistent access to ongoing psychiatric and medical follow-up and psychotropic medications. He/She required ongoing psychiatric and mental health follow up to promote maximum stability. The resident required a facility in which there are electronic or structural boundaries that prevent elopement. The resident will benefit from a safe, structured, skilled and supportive environment in which he/she can engage in social interaction with others his/her own age; -The individual needs specific services to address the individual's mental health and behavioral needs, monitoring of behavioral symptoms and trauma informed services, tools of choice or other positive behavioral support services; -Active psychosis and elopement attempts to be addressed in the nursing facility plan of care; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident came to the nurses' station and asked for a cigarette. The resident came back in just a few minutes and gave the nurse back half of the cigarette and the lighter. In ten minutes, the resident came back and asked again for a cigarette. The resident was given the half of cigarette and lighter. Returned the lighter and came back in ten minutes and wanted another cigarette. Staff advised the resident that he/she was passing medication and the resident would have to wait as everyone was busy and the resident had smoked twice; -The resident started yelling and cursing at the nurse and stated that the nurse was sleeping with the resident's spouse, and they weren't divorced yet. The resident kept yelling and cursing. A Certified Nurse Assistant (CNA) assisted the resident back to his/her room. The resident laid down and had not came back out of his/her room. Review of the resident's Progress Note, dated 3/12/25 at 10:47 P.M., showed the following: -The resident was wandering about the facility, rocks back and forth while standing still and wants to smoke every 10-15 minutes. The nurse advised the resident that he/she couldn't smoke every 10 minutes. The resident was ok with that; -The resident was telling the kitchen staff they had stolen his/her spouse. The nurse tried to redirect the resident. Ativan (medication used for anxiety) given as ordered with results. The resident was resting in bed. Review of the resident's Behavioral Note, dated 3/20/25, at 6:49 P.M., showed the resident was pacing in the hall. The resident was hallucinating, speaking to imaginary people, the resident said he/she was going to be