STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265721	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gregory Ridge Health Care Center	7001 Cleveland Avenue Kansas City, MO 64132

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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35013 Based on observation, interview, and record review, the facility failed to provide appropriate treatment and behavioral health services for one sampled resident (Resident #204) who had a known history of self-harm. The resident admitted to the facility on [DATE], with a history of self-harm and recommendation of intensive monitoring. The facility staff failed to consistently implement recommendations made in the resident's Pre-admission Screening and Resident Review (PASRR) assessment and the plan of care related to behavioral health services to ensure highest practicable well-being. The facility failed to ensure the interdisciplinary team reviewed, updated, and implemented individualized approaches to care after incidents of self-harm including: hitting a wall until his/her hand was swollen and greenish on 3/21/25; using broken glass from an overhead light to cut his/her left inner arm on 3/22/25; punching the wall with his/her right fist causing it to be swollen and bruised on 3/23/25; using a razor blade to cut the top of his/her left hand requiring sutures on 3/27/25; banging his/her head on a dresser resulting in a bruise over the left eye on 3/31/25; breaking into the smoking room and being found with his/her head in the ceiling and then slamming his/her body into a door three times, requiring the use of Zyprexa (an antipsychotic) 10 milligrams (mg) intramuscular injection (IM) a medication for self-harming behaviors as an intervention on 4/1/25; and threatening to cut him/herself and banging his/her head on the dresser resulting in two black eyes on 4/5/25. The facility failed to ensure staff had knowledge of resident care needs, including history of self-harm, interventions or resident triggers for behaviors. Facility policy showed residents who have self-harming behavior should have a staff person assigned to them within eyesight. The facility had no documentation or plan for intensive monitoring or oversight. As a result of the facility failure to provide treatment and services the resident was sent the emergency roiagnom on multiple occasions for x-rays and treatment. The census was 115. The Administrator was notified on 4/10/25 at 5:20 P.M. of the Immediate Jeopardy (IJ) which began on 4/8/25. The IJ was removed on 4/10/25, as confirmed by surveyor onsite verification. Review of the facility's Intensive Monitoring Policy, revised 4/30/24, showed: -The purpose of the policy was to ensure a system was in place for residents who required increased monitoring for crisis, behavioral, and/or psychiatric issues. -Residents who required more intensive monitoring due to crisis, behavioral/psychiatric symptoms were to be monitored by the facility staff. (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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Intensive monitoring was defined as periodic (hourly, every two hours, or every shift) check completed on a resident by a facility staff member. -One-to-one monitoring was completed by a designated employee assigned by a Facility Supervisor for residents who required intensive monitoring of a dedicated staff member within eyesight of the resident. -Residents who were showing poor impulse control including crisis, behavior and/or psychiatric issues may be placed on intensive monitoring or one-to-one/two-to-one monitoring at the discretion of the administrative staff or Facility Supervisor. -Based on the assessment of the resident, either intensive monitoring or one-to-one/two-to-one monitoring was to be implemented. -Resident on any type of intensive monitoring was to have an assigned employee within eyesight of the resident until the resident stabilized or returned to prior level of function. -Education on the reasoning of the intensive monitoring, including resident triggers and interventions. -The employee was to therapeutically interact with the resident while monitoring the resident. -The facility's Interdisciplinary Team was to address the resident's behavioral concerns and ensure interventions were in place to address the resident's needs including psychiatry follow-up, counseling, and any medical needs. -Once the resident stabilized and/or returned to prior level of function, the facility's Interdisciplinary Team was to meet and discuss whether to continue or discontinue the intensive monitoring. -The facility staff was to document all completed intensive monitoring. Review of Resident #204's Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care), dated 12/19/24, showed: -He/she had the following diagnoses: --Schizophrenia (a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self). --Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). --Schizoaffective Disorder (a mental condition that causes loss of contact with reality and mood problems). --Bi-Polar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	--Borderline Personality Disorder (BPD - a mental illness marked by an ongoing pattern of varying moods, self-image, and behavior). --Mood Disorder (a variety of conditions characterized by a disturbance in mood as the main feature). --Major Depressive Disorder (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living). --Obsessive Compulsive Disorder (OCD, an anxiety disorder characterized by intrusive thoughts that produce uneasiness, apprehension, fear, or worry; by repetitive behaviors aimed at reducing the associated anxiety; or by a combination of such obsessions and compulsions). --Autism or Autism Spectrum Disorder (a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave). -He/she had behavioral difficulties and/or mental illness symptoms requiring 24-hour monitoring/management. -He/she had a history of hitting the wall in his/her last facility, breaking his/her hand, as well as taking a razor to his/her arm and making a deep laceration. -The resident had a history of numerous placement situations and hospitalization s usually for self-harm or threatening harm to others. -He/she also had multiple suicide attempts including overdosing and cutting himself/herself. -The resident's family voiced concerns the resident would kill himself/herself while cutting. -He/she had a long history of medication non-compliance along with his/her self-harming behaviors, erratic behaviors with multiple psychiatric hospitalization s. -The resident had shown that his/her cutting were not suicidal, but instead to relieve emotional pain, irritability, and agitation. -He/she had cut as recently as December 2024. -Along with his/her history of self-harm and non-compliance, he/she also showed a history of hallucinations, delusions, seclusiveness, destroying property, wandering, OCD, uncooperation with medications, eating, activities, hygiene, along with recently selectively muting himself/herself. -He/she had been on an inpatient psychiatric unit since 12/4/24 on 15-minute suicide watch. -He/she had had behaviors of running down a hallway and slamming himself/herself into walls and doors at the previous placement as well as jumping into the Mississippi River in order to self-harm. -He/she had one-to-one supervision as well when inpatient. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident had expressed a coping mechanism of utilizing a seclusion room with the door open and lights tuned low when he/she was overstimulated. -He/she had participated in being in the seclusion room several times during his/her previous psychiatric stay. -The resident showed poor insight and poor decision-making skills, difficulty with expressing his/her emotions, as well as difficulty with interpersonal relationships. -The final determination stated the resident required close supervision and monitoring to maintain his/her safety due to his/her long history of self-harm and suicidal ideations. -He/she required monitoring of behavioral symptoms, trauma informed services, and positive behavioral support services. -He/she remained at a high risk for self-injury requiring 24-hour monitoring and staff intervention to prevent self-harm, monitor eating, mutism, limited overstimulation, providing a quiet, supervised space away from others to de-escalate in times of increased anxiety/agitation. -The resident was to have a structured environment with low stimulation, minimum visual/auditory distractions, a level of supervision required to prevent harm to himself/herself or others, personal space with a daily schedule of tasks and activities. -A crisis plan was to be developed that indicated clear steps that were to be taken to support the resident during a behavioral crisis including knowing who to contact for assistance, how to work together with the resident during the crisis, and how to determine when the crisis was over. -The crisis plan was to identify the physician, emergency medical services, and/or law enforcement who were to be appropriately contacted. Review of the resident's facility Clinical Admission form, dated 2/20/25 at 11:49 P.M., showed: -He/she was admitted to the facility with no family present. -He/she was ambulatory, showed no medical issues, and his/her vital signs were stable. -He/she showed no signs of issues with his/her mood, was pleasant with no noted negative behaviors. -The resident showed issues with his/her skin with previous lacerations/scars to his/her left forearm, right abdomen, and right thigh. -The care planning portion of the form showed no safety concerns, no concerns with harm to himself/herself or others, no behavior management issues, no disturbed sensory perception concerns, no concerns with social interactions, no concerns for risk of injury, no concern with coping, and did not identify any supervision needs. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by staff and used for care planning), dated 3/16/25, showed he/she: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Was cognitively intact. -Had nearly daily issues with feeling down, hopeless or depressed, having little pleasure in doing things, sleeping too much or too little, having little energy, and feeling bad about himself/herself. -Showed no negative behaviors during the 90-day look-back period. Review of the resident's undated Nursing Care Plan on 4/8/25, showed: -The resident had a problem with his/her psychosocial well-being including ineffective coping, low self-esteem, taking everything personally, an altered perception of reality and at-risk for self-harm. - The care plan did not include any interventions related to supervision needs or known triggers/stimuli that could lead to challenging behaviors. -On 3/21/25 he/she became angry, hitting the wall and throwing objects causing his/her right hand to swell and bruise. Review of the resident's Nurse's Notes, dated 3/22/25 at 4:38 A.M., showed: -On 3/22/25 the resident had been placed on one-to-one staff observation after he/she cut his/her arm in anger. -Administrator A had spoken to the resident who stated when Licensed Practical Nurse (LPN) A asked two Certified Nursing Assistants (CNAs) to watch him/her, they argued about who would provide the one-to-one staff observations as it was a shitty job which he/she said he/she took very personally as if no one wanted him/her. -It was explained to the resident he/she needed one dedicated person to provide observation. -The resident expressed understanding and felt better after discussing the issue. -The resident stated the cutting was only to make him/her feel better and he/she did not have another outlet. -Administrator A gave the resident his/her contact information telling the resident he/she could call if he/she needed to vent his/her feelings. -The resident stated he/she does not show his/her emotions until they explode. -He/she stated when he/she got manic, he/she got very anxious, his/her thoughts raced and became obsessive over certain thoughts, causing him/her to self-harm. -The resident had five new dissolvable stitches in his/her arm yet denied pain. -The resident remained on intensive monitoring and had been since returning from the hospital. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she had cut himself/herself in the past, not trying to kill himself/herself, but instead, cutting made him/her temporarily happy. -He/she provided coping mechanisms such as speaking with his/her family member, coloring and playing his/her Nintendo Switch, which had been damaged by his/her roommate on 3/13/25 and had not yet been replaced by the facility, which he/she had expressed frustration over numerous times. -He/she stated he/she would like his/her service dog to visit him/her, but his/her family with the dog, lived far away. -He/she stated his/her latest self-harming episode was partly, because his/her family member was in the hospital and he/she was worried about that. -He/she stated the family member was his/her best friend and they used to do everything together. -He/she had ordered food that unbeknownst to him/her, had wheat in it, which he/she was allergic to. -He/she then had been made to feel like the allergic reaction was done on purpose and was his/her fault by the Dietary Manager. -He/she broke his/her overbed light and used the casing of the light cover to cut his/her forearm. -He/she felt like a failure and felt overwhelmed as he/she was having issues with his/her roommate and felt punished as the staff was making him/her move rooms, not his/her roommate. -He/she was upset the staff had to remove the food in his/her room which contained wheat or gluten even though he/she knew he/she was allergic and had a bad reaction to those foods. Review of the resident's Nurse's Notes, dated 3/22/25 at 12:38 P.M., showed: -The resident was found sitting on the bathroom floor bleeding from his/her left forearm. -Pressure was applied to the laceration with a towel to stop the bleeding and 911 called. -The resident stated he/she cut himself/herself with the light cover in his/her room. -The resident stated he/she cut himself/herself, because he/she was angry because the staff blamed him/her for an allergic reaction he/she had the night before when he/she ordered food delivery containing wheat and/or gluten, which caused the resident to have to go to the hospital and get medication and fluids for the reaction. Review of the resident's Self-Inflicted Injury Report, dated 3/22/25, showed: -The staff called a code after having found the resident on the bathroom floor bleeding from his/her left forearm. -Pressure was applied to the cut and 911 was called. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident stated he/she cut himself/herself with the light cover in his/her room. -He/she was angry because he/she felt the staff blamed his/her for having an allergic reaction to some food he/she had ordered and because his/her close family member was in the hospital. -He/she was taken to the hospital for evaluation and treatment. -The incident was not witnessed. -The injury was to his/her left forearm. -He/she was completely alert and oriented. -There were no predisposing factors prior to the incident. Review of the resident's Nurse's Note, dated 3/22/25 at 3:51 P.M., showed Administrator A documented: -The resident returned from the hospital and was placed on one-to-one staff observation. -He/she was placed on an antibiotic to prevent infection and orders to keep the stitches clean and dry. During an interview on 4/9/25 at 11:45 A.M., CNA T said: -He/she was working the day shift on 3/22/25, but not providing direct care for the resident. -He/she was not aware the resident had a history of self-harming behaviors. -It would be nice to know what the resident's history was so he/she could have paid closer attention to the resident. -He/she was not aware of what the resident's triggers or interventions were, but he/she could probably find them in the care plan. -He/she had not seen the resident much during the day as each time he/she walked by the resident's room, the resident was in his/her room in bed, refusing to do any activities. -He/she happened to go into the resident's room and found the resident on the floor of the bathroom, bleeding from his/her left forearm. -He/she noticed the resident had a lot of old cutting scars on his/her left forearm on the top of his/her arm and underneath his/her arm at the time he/she found the resident. -The resident had both linear scars and X shaped scars on his/her arms. -He/she called for help and the nurse attended to the resident and sent him/her to the hospital. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident had broken the light above his/her bed and used the glass shards to curt himself/herself. -The resident had not been on one-to-one staff observation prior to his/her cutting. -He/she did not recall having any de-escalating technique or mental health education at the facility, but he/she had a behavioral health background, having worked in mental health facilities in the past, so he/she felt prepared to work with mentally ill residents. Review of the resident's undated care plan on 4/8/25, showed facility staff did not update the resident's care plan with the incident on 3/22/25 or add any new interventions to prevent self-harm. The care plan did not include any interventions related to supervision needs or known triggers/stimuli that could lead to challenging behaviors. Review of the resident's One-on-One Documentation Form, dated 3/23/25, showed the resident assigned one-to-one staff observation from 9:15 A.M. through 9:00 P.M. Review of the resident's Nurse's Notes, dated 3/23/25 at 9:10 P.M., showed: -The resident became angry and began hitting the wall and throwing objects. -A Code [NAME] (an overhead page indicating a resident had escalated their behavior to a point of needing extra staff assistance to keep the resident safe from harm) was called and upon assessment the resident was standing up in his/her room. -LPN F asked him/her to stop and what was wrong. -The resident stated he/she was angry at his/her guardian, because of his/her dog. -The resident's right hand was swollen and turned a greenish color. -911 was called, the physician and guardian were notified, and the resident was sent to the hospital for assessment and treatment. Review of the resident's Self-Inflicted Injury Report, dated 3/23/25, showed: -The resident became angry and began hitting the wall and throwing objects. -A Code [NAME] was called and staff came to assist. -The staff asked him/her to stop and what was wrong. -The resident stated he/she was angry with his/her guardian related to his/her dog. -Upon assessment, his/her right hand was swollen and greenish in color. -911 was called and the resident went to the hospital for evaluation and treatment. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-His/her guardian was notified and stated the resident was angry as he/she did not know where his/her dogs were. -He/she was completely oriented. -There were no predisposing factors. Review of the resident's care plan showed no new interventions put in place after the 3/23/25 incident. The care plan did not include any interventions related to supervision needs or known triggers/stimuli that could lead to challenging behaviors. During an interview on 4/10/25 at 11:40 A.M., LPN F said: -He/she was working 3/23/25. -The resident had not shown any signs of escalation, but had been on his/her phone during the evening. -It appeared that one of the phone conversations the resident had caused him/her to quickly escalate. -The resident was not on one-to-one staff observation as it was only being done during the daytime hours. -No behavioral interventions were put in place after this incident. Review of the resident's Nurse's Notes, dated 3/24/25 at 11:26 A.M., showed: -He/she returned from the hospital with no new orders. -The resident remained on one-to-one staff observation for protective oversight. Review of the resident's Nurse's Notes, dated 3/24/25 at 6:58 P.M., showed: -He/she remained on behavior monitoring with no signs of negative behaviors. -He/she had been in his/her room most of the day, so he/she was discontinued from one-to-one staff observation. Review of the resident's Nurse's Notes, dated 3/27/25 at 1:30 A.M., showed: -It was discovered the resident had a 4.5 centimeter (cm) deep laceration to the back of his/her left hand. -The resident initially stated he/she had fallen and cut his/her hand, however, later disclosed he/she cut himself/herself with a razor blade. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-His/her hand was dressed with gauze and 911 was called to transport the resident to the hospital for treatment. -The resident's guardian, Administrator A, and Nurse Practitioner (NP) were all notified. Review of the Registered Nurse Investigation (RNI), dated 3/27/25 at 8:31 A.M., showed: -The resident cut himself/herself with a razor blade he/she had hidden in a box of tissues. -He/she cut the top of his/her left hand. -The incident was not witnessed. -Pressure was applied to the cut and the resident was sent to the ER. -All appropriate individuals were notified. -Counseling, a new Nintendo Switch, rubber band therapy, therapy dogs were all discussed as coping skills. -The resident was placed back on one-to-one staff observation while awake and environmental room checks of the room were completed. Review of the resident's undated care plan on 4/8/25, showed facility staff did not update the care plan after the 3/27/25 incident and did not add any new interventions to prevent the resident from self-harm. The care plan did not include any interventions related to supervision needs or known triggers/stimuli that could lead to challenging behaviors. Review of the resident's Nurse's Notes, dated 3/31/25 at 3:25 P.M., showed: -The resident stated he/she fell in his/her room. -LPN A asked how he/she fell . -The resident stated he/she did not know. -LPN A observed a bruise over the resident's left eyebrow area. -The resident's room was checked for any items with which he/she could have harmed himself/herself and none were found. -It was later determined after resident interview that the resident admitted to banging his/her head on his/her dresser instead of falling. -All appropriate persons were notified. During an interview on 4/10/25 at 12:22 P.M., LPN A said: (continued on next page)

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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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident became agitated and broke into the smoke room. -He/she was found climbing the window bars into the ceiling. Review of the resident's Nurse's Notes, dated 4/1/25 at 9:33 P.M., showed: -The resident was discovered sitting on top of the heater in the smoke room. -Staff were present and at a safe distance. -The resident agreed to go to Administrator A's office. -The resident was noted to run down the hall and into the unit door three times. -No apparent injury noted and an as needed (PRN) medication was given per the resident's request. -The resident calmed down after having been allowed to vent and verbalize his/her feelings. -All appropriate individuals were notified, and the resident was monitored for safety, increased anxiety and agitation. During an interview on 4/9/25 at 11:15 A.M., CNA I said: -He/she worked 4/1/25. -He/she was just ending his/her shift when he/she heard chaos coming from the smoke room. -When he/she got there, Resident #204 was standing up on the heater, holding onto the bars on the windows with his/her head up through the ceiling tile. -The resident had been fine all day and he/she had no signs of escalating. -As far as he/she was aware, the resident did not say why he/she did this or say anything about being upset to anyone. -Administrator A took the resident to his/her office to calm down. -He/she was not aware of what the resident's triggers or interventions were. -He/she was aware of the care plan, but had not looked at it. During an interview on 4/10/25 at 12:22 P.M., LPN A said: -He/she was just finishing up his/her day when he/she heard someone say to come to the smoke room. -On 4/1/25 the resident had broken into the smoke room and was standing on top of the heater, hanging on to the window bars, attempting to put his/her head into the ceiling. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265721	A. Building B. Wing	04/15/2025

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Administrator A arrived and de-escalated the situation, taking the resident to his/her office. -The resident had shown no signs of escalation during the shift and was not on one-to-one staff observation as far as he/she could recall. -The resident did not say what upset him/her or why he/she did it. Further review of the resident's care plan on 4/8/25, showed staff did not update the care plan after the incident on 4/1/25 and no new interventions were put in place for the resident's self-harming behavior. The care plan did not include any interventions related to supervision needs or known triggers/stimuli (loudness or chaos) that could lead to challenging behaviors. The care plan did not include parameters for when pharmalogical interventions could be used. The care plan did not show an order for an intramuscular injection of Zyprexa at 10 mg ordered for an intervention PRN (as needed) medication for self-harming behaviors. Review of the resident's Nurse's Notes, dated 4/4/25 at 11:28 A.M., showed: -The resident was noted at 10:30 A.M., to be pacing back and forth while on the phone. -When he/she got off the phone, he/she began punching the walls, causing a large hole in the wall. -The resident was removed from the unit and escorted to Administrator A's office where he/she quickly de-escalated. -The resident called and spoke to one of his/her guardians who suggested the resident use his/her ear buds to drown out the chaos around him/her. -The resident's right hand was noted to be red and bruised from punching the walls in his/her room. -The NP was notified and ordered x-rays of the resident's hand. -The x-ray showed no fracture. -All appropriate individuals were notified. Further review of the resident's care plan showed staff did not update the care plan after the incident on 4/1/25 or 4/4/25. The care plan did not include any interventions related to supervision needs or known triggers/stimuli that could lead to challenging behaviors. No new interventions were put in place for the resident's self-harming behavior, including the use of ear buds as a coping mechanism. Review of the resident's One-on-One Documentation Form, dated 4/5/25, showed the resident was on one-to-one staff observation, (provided by CNA I) from 7:00 P.M. to 9:45 P.M., when he/she was sent to the hospital for thoughts of self-harm. Review of the resident's Nurse's Notes dated 4/5/25 at 9:30 P.M., showed: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident came to CNA H and stated he/she was about to explode and harm himself/herself by cutting. -He/she was shaking significantly and did not appear to have been in control of his/her emotions. -He/she was interviewed by the Director of Nursing (DON) and was sent out to the hospital for further evaluation. Review of the resident's medical record showed it did not contain information the resident received trauma informed services or positive behavioral support services as indicated in the resident's PASRR. The resident's medical record showed no counseling services provided to the resident, daily living skills training, development of a personal support network, drug therapy/monitoring, medically related social services, physician services, a structured environment, and structured socialization as directed by the care plan to prevent self resident's self-harming behavior. Review of the resident's One-on-One Documentation Form, dated 4/9/25, showed the resident was on one-to-one staff observation provided by CNA T from 4:30 P.M., to 5:45 A.M. During an interview on 4/9/25 at 3:45 P.M., Hospital Registered Nurse (RN) A said: -He/she had taken care of the resident on the first day he/she was in theER on [DATE] and he/she was out of control the whole time he/she was there. -They had to keep someone with him/her at all times or they were afraid he/she would harm himself/herself. -Hospital RN A was off the day before and back on 4/9/25. -When he/she came back to work on 4/9/25 the resident was completely different. -The resident was calm and cooperative with no voiced intent to harm. -He/she believed the psychiatrist who saw the resident may have changed up some of the resident's medications, but he/she was not sure about that. -The resident told him/her that when he/she had these urges to self-harm, he/she had to do it or someone would have to physically stop him/her as the urges were too great for him/her to stop on his/her own. During an interview on 4/10/25 at 12:28 P.M., CNA H said: -He/she was not aware of what triggered the resident at any point in time when he/she self-harmed, or what interventions were in place other than one-to-one staff observation. -The resident had been on one-to-one staff observation during the day off and on throughout his/her stay at the facility. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A little while after the one-to-one caregiver left 4/5/25, the resident came and said he/she was getting upset and was about to explode and harm himself/herself. -CNA H immediately notified the charge nurse who called the NP and had the resident sent to the hospital. -He/she stayed with the resident until the resident left for the hospital. During an interview on 4/9/24 at 3:32 P.M., the resident said: -They had taken him/her off one-to-one staff observation prior to this last hospitalization on [DATE]. -He/she had been in the ER for three or four days this time. -Sometimes when he/she was