STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265850	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seasons Rehab and Healthcare Center	15600 Woods Chapel Road Kansas City, MO 64139

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 19016 Based on interview and record review, the facility failed to ensure two sampled residents (Residents #40 and #55) out of three sampled residents, who were notified their Medicare Part A coverage would likely end and had benefit days remaining, were provided the Quality Improvement Organization (QIO) contact name and toll free phone number on their Notice of Medicare Non-Coverage (NOMNC), Centers for Medicare (CMS)-10123 form. On 1/31/25 the Administrator was notified of the past non-compliance which took place for a period of months that started on or before 7/9/24 and went through 12/31/24. On 1/2/25 the Social Services Director was given an updated Form CMS-10123 containing the QIO contact name and toll-free number so residents could appeal the decision to end services. On 1/2/25 the Social Services Director received education from Regional Nurse Consultant A on providing the QIO contact name and phone number to residents with benefit days remaining whose services were expected to end. The deficiency was corrected on 1/2/25. Review of the facility's Medicare Denial Process policy, dated April, 2024, showed: -The NOMNC, Form CMS-10123, is required to be delivered to the resident or his/her representative at least two calendar days before Medicare covered services end. -The beneficiary or representative will sign and date the notice acknowledging it was received. -Information provided must include the last covered day of service, the phone number of the QIO, and the time frame for appeal. 1. Review of Resident #40's Form CMS 10123 - NOMNC showed: -The resident started services on 7/5/24 and services were expected to end on 7/11/24. -The resident's representative acknowledged the notice on 7/9/24. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Under the section How to Ask for an Immediate Appeal the form showed the beneficiary must make request to the Quality Improvement Organization (QIO), the independent reviewer authorized by Medicare to review the decision to end services. The request for an appeal should be made no later than noon the day before the effective date of services ending. The beneficiary was to call his/her QIO to appeal or with questions. -Above the signature line was the sentence I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO. -No QIO name or toll-free number was provided on the form for the beneficiary to use should he/she decide to appeal. 2. Review of Resident #55's Form CMS 10123 - NOMNC showed: -The resident's effective date of coverage started 9/3/24 and services were expected to end on 11/26/24. -The resident's representative acknowledged the notice on 11/23/24. -Under the section How to Ask for an Immediate Appeal the form showed the beneficiary must make request to the QIO. The request for an appeal should be made no later than noon the day before the effective date of services ending. The beneficiary was to call his/her QIO to appeal or with questions. -Above the signature line was the sentence I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO. -No QIO name or toll-free number was provided on the form for the beneficiary to use for an appeal. During an interview on 1/31/25 at 10:09 A.M., the Social Services Director said: -He/She was unaware the QIO contact information was not on the NOMNC forms that were presented to Resident's #40 and #55. -On 1/2/25 Regional Nurse Consultant A provided an updated Form CMS-10123 that he/she could type on which contained the QIO contact name and toll-free number.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19016 Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities to meet the needs of two sampled residents (Residents #49 and #176) who didn't like to go to group activities and were dependent upon staff to provide activities for mental, physical, and psychosocial stimulation out of 18 sampled residents. Additionally, the facility failed to ensure there was a way to easily access daily activity participation over time. The facility census was 74 residents. Review of the facility's Activities Program policy, revised 10/24/22, showed: -The purpose of the policy was to encourage resident participation to make life more meaningful, to stimulate and support physical and mental capabilities to the fullest extent, and to enable residents to maintain the highest attainable social, physical, and emotional functioning. -After completion of the initial Activity Assessment and the Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), an Individualized Care Plan will be developed and implemented for each resident. -The Activity care plan will be reviewed and up-dated at least quarterly and with any change of condition. -Activities are tailored to meet the needs of residents with cognitive impairment or other special needs. -The facility will provide equipment and supplies for independent and group activities and for residents with special needs. -No less than quarterly the Director of Activities or designee will make a progress note as part of the resident's health record that includes the resident's level of participation, perceived benefit, response to interventions outlined in the Care Plan, progress made toward goals and recommendations for activities. -The Activity Department will maintain accurate records of each resident's participation in group, independent, and room visit involvement. Participation will be documented daily. 1. Review of Resident #49's admission MDS, dated [DATE], showed the resident: -Was diagnosed with non-traumatic brain dysfunction (a condition in which the brain is damaged by internal factors rather than external force to the head) and dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). -Had adequate hearing (could hear normal conversation) and adequate vision (could see fine detail such as newsprint). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Was severely cognitively impaired. -Had difficulty concentrating nearly every day. -Liked snacks. -Was unable to communicate what activities he/she liked. Review of the resident's Activity care plan, initiated 8/19/24 showed: -Encourage the resident's participation. -Allow the resident to leave activities at any time. -Provide assistance and escort to activity functions. Note: The care plan did not show activities that were meaningful for the resident. Review of the resident's quarterly Activity Interview for Daily Preferences, dated 10/14/24 showed the resident liked snacks but was unable to verbalize other activities of interest. Review of the resident's Activities Quarterly and Annual Participation Review, dated 1/2/25 showed the resident: -Enjoyed walking around, 1:1 visiting with staff, people-watching, sensory activities, listening to music, having snacks, reading, coloring, and bird watching. -Had good hearing and good vision with glasses. Review of the resident's annual MDS, dated [DATE] showed it was somewhat important for the resident to have magazines to read, listen to music, be around animals, and go outside for fresh air. It was very important to have snacks. Review on 1/30/25 of the resident's Activities care plan (initiated 8/19/24) showed it was never updated to include activities that were meaningful for the resident given he/she didn't like group activities. Review on 1/30/25 of the resident's progress notes for 10/1/25 through 1/29/25 showed no Activities progress notes. Daily participation documentation was not found in the resident's electronic record. Daily participation documentation was requested and not provided. Observation of the resident on the following dates and times showed: -On 1/27/25 between 7:20 A.M. and 8:00 A.M. and 8:45 A.M. and 9:20 A.M. the resident was in bed. There was no music or other stimulating activity on the resident's hall or in the resident's room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 1/28/25 from 10:05 A.M. to 10:30 A.M. the resident was in bed. At 12:30 P.M. the Activity Aide came on the unit and told staff he/she would take one of the residents to the bird cage while he/she cleaned the cage. The resident was in bed and wasn't asked if he/she would like to go. -On 1/29/25 at 10:15 A.M. residents were observed in the Day Services/Multipurpose Room while an outside entertainer was playing music. The resident was not at the activity. At 10:20 A.M. the Activity Aide said the resident was not at the music activity. At 10:25 P.M. the resident was observed in bed. No activity was taking place and music was not being played on the unit or in the resident's room. -Observation on 1/30/25 at 1:32 P.M. showed the resident in his/her room sitting on the side of his/her bed. There was no activity taking place or music playing on the living area or in the resident's room. During an attempt to interview on 1/30/25 at 1:35 P.M., when asked if he/she liked music, the resident said he/she didn't know. When asked if he/she liked to walk or be outside the resident did not respond. He/She nodded yes when asked if he/she liked activities on the unit where food was served. During an interview on 1/30/25 at 1:57 P.M. Certified Nursing Assistant (CNA) A said: -He/She had never seen the resident out of his/her room except at meal times. -The resident used to like a roommate, but that resident was no longer at the facility. -The resident might come out of his/her room for a food-related activity. Activities did not bring and Nursing did not pass juice or coffee mid-morning or mid-afternoon. The Activities Director had coffee and donuts sometimes in the activity room, but did not bring that to the resident halls. During an interview on 1/30/25 at 2:13 P.M. CNA B said: -The resident kept to himself/herself. -He/She didn't watch television. -He/She used to follow his/her former roommate around, but that resident was no longer at the facility. -He/She thought the resident would hover around if there was a birthday party or Valentine's Day party on the unit because he/she liked to eat. He/She was diabetic so he/she would need a sugar-free Kool-Aid or soda and a less-sweet snack. -When spoken to by familiar staff the resident would smile so he/she thought the resident would benefit from socials on the hall and 1:1 interaction. During an interview on 1/31/25 at 10:56 A.M. the Activities Director said: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She couldn't find daily documentation for the resident in his/her electronic record. Any activity the resident would have participated in would have been entered on the day he/she participated, but he/she wasn't able to see all daily activities for the entire week, month, or quarter. He/She could only enter the activity on the Kardex for the day. -Activities the resident had participated in included going down the main hall to look at the bird cage and sitting in front of the television on his/her living hall during a [NAME] movie. -They had taken the resident to live music activities before and the resident left the area and needed staff to get back onto his/her hall. -The resident liked the Missouri Conservation magazine and would take it if handed to him/her, but would lose the magazine. The resident used to hunt and fish so he/she tried to find an article the resident would like to stimulate his/her interest. 2. Review of Resident #176's Admission Activity Assessment, dated 12/27/24 showed the resident: -Was admitted to the facility on [DATE]. -Had adequate hearing and poor vision. -Had memories of hunting and fishing in the Ozarks. -Liked to be around animals and watch sports. Review of the resident's Activity Interview for Daily and Activity Preferences, dated 12/27/24 showed the resident's primary respondent said: -It was very important for the resident to have snacks between meals and to go outside for fresh air when the weather was good. -It was somewhat important for him/her to listen to music, be around animals and pets, and participate in religious services. Review of the resident's Comprehensive care plan, initiated 12/28/24 showed the resident had no Activities care plan. Review of the resident's Admission MDS, dated [DATE] showed the resident: -Had a primary diagnosis of a stroke and had dementia. -Had continuous inattention and disorganized thinking. -Had adequate hearing and vision (this contrasted with the poor vision noted on the Admission Activity Assessment.) -Found it very important to have snacks and be outside when the weather permitted and somewhat important to listen to music, be around animals, and attend religious services. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 1/30/25 of the resident's progress notes for 10/1/24 through 1/29/25 showed no Activities progress notes. Review on 1/30/25 of the resident's Comprehensive care plan showed no Activities care plan had been added after 12/28/24. Observation of the resident on the following dates and times showed: -On 1/27/25 between 7:20 A.M. and 8:00 A.M. the resident was at the dining room table. No stimulating activity such as soft background music was taking place during breakfast. Between 8:45 A.M. and 9:20 A.M. the resident was in bed with eyes closed. No activity was going on in the living area. -On 1/28/25 from 10:05 A.M. to 10:30 A.M. the resident was in bed with eyes closed. No activity was taking place on the living area. -On 1/29/25 at 10:15 A.M. residents were observed in the Day Services/Multipurpose Room where an outside entertainer was playing music. The resident was not at the activity. At 10:20 A.M. the Activity Aide said the resident was not at the music activity. At 10:27 P.M. the resident was observed in bed. No activity was taking place and no music was being played on the unit or in the resident's room. -Observation on 1/30/25 at 1:30 P.M. showed the resident was in bed with eyes closed. No activity was taking place on the living area. During an interview on 1/30/25 at 2:03 P.M. CNA A said: -Staff could get the resident to come out of his/her room as long as they offered the resident a coffee or Coca Cola. The resident would attend food-related activities on the living area. -The resident did sometimes read the Daily Chronicle newsletter and had watched part of a football game within the past month. -He/She didn't know if the resident liked music. During an interview on 1/30/25 at 2:11 P.M. CNA B said: -The resident liked to drink coffee. -There was no radio on the unit and nursing staff didn't play vintage music for the residents. He/She didn't know if the resident liked music. -The resident liked talking with staff and had funny sarcasm when he interacted. During an interview on 1/31/25 at 10:56 A.M. the Activities Director said: -He/She was still working on figuring the resident out. He/She spoke with a family member, but got little information about the resident's interests. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It was best to try to grab the resident right after a meal before he/she went back to bed. -The resident had watched a [NAME] movie on the resident hall and seemed to like that. 3. Review of the facility's Activity calendars for October, 2024 through January, 2025 showed: -In October one-to-one visits were listed for the five Tuesdays during the month. It didn't show which of the six halls the one-to-one visits took place on any given Tuesday. All other activities were group activities. -In November, 2024 and December, 2024 there were no one-to-one activities or room visits scheduled. -In January, 2025 room visits took place on Resident #49 and #176's hall on 1/6/25 and 1/22/25. -No scheduled activities were shown on the activity calendars for Saturdays or Sundays. Independent resident activities of choice and an activity cart were shown as available on weekends. During an interview on 1/27/25 at 9:35 A.M. the Activity Aide said: -They had Coffee Club scheduled in the Activity Room on 1/27/25 at 9:45 A.M. -Residents who wanted to attend came to the Activity Room. -There was no coffee and snack brought to the resident halls for residents who couldn't or didn't want to leave their living area. -Almost all the scheduled activities took place off the living halls. During an interview on 1/30/25 at 2:13 P.M. CNA A said: -The Activities Department encouraged residents to go to activities scheduled off the resident halls. -There were no activities done on the resident halls, except when Activities staff left printed coloring pictures and puzzles for residents to do on their own. -There was nothing for residents to do on the weekends except for coloring pictures and puzzles available on the activity cart. -He/She had never seen Activities do one-to-one activities with residents who couldn't or didn't want to leave their living area. -He/She wasn't sure if there were oldies music stations on the television so residents could listen to music on the living area. During an interview on 1/31/25 at 10:56 A.M. the Activities Director said: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Documentation of activity assessments and care plans were done through the resident's electronic record. He/She didn't do progress notes, but documented activity participation daily in the Kardex and quarterly on review forms. They only documented when residents actively participated. They didn't record when residents were encouraged to participate, but refused. -Almost all activities reflected on the monthly calendars were done in the main hallway, the activity room, or the multipurpose room. Sometimes activities were brought to the halls. On Halloween staff dressed up and treats were brought to the resident halls. -Activities tried to do one-to-one activities on each hall twice monthly. -There were radios on the halls that could be used by nursing staff for resident activities. -There were no scheduled activities on the weekend. Each hall had an activity cart with coloring pictures and table activities and residents pursued activities on their own. During an interview on 1/31/25 at 12:51 P.M. the Director of Nursing (DON) said: -All activities should be documented in the resident's electronic record. -He/She thought they were documented in Activity progress notes. -Staff should have access to daily activity participation documentation either through the resident's electronic record or through paper charting. -For residents who don't go to group activities or don't initiate activities on their own, one-to-one activities of interest should be provided by either the Activities or the Nursing staff.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 09895 Based on observation, interview and record review, the facility failed to post the actual hours worked for Registered Nurses (RN's), Licensed Practical Nurses (LPNs), Certified Medication Technicians (CMTs) and Certified Nursing Assistants (CNAs) directly responsible for resident care per shift in locations throughout the facility for view by residents, family members and visitors. The facility census was 74 residents. Record review of the facility Staffing, Schedule and Postings policy dated 10/24/2022 showed: -The facility would post the current date, the total number and the actual hours worked by licensed (RNs and LPNs) and unlicensed (CNAs) nursing staff directly responsible for resident care per shift, and the facility resident census. 1. Record review of the Staffing Ratio and Census Reports dated 12/27/24 through 1/27/25 showed: -The number of RNs, LPNs, CNAs and CMTs for each 24 hour period, rather than for each eight hour shift. -The staffing sheets did not show the total number of hours for RNs, LPNs, CNAs and CMTs for each eight hour shift. Observation of the posted Staffing Ratio and Census Report on 1/28/25 at 11:45 A.M. showed: -The number of RNs, LPNs, CNAs and CMTs for each 24 hour period, rather than for each eight hour shift. -The staffing sheets did not show the total number of hours for RNs, LPNs, CNAs and CMTs for each eight hour shift. -The date of the form was 1/27/25. During an interview on 1/28/25 at 1:35 P.M. the facility Staffing Coordinator said: -The posted staffing sheets showed the number of nurses, CNAs and CMTs for one 24 hour period. -It did not show the hours worked. -He/she was responsible for completing and posting the facility staffing sheets. During an interview on 1/31/25 at 12:00 P.M. the Director of Nursing (DON) said: -Up until 1/28/24 the total hours worked for licensed and unlicensed staff was not included on staffing sheets and the staffing sheets covered a 24 hour period rather than each eight hour shift. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-After a meeting on 1/28/25 and going forward the total hours for each category of licensed and unlicensed staff for each shift would be included on staffing sheets. -The Staffing Coordinator was responsible for posting of staffing. -He/she and the Administrator were responsible for monitoring the posting of staffing. -Staffing sheets were posted at the reception desk and on the resident living units at the nurse's stations.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19016 Based on interview and record review, the facility failed to document behaviors and develop a care plan that included target behaviors (specific behaviors of the resident), and relevant non-pharmacological approaches for one sampled resident (Residents #49) who was prescribed a psychotropic medication (a drug that affects brain activities associated with mental processes and behaviors). The facility census was 74 residents. Review of the facility's Behavior Management policy, undated, showed key components of behavior management included: -Identifying residents whose behaviors may pose a risk to self or others. -Develop individualized and practical care strategies based on assessed needs. -Implement a behavior management program. -Ongoing assessment, monitoring, and evaluation of the effectiveness of the behavior management program including effectiveness of psychoactive drugs. -Nursing staff will document the response to medication, including behaviors and the side effects on the Medication Administration Record (MAR). -The facility will re-asses continued use of psychotherapeutic drug interventions. 1. Review of Resident #49's Admission Record showed: -The resident was admitted to the facility on [DATE] with a diagnosis of Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). Review of the resident's Psychotropic Medication care plan, initiated 8/19/24 showed: -The resident used psychotropic medications. -Staff were to administer medications as ordered. -Every shift will monitor for side effects (unsteady gait, shuffling gait, ridged muscles, shaking, frequent falls, blurred vision, fatigue, loss of appetite, vomiting, and behavioral symptoms not usual for the resident). Note: The care plan did not mention resident target behaviors or symptoms indicating the need for the psychotropic medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265850	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seasons Rehab and Healthcare Center	15600 Woods Chapel Road Kansas City, MO 64139

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Medication Review Report showed the physician ordered medication Quetiapine Fumarate oral tablet 25 milligrams (mg) at bedtime for mood disorder was started on 8/23/24. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff and used for care planning), dated 10/15/24, showed the resident: -Was severely cognitively impaired. -Had fluctuating inattention and continuous disorganization. -Felt down and depressed half or more days. -Had no verbal or physical behaviors directed toward others or other behaviors (e.g.: self-injurious behaviors, disrobing, smearing bodily wastes, making disturbing noises). -Was not diagnosed with a psychiatric or mood disorder such as anxiety, depression, schizophrenia, or psychotic disorder. -Was prescribed a routine antipsychotic medication. Review of the resident's Medication Administration Record (MAR) dated November 2024 behavioral documentation showed: -There were no behaviors on the day shift. -Behaviors occurred six times on the evening shift and twice on the night shift, including hitting, kicking, pushing, entering other residents' personal space, restlessness, and refusing cares. -Interventions used included redirection, removing from the situation, reapproaching, and offering food. Staff documented outcomes of behavioral interventions as either the behavior remained the same or staff were unable to determine if the behavior improved. Review of the resident's November 2024 progress notes showed there were no progress notes in November addressing details of any of the resident's behaviors such as the duration or intensity of the behaviors, possible predisposing causes of the behaviors, or details about the intervention effectiveness which could be helpful for future behavioral care planning and psychotropic medication adjustment. Review of the resident's MAR dated December 2024 showed: -There was one behavior on the day shift and four behaviors on the evening shift. Behaviors included grabbing, hitting, kicking, cursing at others, expressing frustration or anger, threatening others, entering other residents' space, and refusing cares. -Interventions included providing a calm environment, removing from the situation, engaging in a meaningful activity, and reapproaching. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The night shift documented RU thirteen times on the form. The form legend showed R stood for rummaging and U stood for Unable to determine if the intervention attempt was successful. Review of the resident's December 2024 progress notes showed: -A note was written on 12/18/24 at 8:19 P.M. showing the resident continued to remove clothing from his/her roommate's closet and wear them which greatly upset his/her roommate. Staff redirected the resident, but the behavior repeated soon after related to dementia. -No other progress notes in December addressed details of the resident's behaviors, possible predisposing causes of the behaviors, or details about each intervention's effectiveness. During an interview on 1/30/25 at 1:57 P.M. CNA A said: -He/She didn't know how the resident acted when his/her mood was down or what staff were to do to address that. -He/She had never seen the resident out of his/her room except for meals and didn't know if staying in his/her room related to his/her mood. -He/She hadn't seen any behaviors on the day shift. During an interview on 1/31/25 at 12:13 P.M. Licensed Practical Nurse (LPN) A said: -Everyone on a psychotropic medication should be monitored every shift for behaviors. -The resident's care plan should show the diagnosis, target behaviors, and symptoms related to the reason they are on a psychotropic medication. There should be non-pharmacological interventions to address the behavioral issues for all residents on a psychotropic medication such as redirection or whatever usually helped that resident. -Residents on psychotropic medications had a generic order to identify behaviors. -All behaviors should be documented on the MAR and documented in detail in the resident's progress notes. If a resident behavior was documented on the MAR, the resident's electronic record should trigger the charge nurse to write a detailed progress note. -The care plan should reflect target behaviors staff should be monitoring. -The resident used to have more episodes of resisting cares, combativeness, and arguing with a former roommate, but those behaviors had recently decreased while wandering had increased. -Justification for an antipsychotic medication should be documented on a care plan and include target behaviors and symptoms associated with the diagnosis for which the antipsychotic was ordered. During an interview on 1/31/25 at 12:37 P.M. the MDS Coordinator said: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The psychiatrist or psychiatric nurse practitioner saw all the residents who were on psychotropic medications. -If a resident was on a psychotropic medication nurses should chart behaviors on the MAR every shift and document details of behaviors in a progress note. -The care plan should explain why a resident was on an antipsychotic medication and describe target behaviors and symptoms the resident was having such as hallucinations (a perception of something that isn't actually there) or delusions (a belief that is persistently held despite evidence to the contrary). During an interview on 1/31/25 the Director of Nursing (DON) said: -The resident's target behaviors and symptoms should be identified on the care plan. -Psychotropic medications should relate to the resident's diagnosis, behaviors, and symptoms and be reviewed monthly by the pharmacist and physician. -The charge nurse should document behaviors on the resident's MAR and in their progress notes. -Behavioral documentation was used in deciding if psychotropic medications needed adjusting.