STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275049	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Polson Health & Rehabilitation Center	9 14th Ave W Polson, MT 59860

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 50245 Based on observation, interview, and record review the facility failed to have the advance directive for 1 (#17) of 1 resident located in the Disaster Recovery Binder, easily accessible to staff during an emergency. Findings include: Review of resident #17's EHR showed: Advance Directives. Review of resident #12's EHR showed: For Advance Directives and Code Status, see Disaster Recovery binder at nursing station. During an observation on 9/11/24 at 9:55 a.m., resident #17's POLST was not located in the disaster recovery book. During an interview and observation, on 9/11/24 at 9:58 a.m., staff member I stated, I do not see it (#17's POLST in the Disaster Recovery Binder). It would be in the B section. Staff member I stated they (staff) would have to look on Point Click Care (electronic health record) in the uploaded documents, when they explained would staff would find a resident's POLST if it was missing from the Disaster Recovery Binder. During an interview on 9/11/24 at 1:45 p.m., staff member A stated, It (#17's POLST) should have been in the book (Disaster Recovery Binder). Staff member A stated the staff member responsible for entering this information (into the binder) was not as experienced in her position and may not have added the information consistently in Point Click Care. Staff member A stated the Advance Directives were located in the Disaster Recovery Binder.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41952 Based on observation, interview, and record review, the facility failed to ensure a resident's care plan accurately showed the resident's current non-use of interventions for a wheelchair cushion, and for bedside rails, for 1 (#37) of 13 sampled residents. Findings include: During an observation on 9/9/24 at 4:04 p.m., resident #37 was hunched over, sleeping in his wheelchair, with a thin pillow under him and his right leg on the bed. The bed was flat and had no siderails or bar attachments. During an observation and interview on 9/11/24 at 11:20 a.m., resident #37 was sitting on a pillow in his wheelchair. His bed was flat, in a low position, with no bed rails, no pillow, he had one shoe on. Resident #37 did not know what a siderail was and said he never had one, he would just stand up from his wheelchair. During an observation and interview on 9/11/24 at 9:47 a.m., staff member E stated, resident #37 never slept in his bed, only in his wheelchair, because he said the bed and recliner were uncomfortable. Staff member E went into resident #37's room and asked to see his wheelchair. She locked his wheelchair, and he stood up from it, while in the middle of the room. Staff member E started looking at the wheelchair seat, pulling up a noncovered small pillow, a double folded cloth bed protector, a pile of newspapers, and other items resident #37 had been sitting on, but no wheelchair pressure relieving cushion. Staff member E asked resident #37, and he said he never had a cushion in his wheelchair, and he had stuffed the newspapers in it because people would come and throw them away. Staff member E stated she never knew he placed those things in his wheelchair. Staff member E looked up resident #37's EHR and could not find any physician orders or a care plan about a wheelchair cushion. Staff member E stated therapy would get a cushion if residents needed one, or nursing staff could grab one, if therapy was not available. During an interview on 9/11/24 at 9:51 a.m., staff member F stated, resident #37 never slept in his bed and used his wheelchair exclusively. She did not know if he had used a wheelchair cushion and did not know he sat on the pile of items in his wheelchair. During an interview on 9/12/24 at 10:49 a.m., staff member C stated care plan updates could be done by any member of IDT team. Most care plan updates would be done during the morning clinical meeting review of residents or by the MDS nurse, but the facility did not have an MDS nurse currently. During an interview on 9/12/24 at 10:56 a.m., staff member D stated she observed resident #37 use the siderail on his bed the morning of 9/9/24 when she did his skin assessment. Staff member D filled out the siderail assessment for it on 9/10/24. He had grab bars to help stand up from his wheelchair because he never slept in his bed, only his wheelchair. Staff member D went to resident #37's room to look at the bed and found no siderails on it. Staff member D came back out of the room and stated that it was not the same bed because it did not have siderails and she would need to look into what happened. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/12/24 on at 12:13 p.m., staff member A stated resident #37 had siderails on 9/9/24 in the morning, when staff member D assessed him, and staff member D had 24 hours to do the documentation. Then staff member G switched out his bed for a new admission needing siderails on 9/9/24. The bed resident #37 had now did not have siderails, but he did need siderails. Staff member A stated there was a maintenance request from staff member G for the bed side rails. Staff member A stated resident #37 at one point probably did have a cushion. Review of resident #37's EHR showed: - A physician's order for bilateral siderails, initiated on 7/14/23, and currently active. There were no orders for a wheelchair cushion. - Siderail assessments were completed on 7/14/23 and 9/10/24. - A Quarterly MDS assessment was completed on 6/25/24, with no siderails in use. - An Annual MDS assessment completed on 4/22/24, with no siderails in use. Review of a Bed Rail Informed Consent, which was a copy, for resident #37, dated 6/11/24, showed Mobility bar bilat was to Assist w/help. [sic] Review of resident #37's Care Plan, last reviewed 8/28/24, showed the intervention for, bi lat mobility bars to bed to aid with transfers and bed mobility and Skin at risk: .pressure reducing mattress, wheelchair cushion, both initiated on 2/15/24. The resident's care plan was not current and the interventions not utilized. Review of the facility policy, Bed Rails, dated 2017, showed: Bed Rail Evaluation is: a. completed at admission prior to implementation . quarterly or change in condition . the physicians order contains the type of rail . e. are addressed on the care plan and updated appropriately . 3. Bed Rails are only implemented after consent is obtained . [sic]

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. 50245 Based on observations, interviews, and record reviews, the facility failed to answer call lights timely, for 6 (#s 9, 17, 24, 36, 39, and 202) of 13 sampled residents. Findings include: 2. During an interview on 9/10/24 at 7:52 a.m., resident #202 stated during breakfast she can wait up to 30 minutes after pushing the call button. During an interview on 9/10/24 at 7:59 a.m., resident #39 stated the average call light wait time was an hour. He stated, One time it was three hours when I fell down a couple of months ago. During an interview on 9/9/24 at 3:10 p.m., resident #17 stated the average call light wait time was ten minutes. Resident #17 stated the longest he had waited for a call light to be answered was 45 minutes, in the evening. Resident #17 stated, In the evening, I can hear them messing around and talking down the hall. Resident #17 stated, One night I was having chest pains. They took a long time, and it (the chest pain) was gone by then (the time they came). During an interview and observation on 9/10/24 at 8:15 a.m., resident #24 reported she always waits longer in the morning, and the facility seemed to be always short (staffed). Resident #24 stated she frequently voided in her brief because staff did not make it to her in time. Resident #24 stated she sometimes will be sitting in a dirty brief waiting hours for staff. When asked about call lights, resident #24 stated, Sometimes I had to wait two hours. So, I called my guardian, and she got after them. That helped. Resident #24 stated this had happened a couple of times. During an observation on 9/10/24 at 8:41 a.m., staff member H turned resident #39's call light on as resident #39 had asked to be transferred from his bed to the chair for breakfast after medications were given. No staff members came to answer this call light at this time. During an observation on 9/10/24 at 9:00 a.m., two other call lights were on down the same hallway as resident #39's call light. Staff member H continued to pass medications and two other staff members were passing food trays. No call lights were answered at this time. During an interview and observation on who usually responds to call lights, on 9/10/24 at 9:08 a.m., staff member H stated, [Staff member L] is supposed to. She is a very good one. I don't know where she is at. Staff member H then turned and asked a staff member walking by to get resident #39's call light. This staff member stated, Oh, well they'll be getting him food, and continued walking down the hallway. During an interview and observation on 9/10/24 at 9:11 a.m., the surveyor asked staff member H why he was not getting the call light if it had been on for a long time. Staff member H stated usually the other staff get the call lights but if they get behind, then staff member H would help. Staff member H then asked the staff member walking by to get the light. Resident #39's call light was answered after 30 minutes had gone by. Resident #39 wanted to eat his breakfast before moving, because his food was delivered just minutes prior to this. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 9/11/24 at 12:58 p.m., resident #36's call light turned on. At 1:11 p.m. , the call light was still on, and resident #36 stated he wanted his tray to be taken. At 1:12 p.m., staff member I walked in to ask resident #36's roommate a question but did not address resident #36's call light. Resident #36 stretched his arm out and said staff member I's name to get their attention. Staff member I talked with resident #36, and he asked for a pain medication. Staff member I never addressed the reason for the call light being on. At 1:20 p.m., resident #36's call light was answered by a staff member. The call light wait time was 22 minutes. During observations and interviews on 9/11/24 at 2:02 p.m., resident #9 was sitting in her wheelchair halfway out of her room and holding a clean brief. Resident #9 stated to the surveyor, I have to use the bedpan. Resident #9 was located very close to staff member E and the medication cart. Staff member E continued to prepare medications. At 2:08 p.m., resident #9 was still sitting in the hallway with a brief in her hands. Staff member E was still preparing medications. Another call light was going off down the hallway. When asked, staff member E stated, It is the CNAs job to get them (the call lights). I just have one CNA because one is on break right now. Staff member E stated it was part of their responsibility if the other CNAs were unable to get the call lights. During an interview on 9/12/24 at 7:55 a.m., staff member A stated, If a call light is going off. It is all of ours. During an interview on 9/12/24 at 9:43 a.m., resident #9 stated the typical call light time was 15 minutes. She stated she had been out in the hallway with her brief watching for an aide. Resident #9 stated she typically does not make it to the commode in time (due to the delay in call light response) which results in an accident. During an interview on 9/12/24 at 10:05 a.m., staff member K stated it was her impression call lights were to be answered in five minutes or less. Staff member K stated, It is easier to stay ahead of it. Staff member K stated if there are two or more call lights going off when she was passing medications she would typically stop to help to not get behind. During an interview on 9/12/24 at 12:11 p.m., staff member A stated, We do not have a direct call light policy. Prior to the end of the survey, the facility provided a call light policy.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 50245 Based on observation, interview, and record review, the facility failed to provide sufficient interventions for 1 (#40) of 2 residents who had severe weight loss. Resident #40 was self-limiting her intake which contributed to the weight loss. This resident had the diagnoses: Borderline Personality Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Epilepsy, Other Drug Induced Secondary Parkinsonism, as shown in resident #40's EHR and was not consulted with psychiatry. Findings include: Review of resident #40's EHR showed resident #40 weighed 172.4 pounds on 6/4/2024, and she weighed 151.0 pounds on 9/3/2024. This was a 12.41% severe weight loss. Review of a facility provided document, Nutrition/Dietary Note, dated 9/12/24, showed: Resident shows 12.9% loss over 3 months, weight hx shows resident weight of 172.4# on 6/4/24 and weight of 145.1# on 7/9. Between these weight recordings resident was discharged from facility due in part to mental health concerns and weight on 7/9 . [sic] Review of resident #40's EHR showed the following weights: - 3/4/24 weighed 177.6 pounds (17.62% weight loss in six months) - 4/3/24 weighed 178.4 pounds (18.15% weight loss in five months) - 5/1/24 weighed 175.8 pounds (16.42% weight loss in four months) A facility provided progress note, dated 8/29/24, showed: Weight Warning: Resident was noted to have a weight loss of 30 lbs over the last month. during this timeframe resident had behavioral concerns. and was not eating as much. 25-50% of meals. once the medication review, and implementation was completed. Resident comes down to dine for some meals, and consumes 75-100% of meals, and recently has a bmi of 24.4 and no concerns noted at this time. [sic] Review of resident #40's EHR, Nutrition Hydration Skin Committee Review Form, dated 6/11/24, showed: . maintaining weight would be beneficial . slight weight loss may be desirable . Review of resident #40's physician order, with a start date 8/30/24, showed: Calorie Dense Medication Pass. No other calorie increasing supplements were ordered prior to this date. During an interview and observation on 9/9/24 at 3:51 p.m., resident #40 stated, If its 8:00 p.m. I'll get an ice cream sundae because of the nurse on, but other than that, I get goldfish (snack cracker). I get sick of eating that, so I don't want it. There were no snacks or supplements present at this time in resident #40's room. Resident #40 stated she noticed she lost weight, but was happy about the weight loss, as she wanted to weigh 120 pounds. Resident #40 stated, My sister said I should weigh 120 pounds based on my height. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 9/11/24 at 1:16 p.m., resident #40 had eaten about two cups of chicken noodle soup with four cracker packets added. Resident #40 stated, I don't eat that, when the surveyor had asked why she did not eat the dinner roll. Resident #40 stated, I've got to get my weight down to 120 (pounds). Resident #40 did not have any snacks or supplements at the bedside. During an interview on 9/12/24 at 8:51 a.m., staff member J stated a supplement was discussed last week due to #40's weight loss. Staff member J stated, No, when asked if they were aware of resident #40 trying to lose weight, and the family members encouragement for resident #40 to weigh 120 pounds. When staff member J was asked if resident #40 would be too light at 120 pounds, staff member J stated, Yes, that is definitely too light. I will follow up with her and the family. Staff member J recommended education and potentially nutritional therapy/counseling to those residents that needed additional interventions concerning weight management. Staff member J stated they do not participate in the care conferences or IDT meetings. Review of resident #40's care plan, with a revision date 1/9/24, showed: Goal: No unplanned significant weight loss or gain . Interventions: Meal Monitor. If intake 50 percent or less, offer substitute or supplement . Refer to OT/ST as appropriate . Refer to RD as appropriate .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47785 Based on observations, interviews, and record review, the facility failed to follow physician orders to change oxygen tubing for 1 (#34) of 3 sampled residents. This increased the potential for respiratory infection and medical decline. Findings include: During an observation on 9/9/24 at 3:46 p.m., resident #34's oxygen tubing on the portable tank was dated with a piece of tape dated 8/11/24. The tubing on the concentrator being used by resident #34, at that time, was also dated 8/11/24. A review of resident #34's physician's order, dated 3/23/24, showed, O2 tubing to be changed Q2 weeks and prn. During an interview on 9/11/24 at 9:58 a.m., staff member E stated the treatment book has the changes scheduled for the night shift. She stated, It gets charted in TAR when changed. Sometimes the nurse will change it or sometimes the nurse may delegate the task to a CNA. During an observation on 9/11/24 at 10:30 a.m., the tape on the oxygen tubing for resident #34 still read 8/11/24, for both the concentrator, and the portable tank. During an interview on 9/12/24 at 8:40 a.m., staff member C stated, .we don't do it that way. We follow CDC guidelines and change the tubing when it is visibly dirty. [Staff member B] is the one who did that like in her other building and [staff member M] will sign anything but that is not our policy .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41952 Based on observation, interview, and record review, the facility failed to ensure a legible daily nurse staffing posting was placed with the required information, including the census, and that is was posted in an area easily accessible to residents or anyone wishing to view the information. This deficient practice would affect anyone wanting to view the information. Findings include: During an interview and record review on 9/14/24 at 12:17 p.m., staff member A stated the nursing staff kept using the same old copy of the daily nurse staffing posting, so it was hard to read. Staff member A stated he would get a blank master copy to show what was printed for staffing. The copies for the dates requested only had handwritten numbers readable, and none of them showed the resident census number. During an observation on 9/11/24 at 3:53 p.m., the daily nurse staffing posting was posted high on a bulletin board behind the nurses' station. Only handwritten numbers were readable, the copied form information was not. None of the numbers written were the facility census. Review of the facility policy, Daily Nurse Staffing Information, last updated 7/2012, showed: 1.following information . posts daily: a. Center Name b. Current Date c. Total number and actual hours worked by the following categories of licensed and unlicensed nursing staff . d. Resident census at the beginning of each shift 2. Posting Requirements a. The center posts the nurse staffing data on a daily basis at the beginning of each shift b. Data posted as follows: - Clear and readable format - In a prominent place readily accessible to residents and visitors .

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F 0742 Level of Harm - 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. 50245 Based on observation, interview, and record review, the facility failed to provide psychiatric services for 1 (#40) of 1 resident with the diagnoses: Borderline Personality Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Epilepsy, Other Drug Induced Secondary Parkinsonism, as shown in resident #40's EHR. Findings include: During an interview on 9/10/24 at 1:40 p.m., NF2 stated, [Resident #40] has emotional breakdowns and crying. So, I know the meds are holding her together, but they're not quite right . NF2 expressed frustration during the conversation and stated she knew resident #40 was not completely okay because she was still having hallucinations, and she never used to, prior to admission. NF2 stated, No, I do not think this is her new normal. NF2 stated she had tried numerous times to get in touch with a nursing home facility closer to her location, but it had been weeks, and there were no changes or updates. NF2 stated, It is hard to care for [#40] when she is four hours away. NF2 stated she was hoping at her physical location there were more psychiatric providers available for resident #40 because she was not receiving the psychiatric assistance at her current facility. During an interview on 9/11/24 at 1:20 p.m., staff member I stated they believed the facility was trying to get resident #40 a consultation with psychiatry. Staff member I stated, I think that is the plan. When staff member I was asked about resident #40's hallucinations, staff member I stated resident #40 does still have the hallucinations and stated, I do not think this is her new normal. Review of a [Facility Name] Emergency Department (ED) Note, dated 7/3/24, showed: . who presents to the ED for evaluation of AMS/weakness . 2 weeks cognitive/physical decline, auditory and visual hallucinations/delusions (vision of family members killing dogs, complaining of a cat moving into her room), unsteady on feet. PT/Aides said declining more today - not feeding herself, speech deteriorated into gibberish. Crying and wailing today for unknown reason. Has been at [Facility Name] for several months . The ED note also showed: . if a pharmaceutical issue is at play. Seroquel and olanzapine have been increased recently b/c of behavioral concerns. Oxycodone was held today and her ativan dose has been decreased from 1 mg/d to 0.25 mg/d. She's encephalopathic, so polypharmacy could be playing a role. [sic] Review of resident #40's EHR showed a physician's communication document, dated 8/14/24, Resident continues to hallucinate, and she is very distressed someone is hurting animals in the facility. Could the hallucinations be a side effect of one of her medications? The physician signed the document, but no follow up orders were given, or rationale noted. Review of resident #40's progress notes showed hallucinations were documented in the progress notes from 5/5/24 to 8/7/24: - 5/5/24 - 5/9/24 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Actual harm Residents Affected - Few	- 5/11/24 (review of progress note showed: [NF2] was informed that there is a .meeting between a psychiatrist and [staff member B] this coming Wednesday. [NF2] stated that she is in favor of these steps . - 5/15/24 -5/16/24 - 5/18/24 -5/20/24 -5/22/24 (review of the progress note showed: [NF2 feels like Abilify is causing the hallucinations and delusions and stressed she would like her [#40] to be taken off of it . - 5/24/24 - 5/29/24 - 6/14/24 - 6/17/24 - 8/5/24 - 8/7/24 Review of resident #40's EHR showed resident #40's initial admitted was 1/9/24. During an interview on 9/11/24 at 2:19 p.m., staff member A stated the facility was unable to get resident #40 psychiatric services due to a small number of providers in the area, and the newer plan of moving resident #40 closer to family, in a different town and facility. Staff member A stated resident #40 was accepted to the new facility on 9/11/24. Staff member A stated the facility tried telehealth options. Staff member A later stated resident #40 refused telehealth. No documentation of the telehealth refusals were provided, but were requested on the Facility Documentation Request Sheet #5 (at 9/12/24 at 12:13 p.m.) before the end of survey. Staff member A stated the facility was working with a [behavioral health service] company who was trying to get roots down for therapy for residents since May. Staff member A stated, Psychiatry is what she truly needs. Staff member A stated resident #40 had paranoia and schizophrenia. During an interview on 9/12/24 at 9:50 a.m., staff member K stated resident #40 had a consult with neurology due to parkinsons and her shakiness. Staff member K stated she believed resident #40 did see psychiatry once a month. Staff member K stated, [staff member N] comes in and is a psychiatrist. If she is not seeing them, I think she should. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275049	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Polson Health & Rehabilitation Center	9 14th Ave W Polson, MT 59860

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 0742 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/12/24 at 10:49 a.m., NF1 stated, No counselors, psychiatry, or psychology; we are not providing anything involving mental health at this time because we do not have credentialing with them [the facility] yet. NF1 stated the physicians would start therapy services starting in October. During an interview on 9/12/24 at 8:50 a.m., staff member A stated [staff member N] no longer works at the facility. Staff member A stated the focus changed from finding psychiatric help to getting resident #40 moved to a different facility as the family requested. Review of a facility provided document, Social Services Note, dated 8/23/24, showed: Per resident and residents' (family member) request [staff member] has been working on locating a different center for resident that is closer to . Review of a facility provided document, Nursing Progress Note, dated 8/17/24, showed: This nurse explained there is a behavioral health service for the resident but will have to wait . [sic] Review of a facility provided document, Social Service Admission and History Evaluation, dated 1/15/24, showed: A completed admission evaluation which comprised of psychosocial/mood/socialization/functionality/needs/etc. areas were assessed. No documentation was provided for resident #40 concerning psychiatric appointments, psychiatric physician notes, follow ups, referrals, etc. Review of the Facility Document Request Sheet #5 (requested at 9/12/24 at 12:13 p.m.) showed the following requested documents: - Refusal of telehealth consent - [resident #40] - Request to [City] facility transfer - [resident #40] - Referral to [City] psychiatry - [resident #40] - Staff training - trauma informed, behavioral health, dementia training