STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365779	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyant Woods Healthcare Center	200 Wyant Rd Akron, OH 44313

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on medical record review, review of admission documents, staff interviews, and review of facility policy, the facility failed to timely implement effective and individualized interventions to address behavioral health concerns. In addition, the facility failed to monitor the effectiveness of interventions once implemented. This affected one (#70) of three residents reviewed for behavioral health services. The facility census was 167. Findings include: Review of the medical record for Resident #70 revealed an admitted [DATE]. Further review revealed Resident #70 passed away in the facility on 04/26/24. Resident #70 had diagnoses including left non-dominant side hemiplegia and hemiparesis following cerebral infarction, type one diabetes mellitus, psychosis, anxiety disorder, major depressive disorder, delirium, and insomnia. Further review of the medical record revealed Resident #70 was transferred from another facility. Review of admission documents, which included progress notes from the previous facility, revealed the following behaviors: 04/09/24 Resident yelling out, refused to use call light, called staff inappropriate names, used foul language, and wanted someone to stay in the room with her; 04/10/24 behaviors of yelling out; 04/11/24 Resident yells out; 04/15/24 at 12:28 A.M. Resident yells out often, almost constantly, tries to get out of bed, pulled tube feeding line apart, resident needs constant monitoring; and 04/15/24 at 9:40 A.M. Resident continues to yell out frequently and several attempts to self-transfer, interventions ineffective except sitting with resident and providing 1:1. Review of the Nursing Admission Evaluation, dated 04/17/24, indicated Resident #70 exhibited no behaviors and included care planning for psychosocial well-being. Interventions included to observe for signs and symptoms of psychosocial issues and initiate resident specific interventions. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care initiated 04/18/24 revealed no care plan interventions related to behavioral challenges. On 04/19/24, a focus area was initiated for the use of antipsychotic and antidepressant medication. Interventions included administer medications as ordered, monitor for side effects, encourage resident to voice feelings and discuss coping skills, maintain consistent daily routine when possible, provide calm environment and limit over stimulation. Further review revealed on 04/23/24 (six days after admission), a care plan focus area was initiated, which indicated Resident #70 had a behavior problem: yelling out, delusions, agitation, resistive to personal care, crawling out of bed onto fall mat, removing soft boots and dressing to left foot, and crawling and rolling on the floor. Interventions included administer medications as ordered, observe and document effectiveness and side effects of medications, educate resident/resident representative to medication effectiveness, behavioral health consults as needed, encourage active support by family/resident representative, encourage to maintain as much independence and control as possible, intervene as necessary to protect the rights and safety of others, minimize the potential for disruptive behaviors by offering tasks that divert attention, monitor behavioral episodes and attempt to identify underlying causes, notify the provider of increased episodes of behaviors, non-pharmacological interventions to include 1:1 support, reorient, redirect, and reapproach, observe and anticipate resident's needs, praise any indication of progress in behaviors, approach/speak in a calm manner, and communicate with resident/resident representative regarding behaviors and treatment. Review of physician orders, dated 04/18/24, revealed Resident #70 was ordered quetiapine 50 milligrams (mg) one tablet via feeding tube two times daily for psychosis, venlafaxine HCl oral tablet 50 mg one tablet via feeding tube three times a day for depression, monitor for antidepressant and antipsychotic medication side effects, bed against wall per resident preference, fall mat to floor to open side of bed, and a perimeter mattress to define edges. Review of the Medication Administration Record (MAR) from 04/17/24 through 04/26/24 revealed on 04/18/24, 04/19/24, 04/21/24, 04/22/24, 04/23/24, and 04/25/24 Resident #70 was documented to have delusions, on 04/22/24, 04/23/24, 04/24/24, and 04/25/24 Resident #70 was documented to yell out, on 04/19/24, 04/22/24, 04/23/24, and 04/24/24 Resident #70 was documented to be agitated, on 04/23/24 Resident #70 was documented to resist personal care, and on 04/23/24, 04/24/24, and 04/25/24 Resident #70 was noted to crawl onto floor mat. Interventions included one on one support, reorientation, redirection, and reapproach. There was no documentation to evaluate the effectiveness of interventions. Review of an undated Witness Statement revealed Nursing Supervisor (NS) #802 provided one to one care for Resident #70 on 04/18/24, 04/19/24, 04/22/24, 04/23/24, 04/24/24, and 04/25/24 for two to three hours each day. NS #802 provided nail care, braided the resident's hair, listened to music, put puzzles together, colored, and attempted to do word searches. Emotional support was given, and Resident #70 was receptive. No additional information was included to determine the effectiveness of each intervention. Review of a nursing note dated 04/18/24 at 5:00 P.M. revealed Resident #70 was observed crawling onto the floor mat. Resident #70 indicated she was stretching. Staff assisted Resident #70 back to bed. Record review revealed no documented evidence of staff interventions at this time to address the resident crawling onto the floor mat. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician's order, dated 04/19/24, revealed to monitor every shift for behaviors of yelling out, delusions, agitation, crawling out of bed onto fall mat, and resistance to personal care. Non-pharmacological interventions included one on one support, reorientation, redirection, and reapproach. Review of a nursing note dated 04/19/24 at 8:47 A.M. revealed Resident #70 was pulling on soft boots to remove them and had already removed a wound care treatment. Boots were properly placed back on the resident's feet and floor nurse notified of treatment needing replaced. Record review revealed no additional documented evidence of staff interventions at this time to address the resident removing the wound care treatment or information as to why the treatment was removed. Review of a nursing note dated 04/19/24 at 4:42 P.M. revealed Resident #70 was agitated for most of the day. Resident #70 was observed trying to crawl out of bed multiple times. The note indicated Resident #70 was confused at times. Record review revealed no documented evidence of staff interventions at this time to address the resident's behavior. Review of an attending physician progress note dated 04/20/24 revealed Resident #70 had a history of depression and staff reported Resident #70 was easily anxious. The attending physician indicated Resident #70 would likely be seen by psychological services. Further review revealed no additional information on Resident #70's behaviors or interventions implemented at that time. Review of a Medication Administration Note dated 04/21/24 at 7:26 A.M. revealed Resident #70 refused to wear soft boots for skin integrity. Record review revealed no documented evidence of staff interventions at this time to address the resident's behavior. Review the the Medicare Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had moderately impaired cognition and moderate depressive symptoms. There were no behaviors identified on the assessment. Additional review of a physician order dated 04/23/24 revealed Resident #70 was ordered hydroxyzine pamoate (Vistaril) capsule 50 mg one capsule every six hours as needed for anxiety. Further review of the plan of care revealed on 04/23/24 a care plan focus area was initiated, which indicated Resident #70 had a behavior problem: yelling out, delusions, agitation, resistive to personal care, crawling out of bed onto fall mat, removing soft boots and dressing to left foot, and crawling and rolling on the floor. Interventions included administer medications as ordered, observe and document effectiveness and side effects of medications, educate resident/resident representative to medication effectiveness, behavioral health consults as needed, encourage active support by family/resident representative, encourage to maintain as much independence and control as possible, intervene as necessary to protect the rights and safety of others, minimize the potential for disruptive behaviors by offering tasks that divert attention, monitor behavioral episodes and attempt to identify underlying causes, notify the provider of increased episodes of behaviors, non-pharmacological interventions to include 1:1 support, reorient, redirect, and reapproach, observe and anticipate resident's needs, praise any indication of progress in behaviors, approach/speak in a calm manner, and communicate with resident/resident representative regarding behaviors and treatment. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/23/24 at 7:37 A.M. with State tested Nursing Assistant (STNA) #809 revealed Resident #70 was on her assigned hallway. STNA #809 noted Resident #70 had challenging behaviors including rolling onto the floor, screaming, taking clothing off, and repeatedly pressing her call light, despite staff just leaving the room. STNA #809 indicated staff had to go into Resident #70's room frequently to comfort her; however, it was challenging when there were others to care for. A telephone interview on 04/23/24 at 2:15 P.M. with Licensed Practical Nurse (LPN) #804 revealed Resident #70 was on his assigned hallway on 04/21/24. LPN #804 indicated Resident #70 was screaming a lot on his shift. LPN #804 indicated he had to go into her room several times to reassure her she was okay. LPN #804 indicated this was the first time he had worked with Resident #70 and she was making strange comments he did not understand. Interview on 04/23/24 at 2:28 P.M. with STNA #807 revealed Resident #70 was on her assigned hallway. STNA #807 indicated Resident #70 screamed a lot during her shift. STNA #807 indicated she provided routine care for Resident #70 including dressing and incontinence care. STNA #807 reported Resident #70 was accepting of care but used inappropriate language. STNA #807 indicated Resident #70 did not have behaviors when staff were in the room talking with her; however, she had others to care for so was unable to stay in the resident's room for her entire shift. Review of a nursing note dated 04/23/24 at 3:21 P.M. revealed Resident #70 had multiple episodes of screaming out for help and when staff respond she had no specific request. Resident #70 was not redirectable. Resident #70 was brought to the activities room and started yelling again. Resident #70 was then brought to the nursing station and offered an activity but refused. Redirection and emotional support were offered with no success. Telephone interview on 04/23/24 at 3:06 P.M. with LPN #806 revealed Resident #70 yelled all night, despite staff checking on her. LPN #806 indicated when she checked on Resident #70 she would report she did not need anything. LPN #806 indicated Resident #70 also used the call light repeatedly. LPN #806 indicated this behavior was baseline for Resident #70. Interview on 04/23/24 at 4:09 P.M. with the Administrator revealed Resident #70 was transferred from another facility due to behaviors. The Administrator confirmed the facility had been informed Resident #70 had behaviors of putting herself on the floor, fidgeting with the call light, yelling out and was a fall risk. However, the Administrator indicated Resident #70's behaviors were more severe than reported from the previous facility. Review of a Behavior Note dated 04/23/24 at 9:52 P.M. revealed Resident #70 had multiple episodes of screaming and increased anxiety. The physician was notified of the behaviors and gave a new order for hydroxyzine pamoate 50 milligrams (mg) tablet as needed. Review of a Medication Administration Note dated 04/23/24 at 10:30 P.M. revealed Vistaril was administered for increased anxiety and yelling. Review of a follow up note dated 04/23/24 at 11:30 P.M. revealed Vistaril administration was unsuccessful and Resident #70 continued to yell. Review of a Medication Administration Note dated 04/24/24 at 3:45 A.M. revealed Vistaril was administered for uncontrolled yelling and anxiety. Review of a follow up note dated 04/24/24 at 4:42 A.M. revealed Vistaril was effective. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Medication Administration Note dated 04/24/24 at 9:45 A.M. revealed Vistaril was administered for anxiety. Review of a follow up note dated 04/24/24 at 10:44 A.M. revealed Vistaril was ineffective. Resident #70 was noted to have increased behaviors. Record review revealed no documented evidence any additional staff interventions were attempted at this time to address the resident's behaviors. Review of a nursing note dated 04/24/24 at 1:50 P.M. revealed Resident #70 with labile moods (rapid, exaggerated changes in mood) and inappropriate affect. Resident #70 had delusions and disorganized thought process. Resident #70 had intermittent screaming out without a cause and redirection was not very effective. It was noted Resident #70 could be distracted with activities. Record review revealed no documented evidence of any specific activities provided for distraction or additional staff interventions attempted at this time to address the resident's behaviors. Review of a Medication Administration Note dated 04/24/24 at 5:48 P.M. revealed Vistaril was administered for anxiety. Review of a nursing note dated 04/24/24 at 5:49 P.M. revealed Resident #70 was yelling and climbing onto the floor mat. Vistaril medication was ineffective. Record review revealed no documented evidence any additional staff interventions were attempted at this time to address the resident's behaviors. Review of a Medication Administration Note dated 04/24/24 at 11:50 P.M. revealed Resident #70 was having increased anxiety with screaming and yelling. Vistaril was administered. Review of a nursing note dated 04/25/24 at 4:53 A.M. revealed Resident #70 had increased anxiety when her husband left. Resident #70 continued to yell out and crawl onto the floor. Resident #70 did not sleep despite administration of Vistaril. Resident #70 was brought to the nurse's station and offered ice chips. When Resident #70 was put back to bed she continued to yell out and crawl onto the floor mat. Record review revealed no documented evidence any additional staff interventions were attempted at this time to address the resident's behaviors. Review of a nursing note dated 04/25/24 at 9:20 P.M. revealed Resident #70 had increased anxiety. Resident #70 was yelling and crawling on the floor. Education was attempted. Record review revealed no documented evidence any additional staff interventions were attempted at this time to address the resident's behaviors. Review of a nursing note dated 04/25/24 at 11:10 P.M. revealed Resident #70 was screaming and yelling. Resident #70 was brought to the nurse's station so she could see the staff. Interview on 04/29/24 at 12:39 P.M. with the Administrator revealed Resident #70's behaviors were addressed in the care plan. The Administrator indicated Resident #70 had one on one interactions when she was yelling or experiencing behavioral challenges. The Administrator indicated Resident #70 had an order to see psychological services on 04/26/24; however, she passed away prior to the appointment. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/29/24 at 1:48 P.M. with Assistant Director of Nursing (ADON) #842 and the Administrator revealed there were no set behavioral interventions for all residents and they had to test out interventions to determine what would be effective. ADON #842 confirmed there was no documentation for the effectiveness of behavior interventions attempted with Resident #70. Review of facility policy titled Behavior Management General, undated, revealed residents would be provided with a resident centered behavioral management plan to safely manage the resident.