STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555213	A. Building B. Wing	04/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Care Center, LLC	1640 N. Fair Oaks Avenue Pasadena, CA 91103

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362 Based on observation, interview, and record review the facility failed to ensure one (1) of 1 sampled resident (Resident 1) who was assessed at risk for elopement (a resident who is incapable of adequately protecting himself, and who departs the health care facility unsupervised and undetected) did not elope after going out-on- pass (OOP, temporary permission of a resident to leave the facility in a specified time) on 4/15/2025 at 6 PM by failing to: 1. Develop a care plan and interventions to address Resident 1's risk for elopement. 2. Implement procedures based on the facility's Elopement Risk policy to search for Resident 1 when Resident 1 did not return to the facility while OOP. 3. Ensure facility staff implement its elopement policy by failing to report to local police, administrator, and resident representative within two (2) hours and to California Department of Public Health (CDPH) within 24 hours from when Resident 1 eloped on 4/15/2025. 4. Ensure the facility has a system in place to identify risks for residents who independently go OOP such as wandering, falling, and/or injuries. As a result, Resident 1 left the faciity on OOP unsupervised on 4/15/2025 and did not return. This had the potential to be exposed to harsh environmental conditions including excessive heat and or cold, potential of being hit by a car and medical complications including malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat), dehydration (body loses too much water and other fluids that it needs to work normally), heat stroke (a life-threatening condition where the body's temperature rises dangerously high), and death. On 4/17/2025 at 10:16 PM, while onsite at Facility 1, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) was called in the presence of Director of Nursing (DON) and Administrator (ADM) due to the facility's failure to supervise Resident 1 to prevent Resident 1's elopement from the facility. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/19/2025 at 4:35 PM the facility submitted an acceptable IJ removal plan (IJRP). After verification of IJRP implementation through observation, interview, and record review, the IJ was in the presence of the DON and ADM The IJ Removal Plan dated 4/19/2025, included the following: A. On 04/18/2025, all seven residents with out on pass order was reviewed and updated including the duration, purpose, and companion. If the resident will not return after specified duration, facility will call resident/family/companion for update on whereabouts and the time of return. If resident request to go out on pass independently, resident must meet all of the following criteria to be considered eligible and Interdisciplinary Team will review request to go out unaccompanied and document in Interdisciplinary notes. a. Cognitive Competency (Recent BIMS) b. Behavioral Stability (No recent history of elopement) c. Medical Stability (Medically cleared by Attending Physician) d. Functional Mobility B. MDS Coordinator and Registered Nurse Supervisor, re-assessed all seven residents with out on pass order and baseline care plan was updated. Elopement Risk Assessment was done for all 56 residents. Of those, 54 residents were identified as low risk for elopement and two residents were identified as high risk. C. Elopement Risk Policy and Procedures was revised and updated on 04/18/2025. The license personnel were in-serviced and educated on 04/18/2025 regarding timely assessment and identification of residents with high risk of elopement. Any episode of elopement reported and communicated to the Director of Nursing and Administrator so the facility leadership will be able to inform residents family, physician, regulatory Police Department, Ombudsman, California Department of Public Health and other regulatory agencies. D. Director of Staff Development/Director of Nursing in-service the license personnel regarding Policy and Procedure for elopement to emphasize in reporting to local police, administrator, and residents' representative within 2 hours and to California Department of Public Health within 24 hours when resident elopement. E. All residents with out on pass order was reviewed and updated including the duration, purpose, companion, and return time within four hours. A log was available to both nursing stations, regarding the time out and estimated time to return to the facility. Other residents who have potential to be affected by the deficient practice: A. Residents on high risk for elopement are potentially affected by the deficient practice. There were two residents identified as high risk after reviewing clinical records. The identified residents were re-assessed, care plan was developed and implemented, including monitoring every two hours. Log was available in the nursing station. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	B. An in-service was provided to License Nurses and direct care giver on 04/18/2025 by the Director of Staff Development and Social Service Director pertaining to: How to alert staff about resident elopement or missing How to locate or search the resident Reporting to governing agencies within 2 hours and CDPH within 24 hours. Measures that will be put in place to ensure that a deficiency will not occur A. The Director of Nursing/ Designee and Director of Staff Development conducted in-service to License Nurses and Certified Nursing Assistants on 04/18/2025 pertaining to the following: 1. Revised Policy and Procedure for Out on Pass Physician order for out on pass Duration and companion Protocol if the resident did not return after Specific duration Resident's decision against medical advice 2. Policy and Procedure for Elopement B. During daily angel rounds the Department Managers will check the out on pass log and discuss in the daily stand-up meeting. Monitoring A. The Director of Nursing Services/Registered Nurse Supervisor is responsible for monitoring the residents on a daily basis to ensure that the deficient practice will not be impacted. Results of the findings will be submitted and discussed to QAPI Committee during the monthly/quarterly QAPI meeting of its effectiveness. Findings: During a review of Resident 1's admission record, the admission record indicated the facility admitted Resident 1 on 3/11/2025. Resident 1's diagnoses of psychoactive substance abuse(drug addiction, is a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medicine), unspecified alcohol- induced disorder (a medical condition characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences), generalized muscle weakness (a decrease in muscle strength), and unsteadiness on feet (the person is walking in an abnormal, uncoordinated, or unsteady manner). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a record review of Resident 1's Elopement Risk Assessment, dated 3/11/2025, the elopement risk indicated Resident 1 was at risk for elopement. During a review of Resident 1's Order Summary Report, dated 3/18/2025, the Order Summary Report indicated Resident 1 may go out on pass two times a week. During a review of Resident 1's Minimum Data Set (MDS, standardized care and screening tool), dated 3/24/2025, the MDS indicated Resident 1 had an intact cognitive (process of thinking and reasoning) skills for daily decision making. The MDS also indicated Resident 1 required partial moderate assistance (Helper does less than half the effort. Helper lifts, holds or support trunk or limbs, but provides less than half the effort) with walking 10 feet (ft., a unit to measure the length or distance) once standing and walking 50 ft. with two turns (once standing, the ability to walk at least 50 ft. and make 2 turns). During a concurrent review of Resident 1's Out on Pass (OOP)/ Leave of Absence log and interview with Registered Nurse 1 (RN1) on 4/17/2025 at 2:04 PM, RN1 stated Resident 1 left the facility by himself to go to the store and did not return at the expected time on 4/15/2025 at 9PM. During a review of Resident 1's nurses progress notes, dated 4/15/2025 at 11:08 PM, the progress notes indicated resident has not returned from OOP. The progress notes also indicated Licensed Vocational Nurse 1 (LVN1) called Resident 1 on his cellular phone, but the resident did not answer. During a review of Resident 1's nurses progress notes, dated 4/16/2025 at 5:58 AM, the progress notes indicated Resident 1 had not returned to the facility. During a review of Resident 1's nurses progress notes on 4/16/2025 from 10:33 AM to 1:27 PM, the nurses progress notes indicated Resident 1 was OOP. During a review of Resident 1's nurses progress notes from 4/16/2025 at 1:28 PM to 4/17/2025 at 7:59 AM, the nurses progress notes did not have any further documentation on the resident's whereabouts. During a review of Resident 1's nurses progress notes, dated 4/17/2025 at 8AM, the progress notes indicated, a late entry for 4/16/2025 at 8:30 AM that Resident 1 had not returned to the facility. Registered Nurse 1 (RN1) attempted to call Resident 1 but there was no response. RN 1 informed the medical doctor (MD1, primary physician), the Director of Nursing (DON), Administrator (ADM) and Social Service Director (SSD) that Resident 1 was not back from OOP. There were no new orders received from MD1. During a concurrent interview and record review on 4/17/2025 at 2:10 PM with RN1, Resident 1's Order Summary Report was reviewed. RN 1 stated order summary report dated 3/18/2025 indicated may go out on pass two times a week. RN1 stated Resident 1's OOP order was not specific because it did not indicate who will accompany the resident and for how long the resident may go OOP. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/17/2025 at 4:35 PM with LVN 1, LVN1 stated Resident 1 left the faciity on [DATE] at 6PM for OOP and was expected to return at 9PM the same night (4/15/2025). LVN 1 stated Resident 1 was not back at 9PM (4 hours after Resident 1 left) so LVN 1 called Resident 1 on his cellular phone to verify the resident's whereabouts but did not get a reply. LVN1 stated he did not inform the DON, ADM or the police department. LVN 1 also stated he did not search for Resident 1 when he did not return as expected at 9PM or throughout his shift (3PM to 11PM on 4/15/2025). During an interview on 4/17/2025 at 4:40 PM with RN1, RN1 stated she notified MD1, DON, ADM and SSD on 4/16/2025 at 8:30 AM (11 hours and 30 minutes after) that Resident 1 has not been back at the facility since Resident 1 had gone OOP on 4/15/2025 at 6PM and was expected to return on 4/15/2025 at 9PM. RN1 also stated the facility did not search for the resident and neither did RN 1 report to the police nor to the department of public health about the Resident 1 not being back to the facility after OOP on 4/15/2025. During a review of Resident 1's Social Service Notes, dated 4/17/2025 at 5:42 PM, the Social Service notes indicated Resident 1 went OOP on 4/15/2025 at 4PM according to the signed OOP log. Resident 1 has not been back to the facility since 4/15/2025. During an interview on 4/17/2025 at 4:55 PM with the DON, the DON stated the facility did not search the facility and surrounding streets for Resident 1 on 4/15/2025 to 4/16/2025 because her understanding is that Resident 1 was not returning to the facility and did not consider it as an elopement. The DON confirmed that Resident 1 was in fact missing. The DON stated RN 2 reported to the police on 4/17/2025 at 3:15 PM (45 hours and 15 minutes from when resident left the facility) that Resident 1 has not been back to the facility since 4/15/2025 when resident went OOP. The DON stated she along with the IPN and SSD started calling hospitals and searched the facility surroundings on 4/17/2025 at 1:40 PM. During an interview on 4/17/2025 at 4:48 PM, the DON stated Resident 1 was at risk for elopement according to the elopement risk. The DON stated Resident 1 should have a care plan for elopement to ensure resident safety. During a concurrent interview and record review on 4/18/2025 at 12:45 PM with RN1, Resident 1's care plan was reviewed. RN1 stated Resident 1 does not have care plan for OOP and risk for elopement. RN 1 stated Resident 1 should have a care plan when going OOP and for risk for elopement. During an interview on 4/17/2025 at 6:48 PM with the DON, the DON stated any resident can go OOP even at nighttime if the resident is alert and oriented times four (4) and based on the resident's assessment such as if the resident is able to walk and can go by themselves. During a review of the facility's OOP policy, revised 7/2024, the policy indicated the resident may go out by him /herself if he/she is self-responsible depending upon physician's order. During a concurrent interview and record review on 4/17/2025 at 6:50 PM with the Administrator, Resident 1's Order Summary Report, dated 3/15/2025 was reviewed. The ADM stated Resident 1's order to may go out on pass two times a week was a blanket order because it is not specific. The ADM stated the order did not indicate how long was Resident 1 allowed to be OOP and did not indicate if Resident 1 can go OOP independently or be accompanied by a responsible person while OOP. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on 4/17/2025 at 6:55 PM with the Administrator, the Policy and Procedure titled, Out on Pass/ Against Medical Advice (AMA)/ Doctors Appointment, revised 7/20/2024 was reviewed. The ADM stated the policy did not have a timeframe indicating a duration of time for when the resident can be OOP. The ADM further stated facility staff should know procedures to follow when the resident does not return from OOP that include searching for residents if residents have not returned within a 4-hour timeframe, report to the responsible party, MD, ADM, DON, local police, and California Department of Public Health. During a concurrent interview and record review on 4/17/2025 at 7 PM with the Administrator, the Policy and Procedure titled, Elopement Risk Precautions and Procedures revised 7/2024 was reviewed. The ADM stated according to the policy, if the resident is not found within 2 hours, notify the local police, administrator, and resident representative and to notify California Department of Public Health (CDPH) within 24 hours from when Resident 1 eloped. The ADM confirmed that IPN reported Resident 1 missing to the local law enforcement on 4/17/2025 at 3:15 PM. During a review of the facility's Policies and Procedure (P&P) titled, Out on Pass/ Against Medical Advice/ Doctors Appointment, revised 7/2024, the P&P indicated to provide opportunity for the resident to participate in family and community life to maintain optimal functioning, the facility will respect resident's rights to be OOP unless otherwise contraindicated to the resident's medical needs. The P&P indicated the resident may go out by him /herself if he/she is self-responsible depending upon physician's order. During a review of the facility's P&P titled, Care Plan, revised 4/2024, the P&P indicated a care plan is a summation of the residents' concerns, goals, approaches and interventions in order to meet the goals and help minimize if not totally eradicate residents' problem. The P&P also indicated the resident care plan is developed within 7 days upon resident's admission, reviewed quarterly, annually or as often as needed as there is a change in condition. The evidence of a care plan that has been reviewed should include but not limited to the new interventions that have been added in addition to the current ones. These interventions should be in chronological order as implemented and carried out. During a review of the facility's P&P titled, Elopement Risk Precautions and Procedures, revised 7/2024, indicated the facility to identify residents who are wanderers or who are a threat to leaving the facility unattended without the knowledge of the facility staff. The P&P indicated to ensure the resident's safety utilizing the least restrictive means available. It also indicated when a resident believed to be missing, the following steps will be implemented: 1. The charge nurse shall be alerted that the resident is missing 2. The charge nurse of designee shall alert staff about the resident elopement or missing. All employees are to report to the nurse station. The charge nurse/ supervisor will explain the situation and designate where each staff person is to search. 3. Search the building: closet, shower, bathrooms and ground thoroughly. 4. If the facility search is unsuccessful, the surrounding streets and yards will be searched. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. If the resident was not found within 2 hours, notify local police, administrator and responsible party. 6. Give the police a description and current photo of the missing resident. 8. If resident is not found within 24 hours even with the assistance of the police department of if found and resident sustains injury, department of public services will be notified in 24 hours.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 45523 Based on interview and record review, the facility failed to ensure one of two samples residents (Resident 1) received appropriate treatment and services to correct the assessed problem and provided behavioral health services for Resident 1, whose primary diagnosis includes alcohol use, unspecified with unspecified alcohol-induced disorder (alcohol use without specific details about the extent or nature of the related disorder), other psychoactive (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) substance abuse, uncomplicated (many illegal drugs and substances including alcohol, caffeine, nicotine, marijuana, and certain pain medicines), imprisonment and other incarceration (confinement to a jail, prison or other penal institution or correctional facility) by failing to: 1. Ensure to refer Resident 1 to a psychologist (a professional who practices psychology [the scientific study of human mind and its functions, especially those affecting behavior in a given contect] and studies mental states, perceptual, cognitive, emotional, and social processed and behavior) for appropriate counseling and behavioral services for alcohol use, unspecified with unspecified alcohol-induced disorder and psychoactive substance abuse. 2. Develop and implement person-centered care plan (a holistic approach to planning and providing services that focuses on the individual's unique needs, preferences, and goals) that included and support the behavioral health care needs for Resident 1's alcohol use, unspecified with unspecified alcohol-induced disorder and psychoactive substance abuse. These deficient practices had the potential to cause complications (an unfavorable result of a disease, health condition, or treatment) of Resident 1's alcohol use and psychoactive substance abuse which can negatively affect Resident 1's quality of life. Findings: During a review of Resident 1's admission record, the admission record indicated the facility admitted Resident 1 on 3/11/2025. Resident 1's diagnoses included psychoactive substance abuse, unspecified alcohol- induced disorder, generalized muscle weakness (a decrease in muscle strength), and unsteadiness on feet (the person is walking in an abnormal, uncoordinated, or unsteady manner). During a review of Resident 1's admission record, the admission record indicated the facility admitted Resident 1 on 3/11/2025. Resident 1's diagnoses included psychoactive substance abuse, unspecified alcohol- induced disorder, generalized muscle weakness (a decrease in muscle strength), and unsteadiness on feet (the person is walking in an abnormal, uncoordinated, or unsteady manner). During a concurrent record review of Resident 1's Out on Pass (OOP)/ Leave of Absence log and interview with Registered Nurse 1 (RN1) on 4/17/2025 at 2:04 PM, RN1 stated the OOP log indicated on 4/15/2025 at 6PM Resident 1 left the facility alone to go to the store (not accompanied by facility staff or family). (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/17/2025 at 2:10 PM with Registered Nurse (RN1) Resident 1's Order Summary Report was reviewed. RN 1 stated order summary report dated 3/18/2025 indicated may go out on pass two times a week. RN1 stated, the residents usually go OOP for 4 hours. RN1 also stated Resident 1's OOP order was not specific because it did not indicate who will accompany the resident and for how long the resident will be out of on pass. During an interview and record review with RN1 on 4/17/2025 at 2:12 PM, Resident 1's paper clinical record and electronic health records (EHR) dated from 3/11/2025 to 4/15/2025 were reviewed. Resident 1's paper clinical record and EHR did not have no documented evidence the facility developed and implemented a person-centered care plan for Resident 1's behavioral health care needs specific to Resident 1's alcohol use, with unspecified alcohol-induced disorder and psychoactive substance abuse. RN1 stated there were no care plans develop to address Resident 1's alcohol use and no CP the address Resident 1's psychoactive substance abuse. During a concurrent interview with RN1 on 4/18/2025 at 1:25 PM, RN1 stated Resident 1's CP should have been developed and implemented to address Resident 1's alcohol use and psychoactive substance abuse the ensure safety of the resident since it was possible that the resident will be using psychoactive substance or drinking alcohol while in the facility or when resident is OOP. During an interview with the Director of Nurses (DON) on 4/18/2025 at 4:20 PM, the DON stated, Resident 1 should have a CP developed and discussed during Interdisciplinary Care Team (IDT- a team of healthcare professionals who collaborate to provide comprehensive care for residents, encompassing their medical, social, and emotional needs) to have interventions in place for Resident 1's alcohol use, with unspecified alcohol-induced disorder and psychoactive substance abuse. The DON stated interventions in the CP should be Resident 1 to be monitored frequently, and the need for behavioral health services such as psychologist counseling or referrals should have been addressed, because of the potential for complications from alcohol use and psychoactive substance abuse which can place Resident 1 at risk for accidents or injury. During a concurrent interview and record review with the DON on 4/18/2025 at 5:00 PM, Resident 1's paper clinical record and EHR from admission (3/11/2025) up to 4/15/2025 were reviewed. The DON stated, Resident 1's paper clinical record and EHR did not indicate documented evidence that a CP for Resident 1's alcohol use and psychoactive substance abuse were developed for Resident 1 or any person-centered interventions were implemented to provide behavioral health services to Resident 1 that included counseling for Resident 1's alcohol use and psychoactive substance abuse. The DON stated, there was no documented evidence there was an order/ or referral placed for Resident 1 for psychiatrist/ psychologist consult. The DON stated, not having a plan of care, and behavioral services, Resident 1 had the potential for worsening alcoholic condition, alcoholic behavior or even possible elopement. A record review of the facility's Policies and Procedures (P&P) titled Care Plan revised date 4/2024 indicated Policy: A care plan is a summation of the residents' concerns, goals, approaches and interventions in order to meet the goals and help minimized if not totally eradicate residents' problem. The P&P also indicated the resident care plan is developed within 7 days upon resident's admission, reviewed quarterly, annually or as often as needed as there is a change in condition. The evidence of a care plan that has been reviewed should include but not limited to the new interventions that have been added in addition to the current ones. These interventions should be in chronological order as implemented and carried out. (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 - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Substance Use Disorder dated 1/20/2025, the P&P indicated, Residents who are admitted to the facility with substance use disorder (SUD) will receive the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being, provided by the facility and in accordance with the comprehensive assessment and care plan. The P&P also indicated the policy interpretation and implementation includes: c Substance use disorder (SUD) is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. c The care plan will address the individualized needs the resident may have related to the mental disorder or the SUD. c The resident's history of substance use disorder and risk for using substances which could lead to an overdose while in the facility are identified to the extent possible and documented in the medical record. c In addition, safety and health concerns specific to the resident and his or her history are identified: Health and safety considerations related to substance use disorder may include potential for wandering and elopement. c Care plan interventions are directed at maintaining the safety of the resident, staff and other residents and not necessarily on addressing the underlying addictive behaviors. Examples of appropriate care interventions for a resident with SUD include: a. monitoring the resident for signs and symptoms of substance use (changes in behavior, unexplained lethargy, odors, new needle marks, slurred speech, lack of coordination, etc.) and overdose, especially after returning from a leave of absence or during/after visitation. b. increasing supervision of the resident and, if needed, the resident's visitors; and c. supporting the resident's efforts to prevent substance use such as coordinating behavioral health services, medication assisted treatment, and 12-step meetings. During a record review of the facilities undated P&P titled Problematic Behavioral Management, indicated, As part of the initial assessment, the multidisciplinary team and physician will identify individuals with a history of impaired cognition (for example, dementia or mental retardation), problematic behavior, or mental illness (for example, bipolar disorder or schizophrenia). The P&P indicated licensed nurse will identify, document, and inform the Physician about an individual's mental status, behavior, and cognition. This will include details about any problematic behavior such as onset, frequency, and precipitating factors. Nursing staff will document the nature, duration, and associated features of any changes over time in behavior, cognition, or mood.