STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRANKLIN REHABILITATION & HEALTHCARE CENTER	900 3RD STREET SOUTH FRANKLIN, MN 55333

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 0740 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure appropriate behavior management and consultation occurred to manage physical behaviors for 3 of 3 residents (R1, R2, R3). Findings include Review of the 3/4/20, report filed to the State Agency (SA) identified at 5:30 p.m. a resident-to-resident altercation between R2 and R3 occurred in the locked unit dining room over a coffee mug. R2 grabbed a coffee mug and hit resident R1 in the face with the mug, causing the mug to break. R2 pushed R1 from his chair, causing R1 to fall to his left side on the floor. Staff assisted resident R1 out of the dining room and attempted to redirect R2 out of the dining room, R2 was not responsive to redirection. The [DATE], 5-day investigation report of the 3/4/20 incident, submitted to the SA identified R1 and R2 had an altercation. R2 struck R1 with a coffee mug. R1 was not injured and the residents were separated. R2 was transferred to the emergency department (ED). R2 returned the next morning with an order for [REDACTED]. R2 returned from the hospital the following day, and placed on one-to-one supervision when he went outside his room. Staff were educated to ensure R2 was in staff line of sight at all times when out of his room to intervene when R2 became verbal to prevent physical altercations. Review of the 3/6/20, report filed to the SA identified at 8:30 a.m. R2 and R3 were in the locked unit dining room having a snack. R3 was requesting more food. R2 told R3 he had just eaten. R3 told R2 to shut up. R2 entered R3's personal space and told R3 not to talk to him like that. R2 struck R3 on the left side of his face, and grabbed R3's shirt to attempt to pull R3 out of his wheelchair. Staff intervened, and removed R3 from the dining room and assisted him to the unlocked unit east dining room. R3 sustained no injury. R2 was transported to the ED for a mental evaluation. Review of the [DATE], 5-day investigation report for the 3/6/20 incident, submitted to the SA identified the dining room was left unsupervised when R2 was out of his room. Changes were made to ensure anytime residents with histories of verbal and physical aggression were out of their rooms, staff were to be present to ensure all residents were safe. On 3/7/20, R2 returned to the facility with orders for [MEDICATION NAME] and had one-to-one supervision when he was out of his room. R3 had no injuries. The facility continued to seek alternative long-term care placement for R2. The report made no mention of changes made to ensure residents had supervision when they were out of their rooms R1's 2/18/20, quarterly Minimum Data Set (MDS) identified R1 had short-term and long-term memory problems. R1's decision-making skills were severely impaired. R1 had inattention and disorganized thinking. R1's mood assessment identified R1 had little interest or pleasure doing things, had trouble falling asleep, concentrating, and had slowed speech, and was short-tempered and easily annoyed. R1 had behaviors not directed towards others. R1 was able to eat independently and walk throughout the facility independently. He required extensive assistance of two staff to perform hygiene, dress, and toilet. R1's [DIAGNOSES REDACTED]. R1 used antidepressants and antipsychotics daily. R1's 3/12/20, care plan identified R1 used antidepressant and antipsychotic medications. Staff were to monitor R1's target behaviors included inappropriate comments towards staff, combativeness with cares, and verbal altercations with other residents. Staff were to separate R1 from other residents immediately when verbal or physical aggression occurred. Staff were to refer to R1's psychiatrist for medication and behavior intervention recommendations as needed. R1 was independent with ambulating throughout the facility, and required assistance of one staff for personal cares. R1 had impaired speech and had difficulty making himself understood. Staff were to anticipate R1's needs, and provide a calm unhurried environment. R1 made poor decisions and was unable to make safe choices. Staff were to provide 15-minute checks for 72 hours, provide cues and reminders as needed, and to separate R1 from other residents known to agitate R1. Staff were to provide redirection when R1 wandered into other residents' rooms, and remove R1 from potentially dangerous situations. R1's psychiatric progress notes identified R1 received psychiatric care on an as needed (PRN) basis. R1's 2/18/20, visit identified R1 had no new problems and no medication changes. The notes made no mention R1's psychiatrist was notified of R1's 3/4/20, resident-to-resident altercation. R1's 2/10/20, physician visit note identified R1's medications were reviewed, No additional documentation or physician recommendations were included in R1's physician notes following the altercation with R2. R1's 15-minute check documentation were requested and not provided. R2's 1/14/20, quarterly (MDS) identified R2's had moderately impaired cognition. R2 had physical and verbal behaviors directed towards others. R2 was independent with all personal cares, and was able to walk throughout the locked unit independently. R2's [DIAGNOSES REDACTED]. R2's medications included [MEDICATION NAME] (anti-depressant) 40 milligrams (mg) daily for adjustment disorder with depressed mood; [MEDICATION NAME] 500 mg twice daily for adjustment disorder started on 3/5/20; [MEDICATION NAME] 25 mg daily for alcohol dependence with alcohol induced persisting dementia started on [DATE]. R2's 3/2/20, care plan identified R2 had behavior problems related to dementia with behavioral disturbance, and had a history of [REDACTED]. R2 also had a history of [REDACTED]. Staff were to intervene and separate residents when R2 was provoked or was provoking other residents; monitor and document target behaviors; provide praise when R2 had improvements in behaviors and encourage participation in activities. Staff were to separate R2 and other residents when verbal or physical altercations occurred. Staff were to discuss and provide education to R2 about behaviors when he was reasonable. Staff were to explain all procedures to R2 to allow him to adjust to changes. R2 used [MEDICATION NAME] inhalers to use when having urges to smoke. Staff were to encourage him to use the inhaler and remind R2 the locked unit is a non-smoking unit. Staff were to walk away and provide time for R2 to deescalate when he had agitation related to smoking. Staff were to provide non-pharmaceutical interventions to decrease target behaviors, and refer to the psychiatrist for medication and behavioral interventions as needed. Staff were to report behavior changes to the physician. R2's care plan made no mention of R2's [DIAGNOSES REDACTED]. R2 required supervision in the dining room. R2 was on 15- minute checks and was 1:1 when out of his room. R2 had poor cognition and had inappropriate behaviors. Staff were provide constant reminders and to redirect R2 when behaviors occurred if possible. R2's 3/4/20, and 3/6/20, ED and hospital documents were requested, but not provided. R2's physician communication records for 3/4/20, and 3/6/20 were requested, but not provided. R2's 1/9/20, physician visit note identified R2 had increased verbal aggression and wandering issues. R2 had smoking urges during the night. R2 was worsening, but no behavioral medication changes or behavior modification interventions were made during the visit. Staff were to continue redirecting R2 and monitor for improvement. R2 was under the care of a psychiatrist, and plan was to see what suggestions the psychiatrist had regarding behavioral concerns. There was no mention staff had followed up with the psychiatrist. R2's 2/1/20 psychiatric note identified staff reported R2 had been more irritable. R2 started taking [MEDICATION NAME] 250 mg three times daily. No changes were made to R2's medications. No additional recommendations were provided, and the note made no mention of R2's verbal and physical aggression with other residents on 3/4/20, and 3/6/20. R2's Resident Location Charting (15-minute checks) identified R2 was placed on 15-minute checks between 2/1/20, and 2/7/20. R2's checks had lines drawn through many check times and made no mention of where R2's location was during the checks. R3's 2/4/20, quarterly MDS indicated that R3 had moderate cognitive impairment. R3 had severe depression symptoms. R3 had frequent behavioral symptoms

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) directed towards others. R3 ate independently, and walked independently in his room. R3 used a wheelchair to motivate independently in the hallways, and required staff supervision when moving throughout the facility. R3's [DIAGNOSES REDACTED]. R3's care plan identified R3's behaviors included cursing, shouting, wandering into other resident's rooms, making repetitive requests, and combativeness and refusal of cares. R3 had a history of [REDACTED]. R3 lacked safety awareness, and was at risk for abuse. Staff were to keep R3 safe by explaining provision of care. Staff were to intervene and remove R3 from verbal altercations immediately, and were not to place R3 near others known to disturb him. R3's physician notes were requested. R3's last visit documented in R3's paper chart occurred on 12/9/20. No additional notes were provided as evidence R3's behaviors were addressed following altercations on 2/5/20, 2/12/20, 3/4/20, and 3/6/20. R3's 2/1/20, psychiatric note identified R3's [MEDICATION NAME] was discontinued in October, 2019. R3 had no increased in problems. No changes occurred with R3's treatments. There was no documentation to identify the psychiatrist was made aware of R3's yelling out or of R3's altercations on 2/5/20, 2/12/20, 3/4/20, and 3/6/20. Review of reports submitted to the SA identified the facility had 10 resident-to-resident abuse allegations during the past 4 months. Review of February, 2020 and March, 2020, incident reports identified the following resident to resident incidents: (1) On 2/4/20, R1 was in the hallway near R5. R5 reached out to touch R1. R1 grabbed R5's arms and pulled them forcibly behind R5's back. Staff intervened and separated the residents. R1 was placed on 15-minute checks for 72 hours. R5 had no injuries. (2) On 2/5/20, a verbal and physical altercation occurred between R2 and R3. R3 was in the hallway with staff yelling out for coffee. R2 approached R3 and poured water over his head. R2 was redirected from the area. R3 was dried off and returned to the dining room. The interdisciplinary team (IDT) review on 2/11/20, identified no further incidents were observed, and R3 resumed normal activities. There was no mention the behavior interventions had been addressed or reviewed by the psychiatrist. (3) On 2/5/20, an altercation occurred between R4 and an unidentified resident. R4 was in the hallway near a resident she did not like and poured water on his head. R4 stated she did not like the resident. R4 was placed on 15-minute checks for 72 hours. R4 was evaluated by the psychiatrist and diagnosed with [REDACTED]. (4) On 2/12/20, a verbal altercation occurred when R2 and R3 were left unsupervised in the dining room. Staff responded to R2 yelling and cursing into R3's ear telling him to shut up. R2 and R3 were separated. R3 was assisted to the unlocked dining area to watch TV under staff supervision. R2 left the dining room and went to his room. IDT review on 1/13/20, identified R3 was placed on 15-minute checks. Staff were to continue to monitor R2 for anxiety and behaviors and intervene with future incidences. There was no mention the behavior interventions had been addressed or reviewed by the psychiatrist. (5) On 3/4/20, a verbal and physical altercation occurred between R2 and R3 at 12:50 a.m., in the locked unit hallway. Staff responded R2 yelling and cursing at R3. R3 standing in front of his wheelchair in a puddle of water the hallway with wet clothing. R2 stated he had thrown water at R3 because he yelling. R2 was unable to be redirected and continued yelling at R3 and staff. Staff removed R3 from the locked unit for supervision. R2 returned to his room following the altercation. An [DATE], IDT note identified R2's care plan was updated to reflect he had a history of [REDACTED]. There was no mention the behavior interventions had been addressed or reviewed by the psychiatrist. Interview on 3/13/20, at 10:40 a.m. with registered nurse (RN)-A identified she had computer based training, but was unable to recall when she last had behavior training at the facility. An interview on 3/13/20, at 1:45 p.m. with the director of nursing (DON) identified she had computer based training from a previous job, but had not received training from the facility prior to starting her position on [DATE]. The DON expected staff to make resident and staff safety a number one priority. Staff needed to separate the residents and to use de-escalation techniques to prevent resident altercations and minimize behaviors. Staff were expected to be able to anticipate and identify potential situations before it happens and intervene before altercations occurred. The facility had assigned a computer based de-escalation technique training video. Not all staff had completed the on-line training. There was no resident specific training provided to staff. The DON agreed training on behavior modifications should be resident specific and include recommendations from the psychiatrist. An interview on 3/12/20, at 1:54 p.m. with physician (MD)-A, (primary care physician (PCP)) identified he was the PCP for many of the residents at the facility under his care. During rounds at the facility, MD-A would speak with the nurse regarding resident behaviors and ensured medications were at an appropriate dose and were used according to diagnoses. When a [MEDICAL CONDITION] or antipsychotic medications were prescribed by the psychiatrist, MD-A would not adjust the dosages. [MEDICAL CONDITION] and antipsychotic medications were ordered for newly admitted residents when a psychiatric consultation was not completed prior to admission, or when psychiatric services were not able to address in a timely manner. Overall, MD-A identified psychiatric services were difficult to obtain in this area due to past closures of regional and local psychiatric hospitals. Finding placement for residents with behaviors was difficult because of associated complex behavior management. MD-A was not involved in the IDT because he was not the medical director. He had not discussed non-pharmacological care with the facility. MD-A noticed an increase of admissions to the ED for residents from the facility with behaviors on weekends and when new staff and pool staff worked. MD-A usually had not addressed non-pharmacological interventions with facility staff and had not provided oversight on behavioral management of his patients with behaviors as he would expect the resident's psychiatrist to address those concerns. He was unaware of any discussions between the psychiatrist and PCP's regarding resident behaviors to ensure continuity of care. Interview and document review on 3/13/20, at 2:30 p.m. with the administrator identified he started his position on 2/17/20, and the DON started on 3/2/20. He agreed the facility had not ensured resident behaviors were adequately managed. Staff lacked skills and education to manage difficult resident behaviors. The administrator confirmed staff documentation of 15-minute checks was not adequate to ensure staff were monitoring residents every 15-minutes. No audits were initiated to ensure staff maintained line of sight supervision of residents, especially on the evening and night shifts. The Administrator identified interventions were in the process of implementation. Staff were provided radios with headsets to communicate. Additionally, a video camera system was ordered and were to be installed after [DATE]. No audits for radio use were documented, but he had come to the facility on off hours to ensure staff were utilizing the radios. Additionally, the non-transparent adhesive covering on the nurse station window was planned to be removed, and replaced with see-through Plexiglas to enable the nurse at the nurse station to observe the hallway of the locked unit. Staff training was scheduled for 3/25/20, to address resident behaviors, but no behavior training had occurred to address R2's frequent altercations with other residents, and no resident-specific training was provided regarding behavior management for other residents with behaviors. Review of the staff schedule with the administrator identified he acknowleged the facility was not adequately staffed on the locked unit to ensure residents received line of sight supervision to reduce resident altercations. His goal was to have two NAs and one trained medication aid (TMA) or nurse on the locked unit on all shifts due to increase supervision. The facility was attempting to recruit new staff. Physicians were notified of behavioral issues, but were not yet included in review of resident behavioral management practices at the facility. The psychiatrist was not involved in non-pharmacological behavioral management practices at the facilty. He acknowleged facility staff had not received adequate training to be equipped enough to manage residents requiring behavioral management. He had not yet reviewed the facility assessment to ensure it reflected what services the facility was able to provide, but had stopped taking new admissions in order to develop a plan and provide training for staff to care for the residents residing at the facility. The Quality Assurance Performance Improvement (QAPI) program was needing to be improved. He had started an interdisciplinary team (IDT) meeting daily, which as done after stand-up in the mornings. Behaviors were addressed in IDT. IDT included the DON, the assistant director of nursing, the social services designee, the new activity director, and the dietary manger when they were available. No NAs were included in IDT team meetings as required. An IDT tool was being developed to use at the meetings to ensure review of interventions to ensure they were appropriate and effective. No policy had been developed yet to address behavior management.