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	265514	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARU DEVILLE NURSING CENTER	105 SPRUCE STREET FREDERICKTOWN, MO 63645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to provide protective oversight for two residents (Resident #1 and #3) with psychiatric diagnoses and a history of self harm who resided on the secured behavioral unit. On 02/25/25, Resident #3, who had and had a history of ingesting batteries, swallowed two AA batteries, which resulted in transfer to the Emergency Room (ER) and a procedure to remove the battery. On 02/26/25 at 12:44 P.M., Resident #1 became agitated and made threats of self harm by swallowing items. Resident #1 was placed on 15 minute checks, continued to make self harm threats, and ingested two AA batteries at 3:49 P.M., which resulted in an ER transfer. The facility did not provide documentation or evidence the 15 minutes checks were completed for Resident #1. The facility also failed to keep the environment free of accident hazards by not securing all of the rooms on the secured behavioral unit, when Resident #2 opened an unlocked clean utility room with four safety razors, a large bundle of plastic grocery bags, and two 12 cup coffee carafes full of hot coffee. Resident #2 had a history of ingesting harmful items. The facility census was 74.	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4/8/25

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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The administration was notified on 02/27/25 at 6:51 P.M., of an Immediate Jeopardy (IJ) which began on 02/25/25. The IJ was removed on 02/27/25, as confirmed by surveyor onsite verification.

The facility did not provide a policy regarding accidents/incidents.

1. Review of Resident #3's face sheet showed:
- Admission date of 08/24/24;
-Diagnoses of schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder), insomnia, anxiety, bipolar disorder (a mental health condition characterized by extreme mood swings, including periods of intense happiness or irritability (mania) and periods of deep sadness or hopelessness (depression)), suicidal ideations, suicide attempt, personality disorder (a mental health condition that involves long-lasting, disruptive patterns of thinking, behavior, mood and relating to others), borderline personality (a mental illness that severely impacts a person's ability to regulate their emotions), and post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event).

Review of the resident's Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure individuals are not inappropriately placed in nursing homes), dated 12/02/24, showed;
- Diagnoses of schizoaffective disorder, major depressive disorder, personality disorder, bipolar disorder, PTSD, mood disorder (a mental health problem that primarily affects a person's emotional state), attention deficit hyperactivity

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disorder (a neurodevelopmental disorder characterized by persistent patterns of inattention, hyperactivity, and/or impulsivity that interfere with daily functioning), reactive attachment disorder (a rare and severe mental health condition that affects children's ability to form healthy attachments with caregivers), and oppositional defiant disorder (a behavioral disorder characterized by persistent patterns of angry/irritable mood, argumentative/defiant behavior, and vindictiveness);
- Resident unable to care for self due to recent hospitalization due to swallowing batteries, flat affect, and urge to harm self;
- In September, the resident swallowed two batteries and stated to psychiatry the continued desire to harm self. On 10/05 (2024?), he/she swallowed batteries again;
- Resident had a mental health disability as defined by PASRR;
- Resident was withdrawn, depressed, paranoid, labile (emotional, involves sudden and extreme mood swings) mood, positive suicide attempt by overdose, history of self harm, received Department of Mental Health (DMH) services intermittently since childhood;
- Resident had behavioral difficulties or mental illness symptoms requiring 24 hour monitoring;
- Provision of structured environment, low stimulation, assess and plan for level of supervision required to prevent harm to self or others;
- Crisis intervention to include suicidal precautions. Plan to identify clear steps to be taken to support individual during crisis, specify who to contact for assistance, how staff will work together, as well as identify physician, and law enforcement;
- Support services of referral to DMH;

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- Community based psychiatric treatment required include: medication education and psychiatric follow up;
- Resident's needs at this time could be met in a nursing facility;
- Resident required following supports and services: behavioral support plan, structured environment, crisis intervention services, medication therapy, activity of daily living (ADL) program, and personal support network.

Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 02/11/25, showed:
- Cognition intact;
- Clear speech and able to understand
- Independent with eating;
- Independent for all ADLs and mobility.

Review of the resident's revised Care Plan, dated 02/18/25, showed:
- Resident had a court appointed guardian;
- Resident had impaired psychosocial skills as evidenced by behaviors;
- Resident had impaired decision making/poor judgment and resided on a secured behavior unit;
- Resident had experienced trauma with a diagnosis of PTSD;
- Resident was at risk to harm self or others. Resident was at risk of elopement. There was a history of self harm and suicide attempt by overdose. Resident had frequent suicidal thoughts and self injury behaviors, multiple suicide attempts, severe self mutilating behaviors, overdose, and history of swallowing glass and batteries; divert resident's behavior by using coping skills, don't confront resident, allow resident to explore feelings, report any suicidal

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thoughts or self harming to the nurse immediately.
- On 08/26/24, the resident swallowed a AA battery from the TV remote and was sent to the ER. The resident transferred to another hospital due to trying to jump out of the ambulance several times during the transport. Resident placed on 1:1 until 09/01/24 upon return;
- On 09/20/24, the resident told a CNA he/she had swallowed a battery. A battery was missing from the TV remote. The resident was sent to the ER and transferred to another hospital for a procedure to remove the battery. The resident returned from the hospital and found his/her belonging removed from the room. The resident became aggressive, threw the side table, water pitcher, and attempted to punch the wall. Two Certified Nurse Aides (CNAs) put the resident into a primary restraint technique (PRT - a method designed for one person to safely and effectively restrain a person without causing pain or injury) hold and the physician gave orders for two injections. Resident to be placed on 15 minute checks upon return;
- On 02/25/25, the resident reported to staff he/she asked another resident for batteries that he/she then swallowed. They were AA batteries. The resident was placed on 1:1 and sent to the ER where a procedure occurred and the batteries were removed. Resident placed on 1:1 upon return;
- The resident received psychotropic (drugs that affect the brain and nervous system, influencing mood, behavior, and mental processes. They are used to treat a wide range of mental health conditions) medications. Monitor for side effects and report to physician if observed: Poor coordination, dry mouth, increased heart rate, urinary retention, agitation, hallucinations,

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orthostatic hypotension, drowsiness, blurred vision.

Review of the resident's Nurse's Notes showed:
- On 02/25/25 at 1:59 P.M., the resident reported to staff that he/she asked another resident for some batteries and swallowed two AA batteries. Complained of feeling upset, agitated, and had an urge to swallow the batteries. The resident was placed 1:1, called the physician, and sent to the ER;
- On 02/25/25 at 5:54 P.M., the ER called and reported they found two batteries the resident swallowed in x-ray and was being sent to another hospital for further treatment;
- On 02/26/25 at 8:36 A.M., the hospital called and reported the procedure was completed and both batteries removed. The resident would be discharged back to the facility.

2. Review of Resident #1's PASSR, dated 10/27/21, showed:
- Resident met the federal definition of serious mental illness but didn't require specialized services;
- Resident met the federal definition of intellectual disability but didn't require specialized services;
- Resident met the skilled nursing facility admission requirements;
- Diagnoses of schizoaffective (a condition characterized by abnormal thought processes and deregulated emotions), bipolar disorder (a mental disorder that causes unusual shifts in mood), depression, adult victim of sexual abuse, intellectual disability, Asperger's (a developmental disorder that falls under the broader category of autism spectrum disorder), and elopement risk;
- Resident had auditory hallucinations (where you hear, see, smell, taste or feel things that appear

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to be real but only exist in your mind) and nightmares of abuse, poor insight, referral notes of paranoia (an unfounded and/or exaggerated mistrust of others), disorganization, nonsensical speech;
- Current psychiatric support services at time of evaluation included outpatient psychiatric follow up and a secured behavioral unit;
- One overdose suicide attempt;
- Resident was childlike;
- Support and/or services needed include: community based psychiatric treatment, behavioral support/supervision, day programing/treatment/partial hospital program, financial assistance, medical follow up, individual counseling, medication education, referral to department of mental health, residential services, skills training, and social work services;
- Due to nature of trauma and recent elopement from a residential care facility, the nursing facility was the least restrictive setting. Would need long term trauma based therapy;
- If admitted to a nursing facility, needed assessment and implementation of behavioral support plan to include monitoring of behavioral symptoms and provision of behavioral supports;
- It was recommended the resident received behavior unit services for structure and stability;
- Crisis intervention should include safety plan to address elopement behaviors, stress reactions related to trauma, and plan with clear steps to support resident during a crisis situation;
- Recommended services to include: behavioral support plan, structured environment, crisis intervention services, discharge planning, medication therapy, ADL program, and personal support network.

Review of the resident's face sheet showed:

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- Admission date of 06/05/24;
- Diagnoses of bipolar disorder, major depressive disorder (long-term loss of pleasure or interest in life), and anxiety (persistent worry and fear about everyday situations).

Review of the resident's quarterly MDS, dated 02/18/25, showed:
- Cognition intact;
- Verbal behavior directed toward others;
- Other behavior not directed toward others;
- Wandering;
- Clear speech and able to understand;
- Independent with eating with a mechanically altered diet;
- Independent for all ADLs and mobility.

Review of the resident's Care Plan, last reviewed on 12/03/24, showed:
- Required an anti-anxiety medication;
- Required an anti-depressant medication;
- Resident experienced trauma;
- Resident had behavior symptoms and resided on a secured behavioral unit due to behaviors. Resident was at risk of harm to self or others and elopement. Resident had an overdose suicide attempt, scared of male peers, and was childlike;
- On 09/14/24, the resident reported to staff another resident triggered him/her talking about suicide. The resident brought a glass covering from a light in the bedroom to staff and said he/she was considering using it to slit his/her wrists. Staff encouraged resident to focus on progress and not be influenced by others. Resident placed on 15 minute checks;
- On 11/17/24, the resident became upset because another peer had extra soda. The resident cursed at staff and slammed his/her door. The resident pointed out an abrasion to the

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left wrist when checked on. Said he/she did it last night, but didn't look fresh and no blood present. Staff asked resident about reason of being upset and spoke with resident. Staff encouraged coping skills to be used. Items removed from room that could be a safety hazard and placed on 15 minute checks. Resident is using a marker to draw on arm instead of something to scratch it;
- On 12/22/24, the resident tore off the right index finger fingernail related to being upset over another person. Resident educated by staff on not harming self and possible infection from injury;
- On 12/27/24, the resident had an increase in behaviors and had become verbally and physically aggressive toward staff, peers, and not easily re-directed. Notified physician who ordered a medication change;
- On 01/23/25, the resident had a nightmare and became upset. Staff spoke to resident about nightmare not being real and resident being safe. Resident calmed down;
- On 01/29/25, the resident reported using a coloring pencil to self harm to the left wrist resulting in a 1 centimeter (cm) superficial cut. Staff spoke with resident, encouraged to focus on self and use coping skills. Coloring pencils removed from resident;
- Divert resident's behavior by using coping skills, don't confront resident, allow resident to explore feelings, report any suicidal thoughts or self harming to the nurse immediately.
- Resident required psychotropic medications related to diagnoses of bipolar disorder, restlessness, and agitation;
- Resident had a legal guardian.

Review of the resident's Nurse's Notes showed:
- On 02/26/25 at 9:56 A.M., the resident worked

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with therapy before a smoke break and missed it. When the resident returned to the unit, the resident demanded staff to take him/her to smoke. Before staff could respond, the resident slammed his/her door and was verbally aggressive. The nurse redirected the resident with 1:1 conversation and took the resident to smoke;
- On 02/26/25 at 12:44 P.M., the resident had increased behavioral outbursts made self harm threats of swallowing pens and pencils. When asked why, the resident said, "I don't know, I just do." The pens and pencils were removed from the resident's possession. The resident was placed on 15 minute checks and in the dining room eating lunch. The resident appeared calm with a normal affect;
- On 02/26/25 at 3:49 P.M., the resident came to staff, smiled, and said, "I swallowed a battery." The nurse asked why since he/she didn't have a history of swallowing batteries, and the resident said, "I don't know, I just did." The resident said it was AA batteries from his/her radio. The nurse looked in the radio and found no batteries in it or any his/her room. The Director of Nursing (DON) and the physician were notified with an order to send to the ER for treatment. The guardian was notified of the transfer;
- On 02/26/25 at 5:09 P.M., the resident returned from the ER with instructions to allow the resident to pass the batteries. The resident was placed on 15 minute checks for monitoring. Batteries were removed from his/her room. Resident denied any active self harming thoughts at that time;
- On 02/27/25 at 1:37 A.M., the resident complained of stomach pain earlier in the shift;
- On 02/27/25 at 9:13 A.M., the resident said he/she wanted to kill him/herself and would do whatever it took to do it. The resident placed on

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1:1 until not suicidal.

Review of the resident's 15 minute checks showed:
- No documentation from when the resident returned from the hospital on 02/26/25 at 5:09 P.M., through 02/27/25 at 6:00 A.M.

During an interview on 02/27/25 at 11:00 A.M., Resident #1 said he/she was on 1:1 because he/she had been bad. He/She swallowed batteries from his/her radio. The hospital said he/she had to pass them.

During an interview on 02/27/25 at 11:10 A.M., Certified Nursing Assistant (CNA) A said he/she was Resident #1's primary 1:1 for the day shift on 02/26/25. Resident #1 threatened to self harm multiple days resulting on 1:1. The resident swallowed two AA batteries on 02/26/25. The resident went to the ER.

During an interview on 02/27/25 at 4:56 P.M., CNA E said he/she worked last night and did 15 minute checks when Resident #1 returned. Resident #1 swallowed batteries, went to the hospital, and returned. CNA E came in on 02/27/25 at 6:00 P.M., and said Resident #1 was never on 1:1. CNA E said the 15 minute checks were not documented, but should have been.

During an interview on 02/27/25 at 11:20 A.M., CNA B said Resident #1 was on 1:1 for self harm by swallowing batteries. Resident #1 went to the hospital and was currently figuring out emotions and why he/she did the action.

During an interview on 02/27/25 at 11:25 A.M., CNA C/Unit Coordinator said Resident #1 was

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placed on 1:1 on the morning of 02/26/25, due to getting into an argument with another resident who told him/her to kill himself/herself and to swallow more batteries. Resident #1 became suicidal and was placed on 1:1. When swallowed the batteries on 02/26/25, the staff sent the resident to the ER. He/She saw no care instructions for the resident. The nurse told him/her to watch Resident #1's fecal material for the passing of the batteries. He/She couldn't find the documentation of the 15 minute checks when Resident #1 returned from the hospital.

During an interview on 02/27/25 at 6:00 P.M., CNA F said Resident #1 was monitored last night after returning from the hospital. He/She wasn't aware of any 15 minute checks on Resident #1, but did 10 to 15 checks just because of coming back from the hospital from self harm. Resident #1 had to pass the batteries. No documentation of the checks were done last night, because no one said to do them. He/She had no training provided at this facility.

During an interview on 02/27/25 at 2:30 P.M., CNA C/Unit Coordinator said the charge nurse made the decision on if a resident was placed on 15 minute checks or 1:1. The resident stayed on that monitoring for usually 72 hours and it should be documented in the nurse's notes. He/She wasn't aware of any policy and procedure regarding resident checks, but the whole unit was on 30 minute checks unless it was increased individually. If a resident had verbal threats of self harm or harm to others, they were placed on 15 minute checks. If that escalated to physical harm, then it was moved to 1:1 until they returned to their baseline.

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During an interview on 02/27/25 at 2:45 P.M., the Assistant Director of Nursing (ADON) said the charge nurse decided if a resident was on a 15 minute check or 1:1. There wasn't a policy or procedure for the nurse to follow. If the nurse was not sure, they were able to call the DON or ADON for directions. The point was to keep the resident safe with the least restrictive environment.

During an interview on 02/27/25 at 3:45 P.M., CNA B said if a resident expressed a desire to harm themselves, then he/she let the nurse know and kept the resident in sight.

During an interview on 02/27/25 at 3:55 P.M., CNA C/Unit Manager said if a resident expressed a desire to self harm, he/she redirected and started coping skills. If the resident couldn't be redirected, the nurse was notified. Most of the residents liked to write their feelings down.

During an interview on 02/27/25 at 4:38 P.M., Licensed Practical Nurse (LPN) D said he/she was told in report Resident #1 had swallowed two batteries. Resident #1 went to the hospital and they sent him/her back to pass the batteries. Resident #1 was on 15 minute checks and the staff checked the residents that often anyway on the secured behavioral unit.

3. Observation on 02/27/25 at 3:58 P.M., of the secured behavioral unit showed:
- Resident #2 opened an unlocked clean utility room door with four safety razors in a tub above the sink, a large bundle of plastic grocery bags, and two 12 cup coffee carafes full of hot coffee;
- Another door beside the clean utility room was open and a bucket of mop water sat in it;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265514	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARU DEVILLE NURSING CENTER	105 SPRUCE STREET FREDERICKTOWN, MO 63645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

- Multiple tubes of toxic acrylic paint sat on the counter in the dining room.

During an interview on 02/27/25 at 4:33 P.M., CNA G said the water in the mop bucket on the secured behavior unit had a triple-multisurface cleaner poured into it.

During an interview on 02/27/25 at 6:00 P.M., CNA F said Resident #2 had a history of swallowing items and batteries

4. During an interview on 02/27/25 at 5:00 P.M., CNA C/Unit Coordinator said an administrator from another facility came and did some training on self-harm, behaviors, and de-escalation. Resident #2 had a history of swallowing items and batteries. Generally, Resident #3 would talk real slow and then start cursing and become loud. That's when he/she was going to self harm. No razors should be in the clean utility room. The clean utility room door should be locked and staff should ensure the door was locked after exiting. He/She had the keys to the clean utility closet but all staff knew to lock it. The utility room with the mop bucket was left unlocked and the water should be just regular water because the residents like to mop their rooms to feel productive.

NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level "J". Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265514	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARU DEVILLE NURSING CENTER	**105 SPRUCE STREET FREDERICKTOWN, MO 63645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the "D" level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). Complaint MO249053	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17527	A. BUILDING: _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARU DEVILLE NURSING CENTER	105 SPRUCE STREET FREDERICKTOWN, MO 63645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class I* 1. Please refer to F689. *The higher classification merited due to the effect on the resident. NOTE: At the time of the complaint investigation, the violation was determined to be at an imminent danger Class I level. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the class II level. Complaint MO249053	A4074		

PLAN OF CORRECTION

Provider/Supplier Name:	Claru Deville Nursing Center
Street Address, City, Zip:	105 Spruce Street 63645 Fredericktown, MO.
Date of Survey:	02/27/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265514

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is submitted as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of Claru Deville Nursing Center as to the accuracy of the surveyor's findings, nor the conclusion drawn there from. The facility's submission of this POC does not constitute an admission on the part of the facility that the findings cited are accurate, that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later than 3/3/2025	
F689	The facility immediately locked the door of the utility room on the secured unit.	2/27/2025
	Charge nurse and CNA on duty removed batteries from all immediate access areas.	2/27/2025
	The Nurse on duty will perform checks on the behavior unit every shift to ensure all doors are locked and secured. Nurse on duty will sign off on checks on the 24-hour report.	2/27/2025
	DON will monitor 24 hour reports weekly X 3 months to ensure compliance.	2/27/2025
	Maintenance will install self-locking door knobs on the utility rooms on the secured unit and report completion to Administrator. Maintenance will report any issues with installation at monthly QAPI meetings	2/28/2025
	Staff will be educated regarding documentation of 15-minute checks	2/27/2025
	DON or ADON will educate staff regarding self-harming behaviors and appropriate interventions for those with self-harming behaviors	2/27/2025

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

	DON will audit weekly to ensure all staff have been educated. X 3 months	2/27/2025
	Any resident making threats of self-harming behaviors will be evaluated by a licensed nurse and placed on 15-minute checks. Facility psychiatrist will be notified of any self-harming behaviors within 30 minutes of occurrence.	2/27/2025
	Resident's #1 and #3 are on 15-minute checks and will remain on 15-minute checks until threats of self-harm have ceased and residents are able to articulate to the licensed nurse that they are no longer having desires to self-harm. CNAs on duty on the secured unit will document 15-minute checks, charge nurse will verify completion each shift.	2/27/2025
	When resident #3 verbalizes that she wants to self-harm by swallowing, objects resident #3 verbalizes she is wanting to swallow will be removed from immediate access.	2/27/2025
	Within 22 days of receipt, facility will enter into an agreement with a quality improvement organization that specializes in behavioral health programs.	4/2/2025
	The facility will send the agreement to the Section for Long-Term Care Regulation.	4/3/2025
	The contracted organization (Omnia) shall provide in writing updates every two weeks to facility and the Section for Long-Term Care Regulation.	4/9/2025
	The facility within 30 calendar days of signing of the agreement, ensure that the administrator, nursing staff, social service designee, activities staff and direct care providers are enrolled in Tools of choice training.	4/9/2025
	All trainings will be monitored for completion by the Administrator/ DON and any updates, concerns, and completion issues will be discussed in monthly QAPI meetings.	4/14/2025
	The facility shall show proof of enrollment and provide monthly updates on training progression to the Section for Long-Term Care Regulation.	4/3/2025
	The facility within 30 calendar days of signing of the agreement ensure that the administrator, nursing staff, social service designee, activities staff and direct care providers become certified in Mental Health First Aid.	4/14/2025
	All trainings will be monitored for completion by the Administrator/ DON and any updates, concerns, and completion issues will be discussed in monthly QAPI meetings.	4/14/2025
	The facility will provide proof of enrollment and provide monthly updates on training progression to the Section for Long-Term Care Regulation.	4/3/2025

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.