STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505296	A. Building B. Wing	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis of Bellingham	3121 Squalicum Parkway Bellingham, WA 98225

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Actual harm Residents Affected - Few	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** 37035 Based on observation, interview and record review the facility failed to ensure one of one resident (1) reviewed for Post-Traumatic Stress Disorder (PTSD) treatment and services to attain their highest practicable mental and psychosocial wellbeing and failed to receive recommended psychiatric evaluation prior to a gradual dose reduction (GDR) regarding their psychotropic medications. This failure caused Resident 1 harm in the form of undue psychological distress and placed other residents with behavioral health care at risk of unmet psychological care and treatment. Finding included . Resident 1 was admitted to the facility on [DATE] with diagnoses to include history of mental health concerns including Post Traumatic Stress Disorder (PTSD) Complex, Unspecified Anxiety Disorder, Major Depressive Disorder, Panic Disorder and Conversion Disorder with seizures and/or convulsions. Review of a State Hot Line Report dated 05/12/2022 at 9:41 AM, showed Resident 1 had reported that they were concerned that they had extensive PTSD. The resident stated that it took the psychiatrist, and staff years to get her medication tapered down. Their medication was decreased due to their therapy. The resident stated that they had reach 3 milligram (mg) and that was their limit and that they had told the facility. The resident stated that they took Clonazepam (Klonopin), an antianxiety medication, and was on 1mg a day. The resident stated that they should be on 3 mg. The resident stated that they had yelled at people today because their medication was not correct. The resident stated that they now would lose their train of thought. The resident stated that the facility staff was not listening to them of the need to increase their medication. The resident stated that the staff did not inform them of the change and the decrease in their daily medication. The resident stated that they were losing their ability to keep themself together. The resident stated that would be alleviated if they had the correct medication dosage. The resident stated that they had found a dosage that worked for them, and the facility was not listening to their needs. (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 0742 Level of Harm - Actual harm Residents Affected - Few	In an observation and interview on 05/12/2022 at 2:24 PM, Resident 1 was lying in bed and stated that they were sick and tired. Resident 1 stated that they were extremely angry over the reduction of their Klonopin which affected them psychologically. The resident stated that they had asked for an appointment with the doctor about their medication and not one nurse had advocated for them. The resident stated that they had been on Klonopin for years, back in the 1990's they were on 15 mg as they were a walking psychopath. The resident stated that they had undergone therapy and was able to gradually reduce the dose to 3 mg daily. The resident stated that now with the current reduction of the Klonopin, they were a blubbering idiot. The resident stated that they had not been involved in the discussion of the dose reduction of the Klonopin but was told the State required it to be tested down. The resident stated that they felt like wrecking their room, like a five- or six-year-old. The resident stated that they were on the Klonopin as they had severe PTSD. The resident stated with description that their PTSD was from horrible and traumatic childhood sexual assaults and molestations. Resident 1 stated that the nurses at the facility knew their history as well as the Administrator and the Director of Nursing Services (DNS). The resident continued to express their thoughts and made statements about their life going from one topic to another without consistency in the topic. The resident stated that they had been having so much trouble and felt like they were losing their mind with the reduction of their Klonopin. Resident 1 stated, I am terrified about repercussions from the PTSD, had heard a staff member was a sadist from others. Resident 1 stated, I do not want to go off on someone. I do not want to strike them. I do not want to get upset. I am scared, and pointed to a sign on wall which had the Klonopin dose as twice daily. The resident stated to this day they cannot stand to have anyone behind them, that they were hypervigilant as their PTSD was so severe. The resident stated that their dosage 10 mg of melatonin, 3 mg of Klonopin and usually Valerian Root worked, but they had cut down their medication and now they were not sleeping well. The resident stated that in the past they had gotten themself off the Klonopin but did not sleep for 10 months. The resident stated that they thought they did not need it, that was back . it was a long time ago in their late 30's and early 40's. The resident stated that they would wake up out of nodding off all night long, and their provider had asked why the hell did you do that, coming off Klonopin. Resident 1 stated that their prior provider had said it was imperative to stay on the Klonopin. The resident stated, I am embarrassed about the way I am, but I am the way I am. I just want to go to sleep and have good thoughts. The resident repeated themselves and again stated, I just want to go to sleep and have good thoughts. Review of the resident's Level II Preadmission Screening and Resident Review (PASRR) dated 08/12/21, showed the reviewing Psychiatrist noted that decreasing a benzodiazepine (Klonopin/Clonazepam) by 50% would not likely be tolerated and consultation with psychiatry prior to attempt to taper and taper very slowly. Review of the Significant Change Minimum Data Set (MDS) depression section assessment dated [DATE], showed the resident scored a '3' which was indicative of minimal to normal depression. Review of the Quarterly MDS depression section assessment dated [DATE], three months later, showed the resident had a scored of '9' which was of a decline in mood from minimal/normal depression to mild depression. Review of the resident's Care Plan printed on 05/23/2022, showed no noted intervention related to the recommended psychiatry consult prior to decreasing the resident's Klonopin/Clonazepam. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Review of the February 2022 Medication Administration Record (MAR)showed the resident had an order for Klonopin/Clonazepam 1 mg every eight hours as needed and received 61 doses of which all were noted to have been effective. The Behavior Monitor Record (BMR) showed 115 episodes of anxiety behaviors of which 10 shifts for the month were not documented related to the use of the resident's Klonopin/Clonazepam. Review of the Psychotropic Medication Review dated 03/01/2022 showed an incomplete assessment with no noted assessment of the frequency of the resident's behaviors, psychoactive medication, or side effects. Noted that the DNS made medication suggestions related to decreasing the resident's Klonopin. The team members who contributed to the psychoactive medication review did not include Psychiatry. Review of the Progress Note dated 03/19/2022, showed Primary Care Provider okayed recommendations to discontinue Clonazepam 1 mg every eight hours as needed and ordered Clonazepam 1 mg every 12 hours as needed. The resident was noted to have anxiety with difficulty redirecting and was needing this medication to help with their anxiety, so discontinuation was not an option. The resident was noted to be informed of the change in frequency. Review of the Progress Note dated 03/20/2022, the resident stated they were not informed with the change in their Clonazepam order. The resident stated that they were going to call the State and was going to sue the facility. The resident stated, What don't they understand about PTSD?! Review of the Staff C, Advanced Registered Nurse Practitioner (ARNP), Internal Medicine Progress Note dated 03/22/2022, showed that nursing had reported that the resident had been having increased outbursts. The resident also endorsed recent increased anxiety attacks since recent Klonopin dose reduction. Psychiatric evaluation was recommended for further evaluation. Review of Staff D, ARNP, Internal Medicine Progress Note dated 03/23/2022, showed the resident endorsed anxiety mostly due to PTSD from history of childhood abuse. The note showed the resident reported increased anxiety attacks since the Klonopin dose adjustment and staff also reported increased behaviors. Review of Staff C, ARNP, Internal Medicine Progress Note dated 03/30/2022, showed the resident continued to request an increase in Klonopin due to worsening anxiety from PTSD. The resident reiterated previous management with the higher dose provided much benefit and did not think the current regimen was effective. Review of Staff B, Psychiatric Specialty Physician Assistant (PA) Progress Note dated 03/31/2022, showed the resident continued to request an increase in Klonopin due to worsening anxiety from PTSD. The resident reiterated previous management with the higher dose provided much benefit and did not think the current regimen was effective. Review of the March 2022 MAR showed the resident had an order for Klonopin/Clonazepam 1 mg every eight hours as needed and received 43 doses of which all were noted to have been effective aside from one administration up till 03/19/2022 when the order was reduced to every 12 hours and received 12 doses. The BMR showed 189 episodes of anxiety behaviors of which 10 shifts were not documented related to the use of the resident's Klonopin/Clonazepam. (There was no documentation of medication administration or behavior monitoring from the evening of 03/21/2022 through 03/24/2022) (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Review of the Psychotropic Medication Review dated 04/02/2022, showed an incomplete assessment and with a noted recommendation to hold the resident's Citalopram for seven days. No psychiatric staff participated in the GDR meeting. Review of Staff B, Psychiatric Specialty PA, Progress Note dated 04/08/2022, showed the resident continued to request for an increased clonazepam dose due to worsening anxiety from PTSD. The resident continued to reiterate the previous management of Klonopin 1 mg three times daily proved much benefit and did not think current regime was effective. The Psychotropic med review decided to hold citalopram (an antidepressant) for seven days which was an abrupt withdrawal of an SSRI (selective serotonin reuptake inhibitor) which could cause rebound symptoms and the citalopram would be restarted. Additionally, it was noted Staff B did not want the resident off their citalopram while the resident's anxiety symptoms were uncontrolled. The resident's mood and affect were noted to be angry. Review of the Psychiatric Specialty PA Progress Note dated 04/15/2022, showed that the resident continued to request their Klonopin/Clonazepam be increased due to worsening anxiety from PTSD. The resident continued to reiterate previous management with clonazepam of 1 mg three times daily provided much benefit and did not think the current regime was effective. Review of the April 2022 MAR showed the resident had an order for Klonopin/Clonazepam 1 mg every 12 hours as needed and received 47 doses of which all were noted to have been effective. The BMR showed 236 episodes of which two shifts for the month were not documented related to anxiety behaviors related to the use of the resident's Klonopin/Clonazepam Review of the May 2022 MAR from 05/01/2022 through 05/15/2022 showed the resident had an order for Klonopin/Clonazepam 1 mg every 12 hours as needed and received 23 doses of which all were noted to have been effective aside from one administration. The Behavior Monitor Record (BMR) showed 101 episodes of which five shifts reviewed for half of the month were not documented related to anxiety behaviors related to the use of the resident's Klonopin/Clonazepam In a follow up interview on 05/20/2022 at 10:49 AM the resident stated that they had been waking up with night terrors for the last three nights, having flashbacks reliving things from their past. (Indicative of exacerbation of PTSD symptoms). The resident had expressive flight of ideas from one topic to another. The resident stated that their agreement was that when the Morphine Sulfate (MS) was gone it was all on them and asked meds to be taken out of their formulary on conditions. The resident stated that they had been off the MS as of yesterday or day before, and they were supposed to reduce hydrocodone and they took a whole med away. The resident stated that they were promised once the MS was discontinued, the facility would give them back the Klonopin the following day. Reviewed the resident's Klonopin order which was as needed (PRN), the resident stated that it should have been scheduled and was going back to the hospital's clinic. The resident stated that they were not med needy but would ask for pain medication. The resident stated that they had said, Let's see how far they could go down on pain meds till unable to handle. The resident stated that they would like to get their old doctor and psychiatrist back. The resident stated, I think it is cruel and unusual punishment. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	In an interview on 05/24/2022 at 12:02 PM, Staff A, Licensed Practical Nurse/ Resident Care Manager (RCM), stated that the facility had a GDR quarterly review with residents who were on psychoactive medications. Staff A stated that annually they would try to get resident's psychoactive medications to the lowest dose with a trial and the resident would be on alert for one to two weeks. Staff A stated that if the nursing documentation showed the GDR was not working, they would inform the physician, reassess and if provider felt the need to go back to the prior dose, they would make a note the GDR failed. Staff A stated that they review behaviors on the Behavior Monitor Documentation (BMD) and progress notes in relations to the medications purpose, example an antidepressant to monitor for signs and symptoms of depression. Staff A stated that Social Services would do the preparation for GDR meetings with review of the resident's the BMD and progress notes. Staff A stated that the GDR meeting would have the pharmacist, DNS, RCM, and Social Service Director (SSD) in the meeting. Staff A stated that they were trying to coordinate new psychiatric provider as well now. Staff A reviewed and confirmed the 03/01/2022 Psychotropic Medication Review for Resident 1 was not complete and had no noted targeted behaviors, but they should be noted. Staff A stated that all psychoactive medications should have been reviewed and stated that were a lot of missing pieces that were not noted as reviewed. Staff A stated that the SSD and DNS in correlation would review in GDR and have pharmacist review, but someone should be documenting everything. Staff A reviewed the progress notes from 03/01/2022 and stated that it was a pre generated note from the GDR UDS, that there was no but could add addition items. Staff A reviewed the resident's PASSR level II recommendations and confirmed no there was documentation it had been reviewed. Staff A stated the resident's 04/02/2022 GDR had no indication the PASRR level II was reviewed, and no psychiatric consult was obtained. Staff A stated they felt SSD should review the PASSR recommendations and bring up during the GDR meeting, the RCM usually would not review the PASRR during GDR but would with the resident's care conference. Staff A confirmed the PASRR level II had noted a psychiatric consult prior to attempted [NAME] and [NAME] slowly was recommended. Staff A stated that there had not been a psychiatric consult prior to the resident's GDR. Staff A stated that the facility's policy was to do a GDR regardless, and not everything was reviewed. In an interview on 05/20/2022 at 12:27, Staff B, Psychiatric Specialty Physician Assistant stated that they had not been previously told about resident's GDR meetings and often there would be a discontinuation of the residents' psychoactive medications without talking to the resident and then they would see the resident and they would want to get back on their medications. Staff B stated that the facility had recently had a change in positions since the prior DNS and SSD. Staff B stated that Resident 1 had a PTSD assessment score that supported the routine use of Klonopin 1 mg three times daily. In an interview on 05/25/2022 at 2:02 PM, the DNS stated that they had been with the facility for a couple of weeks. The DNS stated that their expectation was to have monthly GDR meetings. The DNS stated that the upcoming Friday would be their first GDR with the facility. The DNS stated that they would have social services, pharmacy clinician, the psychiatric provider and would review long term residents and admissions. The DNS stated they would document in the meeting for appropriateness, necessity, and medication effectiveness. The DNS stated that they would review who they could provide a lower medication dose. The DNS stated that they would review general behaviors, would create a robust care plan tailored to the resident. The DNS stated that they review resident behaviors and psychotropic usage. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	In conclusion the facility failed to ensure Resident 1, who had a long history of PTSD from childhood sexual trauma, received accurate and complete assessments of their behaviors in association with GDR of their mental health medications and failed to ensure the resident receive the recommended psychiatric evaluation prior to receiving a dose reduction of their mental health medications resulting in harm related to unnecessary increased anxiety and undue distress. Reference WAC 388-97-1060(1)(3)(e)