Table 1: Deficiencies at F742 and Strategies to Prevent These Types of Deficiencies in Your Facility

Description of Deficiency	Considerations to Prevent Deficiencies
Uncertainty surrounding when mental health professionals will visit the facility and how to acquire their services (process for consults), and realistic timelines for mental health consultations.	Examine policies/procedures related to consultations. Policies should be developed in collaboration with nursing, social work, your medical director, and the mental health consultant(s) who will come to your facility. Procedures should specify staff roles when consultation with a mental health professional is ordered. All relevant stakeholders should be educated on the process. Input from the consultants who come to your facility is essential when it comes to determining what would be realistic in terms of consultation timelines. If a provider requests a mental health evaluation within 24 hours, is that realistic in consideration of your policy? If the provider feels that the resident's condition is such that an immediate psychiatric consultation is required, should transportation to a local hospital ER department (where a psychiatrist would be required to see the resident) be more appropriate?
Situations in which a resident asked to see a counselor, but one was not procured by the facility.	Policies and procedures need to be developed in collaboration with all relevant stakeholders to determine how to proceed when a resident makes a request to see a counselor. Recall that even if family members disagree, a resident has the right to see a counselor (some family members may have a vested interest in the resident not divulging certain things to counselors, so in some cases, resistance will be seen). This is true even of residents with a durable power of attorney (POA). The POA document does not give absolute decision-making to the person identified as the power of attorney unless the resident has been deemed incapable. Facilities should consult with their attorney when developing these policies because different states interpret mental health concepts such as capability and capacity differently.
Resident not being able to see the mental health provider of their choice.	If a resident was seeing a mental health professional in the community prior to admission to a nursing home, it should be determined if that professional is willing to continue to provide care at the facility. While tele-psychiatric visits can be an option, not all therapists provide services remotely. If the mental health professional providing care/services to the residents in the community is either unwilling or unable to come to the facility to see the resident after they are admitted, the resident should be told this prior to making the admission decision. At that point, the resident and/or family/responsible party can discuss whether they wish to continue with the admission decision.
Failing to obtain psychiatric consultation in a timely manner.	Policies surrounding obtaining psychiatric consultation should be developed with the input of all relevant stakeholders—including the psychiatric provider. The policy should outline the process for procuring a mental health provider appointment, and facilities should consider contracting with appropriate mental health providers in their geographic location for the purpose of psychiatric consultation when ordered. If you happen to live in an area that is geographically disadvantaged in terms of access to psychiatrists, then contracting for tele-psychiatric services may be considered. Another suggestion would be an ongoing shift report policy that the consultation remains on the nurse's radar until the consultation is scheduled and takes place.
Failing to address referrals to drug and alcohol treatment services.	Policies surrounding addiction services are evolving in many nursing facilities. The likelihood of a resident in your facility requiring treatment for addictive disorders will most likely increase as the opioid epidemic continues to worsen. Relevant policies and procedures need to be developed with the input of all relevant stakeholders. A geographic survey of available drug/alcohol treatment providers in your area would be useful, as would reaching out to several of these providers and working towards partnerships for counselors to come to the facility (if possible) to provide drug/alcohol-related services. If the resident is involved in community support services (e.g., Alcoholics Anonymous or Narcotics Anonymous), learning where meetings are available can be useful.
Issues with 30-day notices of discharge due to the inability to meet care needs.	Prior to admitting a resident with a background of mental health issues/concerns, attention needs to be paid to the type of mental health issue that the individual has and determining a history of violence directed toward self or others. Is there a history of medication noncompliance resulting in severe symptoms that can place the resident (or others) at risk? If this information is not readily available, the administrator needs to consider whether to admit residents with potentially severe and persistent mental illness without additional information. Recall that once the resident is admitted to your facility, they are your resident, and discharging them via the 30-day notice of discharge due to inability to meet care needs is fraught with difficulties. The first question that you may face during an abbreviated survey (initiated by a resident or family complaint after receiving a 30-day notice) by the Department of Health surveyor might be, "If you couldn't meet the resident's needs, why did you admit them?" While facilities need to achieve baseline occupancy levels to maintain financial solvency, there is also concern for the longitudinal implications of admissions that you could not adequately care for.

Description of Deficiency	Considerations to Prevent Deficiencies
Use of psychotropic medications (only) to treat behavioral difficulties.	While a variety of mental health/behavioral concerns are often treated with medications, many of these medications are either partially effective or ineffective.3 Drugs used to treat depression or anxiety disorders (such as Paroxetine or Paxil) can abruptly stop working—a phenomenon known as poop out.4 Because of this, psychotherapy is an essential part of treating both depression and anxiety. When facilities lack staff with knowledge of treatment/care planning for persons with mental health concerns/behavioral difficulties, facility administration should consider partnering with mental health professionals to assist in this process. Recall that once the plan of care is developed for the resident with mental health issues/behavioral difficulties, the care plan needs to be implemented on a consistent basis.
Failing to recognize/treat predictable side effects of medications and failing to make psychiatrist/ psychiatric-mental health nurse practitioner aware of side effects.	Nursing staff are responsible for monitoring the resident's response to treatment, including medications. Inherent in that responsibility is reporting any evidence of untoward reactions to the prescriber. This is particularly true of psychotropic medications, which could have a variety of predictable side effects. Ongoing evaluation of the resident should consider the potential side effects associated with psychotropic medications, and the prescriber of that medication should be made aware of any potential adverse reactions or side effects that put the resident at risk for harm or injury. Does your facility have policies/procedures for baseline and periodic testing for movement disorders for residents receiving antipsychotic medications? Who is trained to do this testing? Is it being done consistently? Consider baseline and annual in-services for all nursing staff on psychotropic medications and side effects, such as dystonic reactions, tardive dyskinesia, serotonin syndrome, and neuroleptic malignant syndrome.
Failure to document non-pharmacologic interventions and lack of consistent evidence of implantation of plan of care.	Even when care-planned interventions for the treatment of mental health issues are adequate, there needs to be evidence that these interventions were consistently used. Additionally, how the resident responded to the intervention should be documented. How is this done in your facility? If you aren't certain, review relevant policies/procedures and train all relevant staff on how to implement and document nonpharmacologic interventions as well as other care-planned interventions for residents with mental health issues/behavioral concerns.
Lack of consistent implementation of suicide policy/protocols.	Every suicidal statement should be taken seriously, and the facility's protocol should be adhered to. If your facility does not have suicide policies and procedures, then they need to be developed in conjunction with all relevant stakeholders, including the medical director, and consulting psychiatrists and psychologists as appropriate. Additionally, all staff in all departments need to be aware of the policy and how to proceed if a resident tells them that they are thinking of suicide. Even more challenging, however, is dealing with the complacency that sometimes occurs with staff who feel that they know the resident so well that they interpret suicidal statements as the resident just blowing off steam or saying things to get attention.
Addressing bereavement (loss of a spouse in the community)—lack of interventions.	For residents who have a spouse living in the community, the possibility of the community-dwelling spouse's death is always present. Skilled nursing facilities should have policies and procedures in place developed by all relative stakeholders regarding informing a resident about the death of a spouse. This may be done by social work, nursing, a family member, etc. However, the intervention should be timely to prevent the resident from learning about the death from their smartphone or via a newspaper or another resident. Ongoing follow-up needs to take place with appropriate interventions to support the bereaved resident. Residents who are having difficulty with bereavement need to be considered for additional support and intervention.
Addressing staff frustration with residents who have mental health disorders (that they do not know how to address), resulting in resident abuse.	Caring for residents who have mental health disorders can create a variety of issues for staff, including compassion fatigue, which can result in your facility staff struggling to demonstrate empathy towards residents with mental health issues/behavioral disorders. Addressing residents with mental health issues can become a challenge for staff and, in some cases, can result in off-the-cuff comments that can be perceived by the resident (or anybody else for that matter) as verbal or psychological abuse. At the time of hire, staff should also know that they may be working with residents who struggle with different mental health issues. Appropriate orientation, training, and ongoing staff development activities should focus on different areas of how to deal with residents who have mental health issues.