STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

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F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents and staff the facility failed to follow their policy for submitting a report of an allegation of abuse to Health Care Personnel Registry for 1 of 1 (Resident #70) resident who reported an observation of resident abuse. The findings included: A review of the facility policy titled "Abuse & Neglect Prohibition" with a revision date of June 2013 read in part, "Facility supervisors will immediately correct and intervene in reported or identified situations in which abuse, neglect, injuries of unknown origin, or misappropriation of resident property is at risk of occurring." The policy also stated "The facility will report such allegations to the state, in accordance with state regulation." A record review revealed resident #70 was admitted to the facility on 7/12/13. A review of the quarterly Minimum Data Set (MDS) dated 4/9/15 revealed the resident was alert and oriented. She had no psychosis or behavioral symptoms. During an interview on 7/7/15 at 11:22 AM Resident #70 reported she had observed a Nursing Assistant (NA) "slam a resident's head against her pillow." She stated the resident was still in the facility. She identified the resident as	F 226	On 7-9-15, NA #3 was in-serviced by the ADON/SDC regarding the reporting process for abuse/neglect. In-servicing also began on 7/9/15 with Department Heads, licensed nurses, CNA, therapy, housekeeping and dietary regarding reporting abuse/neglect. The re-education included types of abuse and neglect and how to notify the Administrative team using the concern forms and calling them when they were not in the facility. Resident #70 was interviewed and statements taken and a 24 hour report completed on 7/8/15 by the Administrator and the District Clinical Director. All interviewable residents were interviewed regarding abuse/neglect and no other issues were found on 7/8/15 by the social worker. The investigation was completed on 7/15/15 and the 5 day Report was submitted with all allegations unsubstantiated by the Administrator. Letter from DHHS on July 16, 2015, stated that the Department determined that an investigation would not be conducted in this case.	8/7/15

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

Electronically Signed | 07/31/2015

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F 226	Continued From page 1 the lady in the next room and called her by name. Resident #70 stated she was speaking up for a resident who was not a capable of speaking up for herself. On 7/8/15 at 9:41 AM Nurse #3 stated Resident #70 was alert and did not have periods of confusion or need redirection. She added that Resident #70 did not make up stories nor was she untruthful. On 7/8/15 at 9:51 AM Medication Aid #1 stated Resident #70 was alert with no confusion and she did not make up stories. During an interview on 7/8/15 at 11:42 AM Resident #70 stated she reported it to the staff member whose name she could not recall but she had an office next to the dining room and had dogs and cats in her office sometimes. She stated the staff member asked her what the NA did. Resident #70 stated she told the staff member what she saw and that the staff member told her she would take care of it. She also stated she did not know the name of the NA but she had seen the NA since the meeting with the staff member she reported the incident to and the NA would hardly speak to her now. On 7/8/15 at 12:05 PM an observation of the office next to the dining room revealed it was the Director of Nursing (DON) office. During an interview with the current DON and the Clinical Division Director on 7/8/15 at 12:10 PM, the current DON stated she had no knowledge of an allegation of abuse reported by Resident #70. The DON stated she sometimes had a dog or a cat in her office and had a gait to put across the door to keep them in her office. On 7/8/15 at 12:25 PM the Administrator provided the files of all abuse investigations for the last 6 months. The allegation by resident #70 was not among the files.	F 226	The facility Administrator will complete a 24 hour report on all allegations of abuse/neglect within 24 hours of report from staff to prevent and protect residents in the future. Staff members will have weekly updates/in-services (on all three shifts) regarding abuse/neglect and the policies regarding reporting any suspicion of abuse/neglect by the Administrator or designee. These updates will be weekly times four and then monthly times 3 months to ensure that staff are properly reporting any suspicion of abuse/neglect. The updates/in-services will be documented on the facility in-service forms. Two interviewable residents will be randomly selected and interviewed weekly times four weeks then monthly times 3 months by the social worker or designee for any possible abuse neglect suspicions. These interviews will be documented on the Resident Interview Forms. Any concerns regarding possible abuse/neglect will be reported to the Health Care Personnel Registry within 24 hours and followed up by a 5 Day Report at the completion of a thorough investigation by the Administrator. Additional Education will be provided to staff as needed by the facility Administrator or the Staff Development Coordinator. The facility Administrator will report results of the in-services and any reportable	

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F 226	Continued From page 2 During an interview with the current DON on 7/8/15 at 3:15 PM she stated she had not returned from a leave of absence until 5/18/15. She stated the facility had used interim DONs while she was on leave of absence. She stated she took any allegation of abuse seriously and would begin to investigate any allegation immediately. She stated she knew that a 24 hour report and a 5 day report were to be filed on any allegation. She stated she had no prior knowledge of this allegation. During an interview with NA #3 on 7/9/15 at 10:42 am she stated that Resident #70 told her that she saw a NA who was rough with a resident when she was pulling her up in the bed. She stated she did not tell anyone at that time but returned to Resident #70 ' s room about 2-3 hours later and asked her again about the incident. She stated Resident #70 told her that she had asked the NA had assisted the resident but NA #3 stated Resident #70 did not say anything else about the NA being rough so she did not report the incident. NA #3 stated it was sometime in May that Resident #70 told her about the incident. On 7/9/15 at 5:04 PM the Clinical Division Director stated she was investigating the allegation. She stated Resident #70 became upset during the interview so she had to stop the interview. She stated the suspected NA who she thought may have been involved and the current DON were suspended. She added that a 24 hour report was completed.	F 226	events Monday through Friday at Interdisciplinary Team stand up and the Quality Assurance Performance Improvement Committee (QAPI) meeting monthly times three months. Additional interventions will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315		8/7/15

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F 315	Continued From page 3 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to secure the catheter for 1 of 2 residents observed for catheter care, (Resident #37). The findings included: Resident #37 was re-admitted to the facility on 5/12/2015, with diagnoses that included septicemia (a blood infection) urinary tract infection (UTI), and sacral stage 3 pressure ulcer. The resident ' s care plan, dated 5/25/2015, listed indwelling catheter as a problem, with " anchor catheter to prevent excessive tension " as an intervention. The resident ' s most recent Minimum Data Set (MDS) assessment, dated 6/23/2015, indicated she was cognitively intact, and needed extensive assistance with activities of daily living. A stage 3 ulcer was present on admission, as well as an indwelling catheter. A physician order dated 7/6/2015, indicated to continue the catheter due to the pressure ulcer on sacrum. On 7/8/2015 at 10:15 AM, an observation of pressure ulcer wound care was conducted for resident #37. No anchor for the catheter was noted at that time. On 7/9/2015 at 1:51 PM, an observation of catheter care was conducted with the nursing	F 315	Resident #37 had a catheter secure anchor placed on 7/9/15 by the Assistant Director of Nursing. The Director of Nursing and Assistant Director of Nursing completed 100% audit all resident with indwelling catheters on 7/29/15, to ensure all residents had catheter secure anchors in place. The facility nursing staff (licensed nurses and CNA) were provided re- education on the importance of secure anchor strap by 8/7/15 by the ADON/SDC. Newly hired staff will receive the education during orientation by the ADON/SDC. The facility Director of Nursing or designee will audit all residents with catheters weekly times four and then monthly times 3 months to ensure that all residents have a catheter secure anchor in place. The audit will be documented on the Indwelling Catheter Secure Audit Tool. (See Attached) The facility Director of Nursing or designee will report results of the catheter secure audits to the Quality Assurance	

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F 315	Continued From page 4 assistant, (NA #1). No anchor for the catheter was used. An interview was conducted with NA #1 on 7/9/2015 at 2:03 PM. The NA stated she had not noticed that an anchor was not present for the catheter to be secured. She stated that the resident did not have an anchor on 7/6/2015 or 7/7/2015, which were the last 2 days she had cared for the resident, before the 7/9/2015. On 7/9/2015 at 3:46 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that the expectation for catheter care was that the resident would be clean, and there would be a leg strap to anchor the catheter.	F 315	Performance Improvement Committee (QAPI) meeting monthly times three months. Any issues will be corrected by the Director of Nursing or the Assistant Director of Nursing. Additional Education will be provided to staff as needed by the facility Assistant Director of Nursing. Additional interventions will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to initiate an ordered nutritional intervention to halt weight loss for 1 of 4 sampled residents (Resident #39) reviewed for weight loss.	F 325	Resident #39 had 5.2 pound weight loss during a 15 day period of her stay in the facility from 3/3/15 -4/28/15. An appetite stimulant was ordered. A Medication Variance Report showed a	8/7/15

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F 325	Continued From page 5 Findings included: Resident #39 was admitted on 3/3/15 with diagnoses that included aspiration pneumonia, hip fracture with surgical repair, coronary artery disease and diabetes. The 3/3/15 facility admission orders included orders for a cardiac diet. On 3/5/15, the physician ordered Remeron (a medication classified as an antidepressant but also used to stimulate appetite) 15 milligrams (mgs) at bedtime for Resident #39 to be used as an appetite stimulant. The order was written by the resident ' s primary care physician (PCP), signed by Nurse #1 and cosigned by Nurse #2. The Vital Sign and Weight Flow Sheet, dated 3/6/15, documented Resident #39's weight as 90 pounds (lbs.). The Admission Minimum Data Set (MDS) with an assessment reference date of 3/10/15 indicated the resident was cognitively intact. The resident was not identified with behaviors or refusing care. She was noted to have functional impairment in range of motion on one side of her lower extremity. The MDS also indicated the resident required extensive assistance with bed mobility, transfer, dressing, eating, toilet use and personal hygiene. She was coded as weighing 90 pounds with no weight loss or gain. The Care Area Assessment (CAA) for Nutritional Status, dated 3/16/15, indicated Resident #39 left significant amounts of food on her tray daily. The Analysis of Findings indicated she required extensive assistance from staff with feeding and received a no added salt diet. Average meal intake was documented as 25% to 100%. Weight was coded as 90 lbs. A decision was made to proceed to care plan for nutritional status. On 3/17/15, the Medical Nutritional Therapy Assessment indicated the resident fed herself in	F 325	transcription/order error. The Director of Nursing and Assistant Director of Nursing completed audit of physicians' orders for past sixty days to ensure that residents with orders for appetite stimulates had been implemented on 7/28/15. This audit was documented on attached audit tool and completed on 7/28/15 and will be repeated monthly times three months. The facility licensed nursing staff were provided re- education on transcription of orders which included documenting the orders on physician's order sheet, faxing all orders to the pharmacy, signing off the orders and transcribing the orders to the MAR for documentation of administration of drug by the ADON/SDC. In-servicing to be completed by 8/7/15. Newly hired staff will receive the education during orientation. The facility Director of Nursing or designee will audit residents with appetite stimulants weekly times four and then monthly times 3 months to ensure that all residents maintain adequate weights and acceptable weight gain. The audit will be documented in the Weekly Risk Assessment Review meetings with the Interdisciplinary Team. The facility Director of Nursing or designee will conduct ten random chart review/audits of transcription of orders weekly times four weeks and then monthly times 3 months. The audits will be documented on the Transcription	

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F 325	Continued From page 6 the room and consumed 25% to 100% of meals with her current body weight (CBW) documented as 90 lbs. The Registered Dietician (RD) documented Resident #39 received Remeron as an appetite stimulant. The RD added Resident #39 ' s intake was inadequate at times so therefore a recommendation was made to add fortified pudding with lunch and dinner, in addition to the Remeron, to increase weight and improve intake. The physician approved the recommendation of fortified pudding. On 3/18/15, the resident's weight was recorded on the vital sign and weight flow sheet as 84.8 lbs. Resident #39's care plan, last reviewed on 3/24/15, indicated she was at risk for potential weight loss related to poor food/fluid intake and aspiration pneumonia. The care plan had a hand written note, dated 3/4/15 that indicated a weight of 90.0 lbs. and on 3/19/15, the resident's weight was recorded as 84.8 pounds which reflected a loss of 5.2 lbs. in 15 days. Review of the March 2015 Medication Administration Record (MAR) revealed the physician's order for Remeron 15 mgs at bedtime was not transcribed until 3/31/15 (26 days after ordered). Nutrition Service Progress notes, dated 4/9/15 indicated the resident's CBW was 89.2 which was 81% of her ideal body weight. Nurse #2 was interviewed on 7/9/15 at 10:03 AM. She stated Remeron was used for depression and an appetite stimulant. Nurse #2 stated when an order was received from the physician, the order was read back to the physician to verify accuracy. She added that sometimes another nurse verified the accuracy of the order. The order was then transcribed to the MAR by the nurse that received the order. The next morning,	F 325	Accuracy Audit Tool. The facility Director of Nursing will report results of the Transcription Audits and the Weekly Risk Assessment Reviews to the Quality Assurance Performance Improvement Committee (QAPI) meeting monthly times 3 months Any issues will be corrected by the Director of Nursing or designee. Additional Education will be provided to staff as needed by the facility Assistant Director of Nursing. Additional interventions will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness.	

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the copies of the order was reviewed by the Administrative nurses. Nurse #2 stated the administrative nurses verified transcription of all orders. Nurse #2 added if Remeron, that had been ordered as an appetite stimulant was not given as ordered, it could potentially cause a decrease in appetite and a continued weight loss. Nurse #2 remembered Resident #39 and stated her intake was variable. The nurse reviewed the 3/5/15 order and confirmed she had signed as receiving the order. She reviewed the March 2015 MAR and confirmed the medication had not been transcribed. Nurse #2 added her signature on the order meant she Nurse #1 had written the order, but she had not verified Nurse #1 had transcribed the order. The nurse reviewed the admission weight dated 3/6/15 and the weight for 3/18/15 and stated the resident's weight declined and added that may have been due to not receiving the Remeron.

On 7/9/15 at 10:16 AM, Nurse #1 was interviewed. Nurse #1 stated Remeron was used as an antidepressant and an appetite stimulant. She described the order process after an order was received. Nurse #1 stated the nurse that received the order was responsible for the transcription of the order to the MAR. Copies of orders are given to administrative nurses who then check the order against the MAR. Nurse #1 reviewed the 3/5/15 order for Remeron and acknowledged she was the nurse that took the order. The nurse reviewed the MAR and stated the Remeron was not given for the entire month of March until the 31st. She stated she may have handed the order off to Nurse #2 who then became responsible for transcribing the order. Nurse #1 stated she had no idea why the order was missed. The nurse stated the negative outcome of not getting the Remeron could be

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weight loss. The nurse reviewed the weights for 3/6/15 and 3/18/15 and acknowledged the resident had weight loss and stated it could possibly had been because Resident #39 had not received her appetite stimulant.
The RD was interviewed on 7/9/15 at 10:30 AM. The RD stated Remeron was used as an appetite stimulant with the expectation of appetite being increased. The RD reviewed the 3/5/15 Remeron order and the MAR that revealed the medication was not started until 3/31/15 and stated starting it that long after the MD ordered the medication did not help the resident. He stated the nutritional assessment was affected, because at the time, the RD that assessed the resident thought the resident was already receiving the Remeron and it was not helping her appetite as reflected by her intake. The RD reviewed the resident ' s admission weight and the weight documented on 3/18/15 and acknowledged the resident had a significant weight loss. He added not receiving the Remeron impacted Resident #39's significant weight loss 10% to 25% because other interventions were placed. An interview was held with the Assistant Director of Nursing (ADON) on 7/9/15 on 10:51 AM. She stated she was unaware of the process for validating orders had been transcribed prior to her start date the end of March. The ADON reviewed the 3/5/15 Remeron order and compared the order to the March 2015 MAR and acknowledged the order had not been transcribed when the physician had ordered the medication. The ADON stated not getting the Remeron could possibly cause the resident not to gain weight. She reviewed the weights and acknowledged the resident had significant weight loss in 12 days.
The facility's consultant pharmacist was

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F 325	Continued From page 9 interviewed on 7/9/15 at 4:03 PM. The pharmacist stated Remeron may cause weight gain secondary to sedation since Remeron blocked histamine receptors in the brain and by virtue of being sedated residents gain weight. The pharmacist added Remeron was a sedating antidepressant and added instead of adding another medication, the resident should have been assessed for the root cause of the weight loss. The Corporate Nurse Consultant presented a Medication Variance Report on 7/10/15 at 10:15 AM. She stated the medication error involving Remeron for Resident #39 had been discovered during a chart audit in March 2015. On the report, the Remeron was described as a transcription/order error. Outcome was identified as no apparent injury, but a question mark with the hand written words "weight loss" was seen under the outcome section. The nurse consultant stated that while action was taken for the medication error/transcription error, no action had been taken for the resident's weight loss. Resident #39 was discharged home on 4/28/15.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		8/7/15

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F 329	Continued From page 10 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to document behaviors for psychotropic medication for 1 of 5 residents reviewed for unnecessary medication, (Resident #5). The findings included: Resident #5 was admitted to the facility on 9/13/2003, with diagnoses that included dementia. The resident ' s annual Minimum Data Set (MDS) dated 5/18/2015 revealed her cognition to be severely impaired and required extensive to total assistance with activities of daily living. She had no hallucinations, delusions or behaviors. She was receiving an antipsychotic medication. The resident ' s care plan dated 6/15/2015, for psychoactive medications, indicated the resident required the antipsychotic medication due to psychosis, Alzheimer ' s, hallucinations and agitation. The interventions included observing for medication effectiveness and documenting via behavioral checklists.	F 329	On 7/09/15 a behavior monitoring sheet was added by the ADON to Resident # 5's MAR for documentation by the licensed staff for resident's behaviors. Additional measures put into place to assure the same alleged deficient practice does not recur are as follows: A chart audit was completed for all residents receiving anti-psychotic medications by consulting pharmacist on 7/9/15. All residents on anti-psychotic medications have appropriate physician orders and updated care plans, along with proper documentation for continued need or changes based on resident¿s episodes of behaviors. All residents with sporadic behaviors were reviewed for changes from scheduled medications to PRN. Nursing Staff (licensed nurses and CNA) were in-serviced on the Psychotropic	

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	345339	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 329	Continued From page 11 The physician orders for July 2015, indicated risperidone (an antipsychotic medication) 0.5 milligrams (mg) to be given at bedtime for psychosis. On 7/8/2015 Ativan (an anti-anxiety medication) 0.5mg daily as needed for excessive anxiety, was ordered by the psychiatric nurse practitioner (NP). A review of the resident ' s chart from November 2014 to July 2015, revealed no behavior monitor sheet for antipsychotic medication. No documentation for behaviors was found anywhere else in the record. An observation of resident #5 was made on 7/9/2015 at 8:25 AM. The resident was dressed and sitting up in a mobile recliner. She had a coat on and blanket over her legs. She only nodded her head in response to questions. An interview was conducted with the nurse (nurse #3), on 7/9/2015 at 9:17 AM. The nurse stated she did not know the last time the resident had behaviors, and she hadn ' t observed the behaviors. On 7/9/2015 at 10:50 AM, an interview was conducted with the nurse (nurse #2). The nurse stated that the psychiatric NP was at the facility on 7/8/2015, and since the resident was having some issues, the NP ordered the Ativan. When asked how the NP would know the resident was having some issues, nurse #2 stated she could look on the MAR. The MAR was examined, but no behavior sheet was noted. The nurse stated that it was the night nurses responsibility to put the behavior sheet on the MAR. On 7/9/2015 at 11:07 AM, an interview was conducted with the nurse (nurse #1). The nurse stated the resident ' s Ativan was probably ordered because of the resident ' s yelling. The behaviors were documented on the medical record care tracker, by the nursing assistants.	F 329	Management system and the appropriate documentation in Care Tracker and on the behavior sheets for all psychotic medications by AON/SDC.. All physician orders for anti-psychotic therapy will be reviewed during the morning meeting by the Director of Nursing or designee and with the Interdisciplinary Team for appropriate behavioral interventions. All new admissions with anti-psychotic medications will be assessed by Director of Nursing or Designee and will place behavior sheets on the MAR upon admission and resident entered into Care Tracker for proper documentation. All MAR's will be reviewed at the end of each month and the appropriate behavior documentation sheets will be put into place for MAR accuracy for the following month by Director of Nursing, ADON, or designees. The Director of Nursing or the Assistant Director of Nursing will conduct random chart audits monthly X 3 months for documentation of behaviors for residents receiving anti-psychotic medications.. The pharmacy consultant and the DON will review residents on anti-psychotic medications on a monthly basis. DON will follow up with each physician based on pharmacy recommendations. Gradual drug reduction based on the resident¿s behaviors will be implemented as warranted. The results of the anti-psychotic medication audits and any negative findings during the consultant pharmacists	

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F 329	Continued From page 12 The care tracker was accessed by nurse #1, for a 30 day look back period. No behaviors were documented. The nurse stated she hadn ' t heard any yelling by the resident for a long time. On 7/9/2015 at 11:14 AM, an interview was conducted with the nursing assistant (NA # 2). The NA stated that the medical record care tracker was where the NA ' s documented the number of times resident ' s behaviors occurred. She proceed to demonstrate the care tracker system. The NA stated the resident had not had behaviors that she could remember, and was agreeable this day. An interview was conducted with the NP on 7/9/2015 at 12:40 PM. The NP stated there was no documentation in the chart for the resident ' s behaviors. The only way she could find out about behaviors was to talk to the staff. She was told by staff that the resident was having problems, but she could not recall the staff member ' s name. She stated that she did not want to increase the resident ' s anti-psychotic medication, so she ordered the anti-anxiety medication, so she could assess how often the behaviors were occurring. On 7/9/2015 at 2:44 PM, an interview was conducted with the facility ' s nurse consultant. The nurse consultant stated that it was her expectation that nurses documented on the behavior sheet in the MAR, for all residents who were on psychotropic medications. On 7/9/2015 at 3:24 PM an interview was conducted with the nurse #2. She stated that she spoke with the NP on 7/8/2015. The nurse reported to the NP that on 7/5/2015, the NA came and told her resident #5 was yelling. The nurse went to the resident room, but the resident was not yelling at that time. She did not witness the behavior. The nurse stated she did not document	F 329	monthly review will be taken to the Quality Assurance Performance Improvement (QAPI) Committee meeting for review monthly times 3 months and to the Medication Management Advisory Committee quarterly. Additional interventions will be implemented as recommended by the QAPI committee and Medication Advisory committee with ongoing evaluation of effectiveness.	

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F 329	Continued From page 13 the behavior because she was only required to document on the residents chart once per month. She would only document if there was a change in condition for the resident. She did not chart on the behavior sheet in the MAR. On 7/9/2015 at 3:53 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated her expectation was for the nurses to document a resident ' s behavior when on a psychotropic medication. She stated that the behavior sheet in the MAR is something the facility had implemented, and used them to monitor for behaviors.	F 329		