STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345066	A. BUILDING _____ B. WING _____	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALSTON BROOK	4748 OLD SALISBURY ROAD LEXINGTON, NC 27295

(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
E 000	Initial Comments An unannounced Recertification survey was conducted 11/29/21 through 12/2/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #KV8T11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 11/29/21 to 12/2/21. Event ID# KV8T11. 5 of the 7 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		12/30/21

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

Electronically Signed | 12/16/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide a cover over a urinary drainage bag for 1 of 4 residents reviewed with indwelling urinary catheters (Resident #184). The findings included: Resident #184 was admitted to the facility on 11/18/21 with diagnoses that included a right hip fracture, retention of urine and diabetes type 2. Review of the nursing progress notes indicated on 11/19/21, Resident #184 had an indwelling urinary catheter placed due to difficulty voiding. The admission Minimum Data Set (MDS) assessment dated 11/25/21 indicated Resident #184 had severe cognitive impairment, required	F 550	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. On November 30, 2021 a Urinary Drainage Bag cover was placed on Resident #184 Urinary Drainage Bag. All Nursing staff have been re-educated on Residents Rights regarding Dignity in conjunction with proper placement of Urinary Drainage Bag covers. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE.	

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F 550	Continued From page 2 extensive assistance from staff for toileting needs and had an indwelling urinary catheter. On 11/29/21 at 10:00 AM, an observation was made of Resident #184 sitting in a recliner chair. She was noted to have a urinary drainage bag attached to the footrest of the recliner chair, without a privacy cover, which could be seen from the hallway. Resident #184 was observed lying in her bed on 11/30/21 at 9:40 AM. The urinary drainage bag was hanging on the right side of the bed without a privacy cover and was visible from the hallway. Another observation occurred on 11/30/21 at 3:55 PM while Resident #184 was lying in bed. The urinary drainage bag was visible from the hallway, hanging on the right side of the bed without a privacy cover in place. Nurse Aide (NA) #6 was interviewed on 11/30/21 at 4:00 PM and stated Resident #184 had just been assisted back to bed and the urinary drainage bag privacy cover was still attached to the wheelchair. She went onto explain residents with urinary catheters would normally have a privacy bag present on the bed as well as the wheelchair if they were able to get out of bed and were working with therapy as was Resident #184. An interview occurred with the Director of Nursing on 11/30/21 at 4:30 PM. She explained residents with urinary catheters should have a privacy cover to the drainage bag and normally a privacy cover would be in place to the bed and the wheelchair.	F 550	An audit of four other residents in the facility with Urinary Drainage Bags was conducted on November 30, 2021 by the Director of Nursing to ensure Urinary Drainage Bag cover was in place. On December 3, 2021 all Nursing staff were re-educated on Residents Rights regarding Dignity in conjunction with proper placement of Urinary Drainage Bag covers. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. All Nursing staff were re-educated on proper placement of Urinary Drainage Bag covers on December 3, 2021. All Nursing staff is required to receive the Urinary Drainage Bag covers prior to assuming their work assignments. Education was completed by the Staff Development Nurse. Any new employees will be trained in Employee Orientation. The Director of Nursing or Designee will check proper placement and proper covering for all Urinary Drainage Bags to ensure resident rights are protected as pertains to Dignity practices. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Director of Nursing or Designee will monitor proper placement and proper	

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F 550	Continued From page 3	F 550	cover for all Urinary Drainage Bags to ensure resident rights as pertains to Dignity practices are being protected. The monitoring will be conducted as follows: 1. Monitor all Urinary Drainage Bags 2 days per week for four (4) weeks; then 2. Monitor all Urinary Drainage Bags 2 days per week bi-weekly for four (4) weeks; then 3. Monitor all Urinary Drainage Bags monthly until resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All training/re-education will be completed by December 30, 2021.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to assess and to complete a quarterly Minimum Data Set (MDS) assessment at least every 92 days following the previous	F 638	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE	12/30/21

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F 638	Continued From page 4 assessment for 1 of 24 sampled residents reviewed (Resident #6). Findings included: Resident #6 was admitted to the facility on 6/16/21 with multiple diagnoses including Hypertension. The last MDS assessment completed for Resident #6 was a quarterly assessment dated 8/11/21. There was no MDS assessment completed after 92 days. MDS Nurse # 2 was interviewed on 11/30/21 at 2:30 PM. She verified that Resident #6's last MDS assessment was completed on 8/11/21. She reviewed her calendar and stated that a quarterly MDS was due and should have been completed on 11/11/21 but it was not, it was missed. The Director of Nursing (DON) was interviewed on 12/2/21 at 1:08 PM. The DON indicated that she expected the MDS assessments to be completed timely per the regulation.	F 638	DEFICIENT PRACTICE. A Quarterly Assessment was completed on November 30, 2021 and transmitted on December 3, 2021 for Resident #6. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. On December 1, 2021 both MDS Nurses were re-educated by an RAI Consultant, RN on Chapter 2 of the RAI Manual on the timely completion and transmission of Quarterly Assessments for all residents. A system audit was conducted on all Quarterly Assessments by the MDS Nurse and verified by the RAI Consultant, RN on December 2, 2021 and no additional deficient assessments were identified. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. A MDS Status Report Log was put into place that requires the MDS Nurse responsible for Quarterly Assessments to daily check the MDS Status Report in American Health Tech (AHT) and Complete the Log indicating that the MDS Status Report was reviewed for all current or upcoming Quarterly Assessments. On December 14, 2021 both MDS Nurses were educated by the Director of Nursing on the MDS Status Report Log and the	

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F 638	Continued From page 5	F 638	process of checking the MDS Status Report in American Health Tech (AHT) and completing the Log. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Director of Nursing or Designee will monitor MDS Status Report in American Health Tech (AHT) Electronic Medical Record (EMR) and the MDS Status Report Log to ensure all Quarterly Assessments are completed and transmitted as required. The monitoring will be conducted as follows: 1. Monitor the MDS Status Report and MDS Status Report Log weekly for all residents for four (4) weeks; then 2. Monitor the MDS Status Report and MDS Status Report Log bi-weekly for four (4) weeks; then 3. Monitor the MDS Status Report and MDS Status Report Log monthly until resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and new monitoring system will be put into place by December	

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F 638	Continued From page 6	F 638	30, 2021.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of Preadmission Screening and Resident Review (PASRR) (Resident # 6), diagnoses (Resident #6), prognosis (Resident #26) and medications (Resident #81) for 3 of 24 sampled residents reviewed. Findings included: 1a. Resident #6 was admitted to the facility on 6/16/21 with multiple diagnoses including major depressive disorder. The admission MDS assessment dated 6/28/21 indicated that Resident #6 was not evaluated by the state for level II PASRR. A state form was reviewed and indicated that Resident #6 was evaluated on 4/22/21 and was determined to have level II PASRR. MDS Nurse #2 was interviewed on 12/2/21 at 9:46 AM. She stated that she had been an MDS Nurse at the facility for 2 years. MDS Nurse #2 stated that she didn't know that Resident #6 was a level II PASRR. She reviewed Resident #6's records and verified that the resident had been evaluated for level II PASRR on 4/22/21. She	F 641	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Resident #6, #26 and #81 assessment modifications was transmitted on December 1, 2021. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. Both MDS Nurses will be re-educated on Chapter 3 of the RAI Manual on proper Coding and Accuracy of Assessments. The MDS Consultant has conducted a review all MDS Assessments for the previous 90 days from December 2, 2021 and found no additional coding inaccuracies. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR.	12/30/21

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F 641	Continued From page 7 reported that she would complete a modification MDS to correct the inaccuracy. The Director of Nursing (DON) was interviewed on 12/2/21 at 1:08 PM. The DON indicated that she expected the MDS assessments to be coded accurately. 1b. Resident #6 was admitted to the facility on 6/16/21 with multiple diagnoses including convulsions. The quarterly MDS assessment dated 8/11/21 indicated that Resident #6 was not coded as having seizure disorder under the diagnoses. Resident #6's doctor's orders were reviewed. Resident #6 has a doctor's order dated 7/19/21 for Keppra (used to treat seizures) 500 milligrams (mgs) twice a day for seizure disorder. Review of the August 2021 Medication Administration Records (MARs) revealed that Resident #6 had received Keppra during the assessment period. MDS Nurse #2 was interviewed on 12/2/21 at 9:46 AM. She stated that she had been an MDS Nurse at the facility for 2 years. She reviewed Resident #6's records and verified that the resident has an order and was receiving Keppra for seizures. She reported that she missed to check seizure disorder under the diagnoses. The MDS Nurse reported that she would complete a modification MDS to correct the inaccuracy. The Director of Nursing (DON) was interviewed on 12/2/21 at 1:08 PM. The DON indicated that she expected the MDS assessments to be coded	F 641	The facility has implemented a system by which all resident assessments will be logged on the Alston Brook MDS Assessment QA Log. This Log contains the following information: Resident name, Type assessment, PASRR Level, Diagnosis, Prognosis, Medication, and Date Completed. In addition this Log contains a QA Check Completed by and date completed. The MDS Nurses will log all resident assessments on this Log and must indicate that these items were present on the MDS assessment. On December 14, 2021 both MDS Nurses were educated by the Director of Nursing on the Alston Brook MDS Assessment QA Log and the process of logging all resident assessments on this Log and indicating that these items were present on the MDS assessment. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Director of Nursing or Designee will review and monitor the Alston Brook MDS Assessment QA Log to ensure accuracy of all assessments as follows: 1. Monitor the Alston Brook MDS Assessment QA Log weekly for all residents for four (4) weeks; then 2. Monitor the Alston Brook MDS Assessment QA Log bi-weekly for four (4) weeks; then 3. Monitor the Alston Brook MDS Assessment QA Log monthly until	

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F 641	Continued From page 8 accurately. 2. Resident #26 was admitted to the facility on 2/1/17 with multiple diagnoses including vascular dementia. The annual MDS assessment dated 9/17/21 indicated that Resident #26 was receiving hospice services, but the prognosis was not checked. Review of Resident #26's doctor's orders revealed that the resident was on hospice since admission of 2017. MDS Nurse #2 was interviewed on 12/2/21 at 9:46 AM. She stated that she had been an MDS Nurse at the facility for 2 years. MDS Nurse #2 stated that she didn't know that she had to check the prognosis if the resident was receiving hospice services. She reported that she would complete a modification MDS to correct the inaccuracy. The Director of Nursing (DON) was interviewed on 12/2/21 at 1:08 PM. The DON indicated that she expected the MDS assessments to be coded accurately. 3) Resident #81 was admitted to the facility on 11/8/21 with diagnoses that included congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). A review of the Medication Administration Record (MAR) for Resident #81 from 11/9/21 to 11/15/21 revealed he received Bupropion (an antidepressant) 100 milligrams by mouth every morning. The admission Minimum Data Set (MDS)	F 641	resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and Alston Brook MDS Assessment QA Log will be put into place by December 30, 2021.	

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F 641	Continued From page 9 assessment dated 11/15/21 indicated Resident #81 was cognitively intact and was not coded for antidepressant use. On 12/1/21 at 4:15 PM, an interview occurred with MDS Nurse #1. She reviewed the MDS and November 2021 MAR, confirming antidepressant should have been coded for 7 days. She felt it was an oversight. During an interview on 12/2/21 at 1:07 PM, the Director of Nursing indicated MDS Nurse #1 was new to the position and felt it was an oversight not to include the antidepressant medication on the MDS assessment. She further stated it was her expectation for the MDS to be coded accurately.	F 641		
F 689 SS=E	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 record review, observation and staff interview, the facility failed to thoroughly investigate each fall to determine root cause and failed to put interventions after each fall to prevent further falls for 2 of 4 sampled residents reviewed for accidents (Residents # 25 & #67). Findings included:	F 689	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. On December 14, 2021 the Falls Interdisciplinary Team conducted a thorough review of dates of falls sited on	12/30/21

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F 689	Continued From page 10 1. Resident #25 was admitted to the facility on 6/11/21 with multiple diagnoses including nondisplaced fracture of the right fibula and tibia. The quarterly Minimum Data Set (MDS) assessment dated 9/17/21 indicated that Resident #25 has moderate cognitive impairment and had falls since admission, reentry or prior assessment with 2 or more injury and one major injury. Resident #25's care plan was reviewed. One of her care plan problems was at risk for falls and fall related injury dated 6/22/21. The approaches (initiated on 6/22/21) included physical therapy (PT) to work on steadying gait, remind to ask staff for assistance in ambulation, keep walker within reach and uses hoyer lift for transfer. There was no revision on the interventions since 6/22/21. The incident reports for Resident #25 were reviewed. The reports revealed that Resident #25 had 5 falls since admission. The report did not include root cause of the falls and what interventions put in place to prevent further falls. The dates of the falls were: 8/7/21 at 2 PM - "the Nurse Aide (NA) was transferring the resident from bed to chair with a slide board and the resident was lowered to the floor without injury." 8/20/21 at 11:51 AM - "the resident yelled out and the Nurse found the resident on the floor with arms out to side. The resident was assisted to bed, assessed for injuries and neuro check started. A skin tear (1 centimeter (cm)) to right mid shin, 2 cm. bruise to right 3rd and 4th base of fingers, hematoma to right eye and forehead were noted."	F 689	the CMS 2567 on resident # 25 and #67 and determined appropriate root cause of falls and reviewed all previous interventions put in place and verified that current appropriate interventions are in place to prevent future falls. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. The Falls Interdisciplinary Team conducted a thorough review of the last 30 days of falls which consisted of 18 residents and documented that each of the 18 residents had a clearly determined appropriate root cause of the fall and reviewed all previous interventions put in place and verified that current appropriate interventions are in place to prevent future falls. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. A system was put into place where the Falls Committee consisting of Interdisciplinary Team members meets immediately following the morning Stand-up meeting to review all falls which occurred in the previous 24 hours. Any falls occurring on the weekend will be reviewed on Mondays. The Falls Committee will ensure that root cause of the fall is clearly documented and	

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F 689	Continued From page 11 9/3/21 at 6:50 PM - "NA informed Nurse that the resident was weak during transfer and was lowered to the floor from a standup lift. Bruise and abrasion to left lower extremity and left toes, redness to right foot and pain to right shoulder and right knee were noted." 9/6/21 at 5:15 AM - "resident was heard from the nurse's station yelling out "help, help". This Nurse and NA in room immediately. Resident was observed on floor on right side of bed in sitting position with back against the bed." 10/5/21 at 8:15 AM - "NA reports preparing to transfer the resident. The resident was sitting on side of bed while NA getting prepared and attempts to transfer self. NA reports unable to safely stop resident once noted transferring self. Noted little sore on right knee and abrasion to left knee." Resident #25 was observed on 11/30/21 at 4:23 PM. She was up in wheelchair on the hallway. She stated that she could bear weight on her right leg and was still working with PT. The Director of Nursing (DON) was interviewed on 12/1/21 at 9:45 AM. The DON stated that 3 administrative staff members (DON, Nurse Manager and Staff Development Coordinator (SDC) meet weekly and discuss the falls. They reviewed the incident reports and discuss what interventions to put in place. The DON reported that all the information they had discussed during the meeting were not documented. The DON was unable to provide documentation that each fall had been investigated and root cause was identified. She was also unable to provide	F 689	appropriate interventions are put into place. The Falls Committee will document all falls on the Alston Brook Falls Committee Review Form. On December 14, 2021 all Falls Interdisciplinary Teams members were educated by the Administrator on the Systemic Changes put into place regarding the Falls Committee and the Alston Brook Falls Committee Review Form. All Falls Interdisciplinary Team members were required to receive the education prior to participating on the Falls Interdisciplinary Team. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Administrator or his Designee will be responsible to ensure that the Falls Committee is meeting daily as required with appropriate Interdisciplinary Team Members to review all falls within the previous 24 hour and weekend falls are being reviewed on Mondays. The Administrator or his Designee will complete a Falls Committee Review Form Log as follows: 1. Monitor the Alston Brook Falls Committee Review Forms once a week for 4 weeks; then 2. Monitor the Alston Brook Falls Committee Review Form bi-weekly for 4 weeks; then 3. Monitor the Alston Brook Falls Committee Review Form monthly until resolved by the Quality Assurance	

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F 689	Continued From page 12 documentation of what interventions had been put in place after each fall to prevent further falls. MDS Nurse #1 was interviewed on 12/1/21 at 4:00 PM. She stated that she was made aware of falls during the morning meeting with the Administrator. She reported that she was not involved in the weekly falls meeting and she was not clear of what interventions discussed during the meeting. The SDC was interviewed on 12/2/21 at 9:20 AM. The SDC verified that the DON, Nurse Manager and herself meet weekly to discuss the incident reports. She reported that during the meeting, they reviewed the incident reports and discussed how to prevent further falls. The SDC stated that during the meeting, they had not investigated nor identify the root cause of the falls. They discussed the interventions but only verbally and not in writing. The Nurse Manager was interviewed on 12/2/21 at 10:10 AM. The Nurse Manager verified that the DON, SDC and herself meet weekly to review the incident reports. They discussed what happened and what type of interventions to put in place. She reported that all the information discussed during the meeting were not documented. 2) Resident #67 was admitted to the facility on 10/27/21 with diagnoses that included left clavicle fracture and Alzheimer's disease. The admission Minimum Data Set (MDS) assessment dated 11/3/21 indicated Resident #67 had severe cognitive impairment and	F 689	Committee. On a quarterly basis the Administrator will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and new Falls Committee Systemic Changes will be put into place by December 30, 2021	

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F 689	Continued From page 13	F 689		

required extensive assistance for bed mobility and transfers. She was coded as having falls prior to admission.

Resident #67's active care plan (initiated on 11/5/21) was reviewed with a problem area for risk of falls with a history of fall prior to admission. The problem area also listed a recent fall resulting in injury. The interventions that were initiated on 11/5/21 included physical therapy for steadying gait, remind to ask staff for assistance with ambulation, keep walker within reach at all times and monitor for attempts to get out of bed or wheelchair unassisted. There had been no revisions to the interventions since 11/5/21.

The incident reports for Resident #67 were reviewed and revealed a fall that occurred on 11/21/21 at 3:45 AM. She was observed on the floor, sitting on her bottom, and stated she was trying to get up because she didn't want to be in the bed anymore. The call light was not used to alert staff. Bruising was starting to form on the left buttock and a small skin tear was above her left eyebrow. The report did not include a root cause of the fall or what interventions had been put into place to prevent further falls.

The Director of Nursing (DON) was interviewed on 12/1/21 at 9:45 AM and stated three administrative staff members (DON, Nurse Manager and Staff Development Coordinator (SDC) met weekly to discuss falls. The members reviewed incident reports, spoke with staff members as needed and discussed what interventions were to be put into place. The DON further explained all the information that had been discussed during the meeting was not documented. She was unable to provide

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F 689	Continued From page 14 documentation that Resident #67's fall had been investigated, a root cause identified or what interventions had been put into place to prevent further falls. MDS Nurse #1 was interviewed on 12/1/21 at 4:00 PM and stated she was made aware of falls during the morning meeting with the Administrator. She reported she was not involved with the weekly falls meeting and was not always clear of what interventions were discussed. An interview occurred with the SDC on 12/2/21 at 9:20 AM. She verified the DON, Unit Manager and herself met weekly to discuss incident reports. During those meetings they reviewed the incident reports and discussed interventions but did not investigate nor identify the root cause of falls. The SDC further stated the interventions were discussed verbally with nothing in writing. On 12/2/21 at 10:10 AM, the Nurse Manager was interviewed and verified she, the DON and SDC met weekly to review incident reports. They discussed what happened and what type of interventions to put into place. The Nurse Manager added the information discussed was not documented.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		12/30/21

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F 692	Continued From page 15 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide double portion of meat and eggs as ordered for 1 of 4 sampled residents reviewed for Nutrition (Resident # 54). Findings include: Resident #54 was admitted to the facility on 1/29/20 with multiple diagnoses including dysphagia and vascular dementia. The quarterly Minimum Data Set (MDS) assessment dated 10/14/21 indicated that Resident #54 has moderate cognitive impairment and she needed extensive assistance with eating. The assessment further indicated that the resident's weight was 150 pounds (lbs.). Review of Resident #54's weights revealed that the resident was gradually losing weight. She weighed 160 lbs. on 5/4/21, 155 lbs. on 8/23/21, 151 lbs. on 10/19/21 and 148 lbs. on 11/15/21.	F 692	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Immediately upon being notified that improper portions were served to resident #54 additional portions were sent out to resident #54. In addition resident #54 dietary tray card for all meals was marked by a large clearly indicated “star” at the top of the dietary tray card to indicate double portions. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. On December 15, 2021 the facility Consultant Dietarian conducted a thorough audit to ensure all residents that	

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F 692	Continued From page 16 Resident #54 has a doctor's order dated 10/7/20 for double portion of meat and eggs at all meals. Resident #54 was observed during a lunch meal on 11/30/21 at 12:42 PM. NA #1 was observed to serve and to feed the resident. The diet listed on dietary card was "puree with nectar thick liquids" and the instruction was to serve double portion of meat at all meals. The tray was observed to have a regular portion of puree vegetable, mashed potato, and puree meat. NA #1 verified that the puree meat was a regular portion and not double portion. The NA further stated that the resident always eat 100% every meal. Resident #54 was again observed during a breakfast meal on 12/1/21 at 8:45 AM. NA #7 was observed to serve and to feed the resident. The tray contained regular portion of puree sausage and puree eggs. NA #7 verified the portion of the sausage and eggs as regular and not double portion. NA #7 stated that Resident #54 always eat 100% of her meal. The Dietary Manager (DM) was interviewed on 12/1/21 at 8:51 AM. The DM reported that she was aware that Resident #54 should have a double portion of meat and eggs for breakfast and double portion of meat for lunch and dinner due to her weight loss. The DM stated that she did not have but 1 cook at this time. She indicated that normally the cook serves on the tray line but because she did not have a cook yesterday and today, a dietary aide (DA) has served on the tray line. The DM added that she would train the DA to read the dietary card and to pay attention to the instruction "double portion." The Registered Dietician (RD) was interviewed	F 692	had orders for double portions was indicated on Dietary Tray Cards. All residents with orders for double portions were indicated on the Dietary Tray cards and receiving double portions. In addition all residents who are ordered double portions; their Dietary Tray Card was marked by a large clearly indicated “star” at the top of the dietary tray card to indicate double portions. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. On December 15, 2021 all Dietary Staff was re-educated by the Consultant Dietarian on serving of proper portions and attention to detail on all Dietary Tray Cards to ensure proper portions and diets are being served. In addition staff was educated on the new Double Portion QA Checklist and process. All Dietary Tray Cards for residents ordered double portions were marked by a large clearly indicated “star” at the top of the dietary tray card to indicate double portions. A system was put into place on the Dietary Serving Line to double check and insure that appropriate double portions are being served prior to tray being sent out to resident. A Double Portion QA Checklist was put into place that list all residents to be served double portions each meal. A Dietary Staff member working the serving line is responsible to physically inspect each tray for those residents designated	

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F 692	Continued From page 17 on 12/1/21 at 1:10 PM. The RD verified that Resident #54 was having weight loss and double portion was the intervention to prevent further weight loss. She stated that her expectation was for the resident to be provided with the double portion as ordered. The Dietary Aide (DA) was interviewed on 12/2/21 at 9:12 AM. She stated that she had been working at the facility as DA for a year. She reported that she helped to cook and to serve on the tray line at times. She indicated that she knew she had to read the dietary card when serving but it was just an accident, she missed to serve the double portion for Resident #54 on 11/30/21 lunch and 12/1/21 breakfast.	F 692	for double portions and verify that plate contains double portions prior to being served to resident. Dietary staff member checks verified and initials the checklist for each resident requiring double portions. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Administrator or his Designee will be responsible to ensure that the Dietary Department Staff are utilizing the Double Portion QA Checklist for each meal by observing random meals, and inspecting the QA Checklist. The Administrator or his Designee will complete and a Double Portion Monitoring Tool Form to ensure compliance as follows: 1. Monitor the Double Portion QA Checklist and observe the Dietary Staff serving line randomly 3 meals a week for 4 weeks; then 2. Monitor the Double Portion QA Checklist and observe the Dietary Staff serving line randomly 3 meals a week bi-weekly for 4 weeks; then 3. Monitor the Double Portion QA Checklist and observe the Dietary Staff serving line randomly 4 meals monthly until resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and	

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F 692	Continued From page 18	F 692	recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and new system will be put into place by December 30, 2021.	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in	F 756		12/30/21

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F 756	Continued From page 19 the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Pharmacy Consultant, facility Physician's Assistant and facility Nurse Practitioner, the Pharmacy Consultant failed to identify the facility's need to identify target behavioral symptoms, to monitor those symptoms, and the need to monitor residents for side effects of psychotropic medications (Residents #12, #14, #67, # 81, #69, #34, #17, and #6). In addition, the Pharmacy Consultant failed to identify and report drug irregularity related to the failure to discontinue a medication as ordered (Resident #25). This was for 9 of 11 residents whose medications were reviewed. The findings included: 1) Resident #12 was originally admitted to the facility on 8/27/21 with a recent readmission date of 9/9/21. Her diagnoses included Alzheimer's disease and major depressive disorder. The admission Minimum Data Set (MDS) assessment dated 9/3/21 indicated Resident #12 had severe cognitive impairment and displayed no behavior issues. Her mood was coded with poor appetite or overeating 2 to 6 days during the 14 day look back period. Resident #12 received 7	F 756	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. On December 14, 2021 new orders were entered for residents #12, #14, #67, #81, #69, #34, #17, #6, and #25 which include target behaviors/symptoms for each psychotropic medication including monitoring for potential adverse side effects. A discontinuation order for resident #25 was written and entered into AHT on December 1, 2021. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. On December 15, 2021 the Pharmacist Consultant conducted a thorough audit all of resident's orders and noted five orders that needed to be discontinued. All noted orders needing to be discontinued were discontinued on December 15, 2021.	

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F 756	Continued From page 20 days of an antidepressant. Resident #12's physician orders included an order for Sertraline (an antidepressant) 50 milligrams by mouth daily. Review of the Pharmacy Consultant medication review notes for resident #12 from August 2021 to November 2021 did not reflect the need for monitoring targeted behaviors or side effects. A review of Resident #12's nursing progress notes from 8/27/21 to 11/27/21 included behaviors such as wandering, pilfering, cursing, and hitting staff as well as crying and tearfulness. Resident #12's Medication Administration Records (MARs) from 9/1/21 to present indicated she received Sertraline as ordered. The MAR did not list any targeted behaviors or side effects for staff to monitor. On 11/30/21 at 1:32 PM, an interview occurred with the Director of Nursing (DON), who stated she was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications. She reported the facility had two software programs with the capability to enter the monitoring of behaviors and side effects on the MAR under a "special requirement" tab, but apparently this was not being utilized by nursing. On 12/1/21 at 1:35 PM, an interview occurred with Nurse #2 who was familiar with Resident #12 and stated there were no specific behavior or side effect monitoring for the use of the psychotropic medications.	F 756	On December 15, 2021 the Pharmacist Consultant conducted an audit of psychotropic medications and of those residents who were audited found that orders for psychotropic medications contained target behaviors/symptoms and required monitoring for potential adverse side effects as required. The Pharmacist Consultant verified that the behavior type and adverse side are reflected on the electronic MAR. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. On December 15, 2021 the Pharmacist Consultant's were educated by the Director of Nursing and Administrator on the need to report irregularities to the Director of Nursing or Medical Director related to the failure to discontinue a medication as ordered. In addition on December 15, 2021 all nurses were educated by the Staff Development Nurse on proper psychotropic medication orders entry into AHT to include diagnosis, target behaviors/symptoms for each psychotropic medication including monitoring for potential adverse side effects. All psychotropic medication orders will include target behaviors/symptoms for each psychotropic medication including monitoring for potential adverse side effects. INDICATE HOW THE FACILITY PLANS	

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F 756	Continued From page 21 An interview occurred with the Nurse Practitioner (NP) on 12/2/21 at 9:45 AM, and stated she was aware target behaviors should be identified, monitored, and documented as well as side effect monitoring for any resident on psychotropic medications. A telephone interview with the Pharmacy Consultant was conducted on 12/2/21 at 11:45 AM. She stated she expected the facility staff to always monitor for adverse side effects and she looked for the evidence of identified target behaviors and side effect monitoring in the physician notes, nursing notes and psychological service notes if applicable. The Pharmacy Consultant was unable explain why she did not recommend the need to identify target behaviors and side effect monitoring for Resident #12 in her recommendations. 2) Resident #14 was originally admitted to the facility on 10/3/19 with a readmission date of 4/9/21. Her diagnoses included a history of a stroke, and major depressive disorder. Resident #14's physician orders included an order dated 4/9/2, for Sertraline (an antidepressant) 25 milligrams by mouth daily. The annual Minimum Data Set (MDS) assessment dated 8/16/21 indicated Resident #14 was cognitively intact and displayed no behavior issues. Her mood was coded as feeling tired or having little energy 7 to 11 days during the 14 day look back period. Resident #14 received 7 days of an antidepressant. Review of the Pharmacy Consultant medication	F 756	TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Director of Nursing or Designee will review all psychotropic medication orders entered to ensure accuracy including diagnosis, target behaviors/symptoms for each psychotropic medication including monitoring for potential adverse side effects. The Director of Nursing or Designee will utilize the Alston Brook Psychotropic Medication Order Audit Log as follows: 1. Monitor the psychotropic medication orders 3 times a week for 4 weeks ; then 2. Monitor the psychotropic medication orders 3 times bi-weekly for 4 weeks; then 3. Monitor the psychotropic medication orders 4 times a month until resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and new system will be put into place by December 30, 2021.	

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review notes for resident #14 from June 2021 to November 2021 did not reflect the need for monitoring targeted behaviors or side effects.

A review of Resident #14's nursing progress notes from 9/1/21 to 12/1/21 included a behavior of refusing medications at times.

Resident #14's Medication Administration Records (MARs) from 9/1/21 to present indicated she received Sertraline as ordered. The MAR did not list any targeted behaviors for staff to monitor nor side effects that may be displayed from the medication.

On 11/30/21 at 1:32 PM, an interview occurred with the Director of Nursing (DON), who stated she was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications. She reported the facility had two software programs with the capability to enter the monitoring of behaviors and side effects on the MAR under a "special requirement" tab, but apparently this was not being utilized by nursing.

On 12/1/21 at 1:35 PM, an interview occurred with Nurse #2 who was familiar with Resident #14 and stated there were no specific behavior or side effect monitoring for the use of the psychotropic medications.

An interview occurred with the facility Physician Assistant (PA) on 12/1/21 at 2:45 PM, and stated she was aware target behaviors should be identified, monitored, and documented as well as side effect monitoring for any resident on psychotropic medications.

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A telephone interview with the Pharmacy Consultant was conducted on 12/2/21 at 11:45 AM. She stated she expected the facility staff to always monitor for adverse side effects and she looked for the evidence of identified target behaviors and side effect monitoring in the physician notes, nursing notes and psychological service notes if applicable. The Pharmacy Consultant was unable explain why she did not recommend the need to identify target behaviors and side effect monitoring for Resident #14 in her recommendations.

3) Resident #67 was admitted to the facility on 10/27/21 with diagnoses that included major depressive disorder, and Alzheimer's disease.

Resident #67's physician orders included an order dated 10/27/21, for Citalopram (an antidepressant) 10 milligrams by mouth every evening.

The admission Minimum Data Set (MDS) assessment dated 11/3/21 indicated Resident #67 had severe cognitive impairment and displayed no behavior issues. Her mood was coded as feeling tired or having little energy 2 to 6 days during the 14 day look back period. Resident #67 received 7 days of an antidepressant.

Review of the Pharmacy Consultant medication review notes for resident #67 from October 2021 to November 2021 did not reflect the need for monitoring targeted behaviors or side effects.

A review of Resident #67's nursing progress notes from 10/27/21 to 12/1/21 included behaviors such as noncompliance, and repetitive

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statements.

Resident #67's Medication Administration Records (MARs) from 10/27/21 to present indicated she received Citalopram as ordered. The MAR did not list any targeted behaviors for staff to monitor nor side effects that may be displayed from the medication.

On 11/30/21 at 1:32 PM, an interview occurred with the Director of Nursing (DON), who stated she was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications. She reported the facility had two software programs with the capability to enter the monitoring of behaviors and side effects on the MAR under a "special requirement" tab, but apparently this was not being utilized by nursing.

On 12/1/21 at 1:50 PM, an interview occurred with Nurse #3 who was familiar with Resident #67 and stated there were no specific behavior or side effect monitoring for the use of the psychotropic medications.

An interview occurred with the facility Physician Assistant (PA) on 12/1/21 at 2:45 PM, and stated she was aware target behaviors should be identified, monitored, and documented as well as side effect monitoring for any resident on psychotropic medications.

A telephone interview with the Pharmacy Consultant was conducted on 12/2/21 at 11:45 AM. She stated she expected the facility staff to always monitor for adverse side effects and she looked for the evidence of identified target behaviors and side effect monitoring in the

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physician notes, nursing notes and psychological service notes if applicable. The Pharmacy Consultant was unable explain why she did not recommend the need to identify target behaviors and side effect monitoring for Resident #67 in her recommendations.

4) Resident #81 was admitted to the facility on 11/8/21 with diagnoses that included congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).

Resident #81's physician orders included orders dated 11/8/21 for Bupropion (an antidepressant) 100 milligrams (mg) by mouth every morning and Aripiprazole (an antipsychotic) 5mg by mouth twice a day.

The admission Minimum Data Set (MDS) assessment dated 11/15/21 indicated Resident #81 was cognitively intact and displayed no mood or behavior issues.

Review of the Pharmacy Consultant medication review notes for resident #81 from November 2021 did not reflect the need for monitoring targeted behaviors or side effects.

A review of Resident #81's nursing progress notes from 11/8/21 to 12/1/21 included no mood or behavior concerns.

Resident #81's Medication Administration Records (MARs) from 11/8/21 to present indicated he received Bupropion and Aripiprazole as ordered. The MAR did not list any targeted behaviors for staff to monitor nor side effects that may be displayed from the medications.

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On 11/30/21 at 1:32 PM, an interview occurred with the Director of Nursing (DON), who stated she was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications. She reported the facility had two software programs with the capability to enter the monitoring of behaviors and side effects on the MAR under a "special requirement" tab, but apparently this was not being utilized by nursing.

On 12/1/21 at 1:50 PM, an interview occurred with Nurse #3 who was familiar with Resident #81 and stated there were no specific behavior or side effect monitoring for the use of the psychotropic medications.

An interview occurred with the facility Physician Assistant (PA) on 12/1/21 at 2:45 PM, and stated she was aware target behaviors should be identified, monitored, and documented as well as side effect monitoring for any resident on psychotropic medications.

A telephone interview with the Pharmacy Consultant was conducted on 12/2/21 at 11:45 AM. She stated she expected the facility staff to always monitor for adverse side effects and she looked for the evidence of identified target behaviors and side effect monitoring in the physician notes, nursing notes and psychological service notes if applicable. The Pharmacy Consultant was unable explain why she did not recommend the need to identify target behaviors and side effect monitoring for Resident #81 in her recommendations.

5. Resident #69 admitted on 9/15/20 with a

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diagnosis of vascular dementia with behavioral disturbance.

The quarterly Minimum Data Set (MDS) dated 11/1/21 indicated Resident #69 had severe cognitive impairments and he exhibited no behaviors during the 7 day look back period for the assessment. He was coded as taking as taking an antipsychotic on a routine basis.

Review of Resident #69's November 2021 Physician orders included the following: Seroquel 25 milligrams (mg) every morning and 25 mg every night at bedtime.

Resident #69's monthly Consultant Pharmacist medication review notes read the following:
6/16/21-no recommendations
7/21/21-be sure specific target behaviors are identified and documented for Seroquel
8/18/21- be sure specific target behaviors are identified and documented for Seroquel
9/21/21-no recommendations
10/19/21-no recommendation regarding Seroquel
11/16/21-no recommendations

Review of Resident #69's medication administration records from June 2021 to November 2021 indicated he received his Seroquel as ordered. There was no evidence of identified target behaviors and no evidence of monitoring for side effects.

Review of Resident #69's nursing notes from 6/1/21 to 11/30/21 included the following behaviors: grabbing female staff, wandering into other residents rooms, pulling the fire alarm, removing brief, smearing feces and grabbing his

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roommates urinary catheter bag and refusing to release.

Observation on 11/29/21 at 1:18 PM, Resident #69 was in his room sitting in his wheelchair. He was cooperative and did not exhibit any signs of agitation, wandering or aggression.

An interview with the Director of Nursing (DON) was conducted on 11/30/21 at 1:32 PM. She stated she was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications. She reported the facility had two software programs with the capability to enter the monitoring of behaviors and side effects on the MAR under a "special requirement" tab, but apparently this was not being utilized by nursing.

An interview was conducted with Nurse #4 on 12/1/21 at 8:30 AM. She stated Resident #69 exhibited wandering behaviors, exit seeking behaviors and inappropriately touched the female staff.

An interview was conducted with Nursing Assistant (NA) #9 on 12/1/21 at 9:00 AM. She stated she was very familiar with Resident #69. She stated the only behaviors she had observed was him wandering into other resident rooms and for some reason, he went around closing any door he saw open.

An interview was conducted with the physician's assistant (PA) on 12/1/21 at 2:45 PM. She stated she depended on the nurses to tell her what behaviors were exhibited for any resident prescribed a psychotropic medications. She stated she was aware that target behaviors

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should be identified, documented and monitored and there should be side effect monitoring for any resident prescribed psychotropic medications.

A telephone interview with the Consultant Pharmacist was conducted on 12/2/21 at 11:45 AM. She stated she recommended the identified concerns in July 2021 and August 2021 because she thought the recommendation had been completed. The Consultant Pharmacist stated when doing her monthly review, it was difficult to review the MARs to ensure target behaviors and adverse side effects were monitored daily. She stated she referred to nursing notes and physician progress notes to monitor for specific behaviors, effectiveness and for side effects of the antipsychotic medications prescribed for Resident #69.

An interview with the Administrator on 12/2/21 at 12:25 PM. He stated he was not aware that the facility was having any issues with psychotropic medications.

6. Resident #34 was admitted 4/12/18 with of anxiety and depression.

Her quarterly Minimum Data Set (MDS) dated 9/30/21 indicated she was cognitively intact and she exhibited no behaviors in the 7 day look back period for the assessment. Resident #34 was coded for taking antianxiety and antidepressant medications.

Review of Resident #34's November 2021 Physician orders included the following: Xanax 0.25 milligrams (mg) every morning, afternoon and at bedtime and Wellbutrin 150mg three times a day.

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Resident #34's monthly Consultant Pharmacist medication review notes read the following:
6/16/21-no recommendations related to Xanax of Wellbutrin
7/21/21-no recommendations related to Xanax and Wellbutrin
8/18/21- no recommendations related to Xanax and Wellbutrin
9/21/21-no recommendations related to Xanax and Wellbutrin
10/19/21-recommendation related to clarification of a Wellbutrin order dated 9/17/21
11/16/21-no recommendations related to Xanax and Wellbutrin

Review of Resident #34's medication administration records from June 2021 to November 2021 indicated she received her Xanax and Wellbutrin as ordered. There was no evidence of identified target behaviors and no evidence of monitoring for side effects.

Review of Resident #34's nursing notes from 6/1/21 to 11/30/21 included the following behaviors: no documented behaviors in June 2021, August 2021, September 2021 and October 2021. Nursing notes dated 7/29/21 , 11/15/21, 11/19/21 and 11/22/21 read she was tearful.

An interview with the Director of Nursing (DON) was conducted on 11/30/21 at 1:32 PM. She stated she was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications. She reported the facility had two software programs with the capability to enter the monitoring of behaviors and side effects on the MAR under a "special

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requirement" tab, but apparently this was not being utilized by nursing.

An interview with the nurse practitioner (NP) was conducted on 12/1/21 at 9:44 AM. She stated she obtained her information about Resident #34 from the staff and her family. The NP stated she expected the Consultant Pharmacist to identify the need for target behaviors and the monitoring for side effects. The NP stated if the facility had a different software program, it was would be helpful, but it was too much for the nurses to work in two different software programs and the hard chart.

An observation and interview was conducted on 12/1/21 at 10:40 AM. Resident #34 was in her room lying in bed. She stated she had not felt like herself lately and noted more confusion.

An interview was conducted with NA #5 on 12/1/21 at 3:55 PM. She stated Resident #34 has been accusing other residents of taking her things and clothing. NA #5 stated it was discovered that Resident #34 was throwing her clothes in the trash and staff had to go retrieve it. She stated she had not observed Resident #34 being tearful.

An interview was conducted with Nurse #5 on 12/2/21 at 9:05 AM. She stated she had not observed any agitation or crying but she had noted an increase in Resident #34 accusing other residents messing with her things.

A telephone interview with the Consultant Pharmacist was conducted on 12/2/21 at 11:45 AM. The Consultant Pharmacist stated when doing her monthly review, it was difficult to review

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the MARs to ensure target behaviors and adverse side effects were monitored daily. She stated she referred to nursing notes and physician progress notes to monitor for specific behaviors, effectiveness and for side effects of the psychotropic medications prescribed for Resident #34.

An interview with the Administrator on 12/2/21 at 12:25 PM. He stated he was not aware that the facility was having any issues with psychotropic medications.

7. Resident #17 was admitted 10/20/20 with a diagnosis of depression.

His quarterly Minimum Data Set (MDS) dated 9/1/21 indicated he was cognitively intact and he exhibited no behaviors in the 7 day look back period for the assessment. Resident #17 was coded for taking antidepressant medications.

Review of Resident #17's November 2021 Physician orders included the following: Cymbalta 60 milligrams (mg) once daily.

Resident #17's monthly Consultant Pharmacist medication review notes read the following:
6/16/21-no recommendations regarding Cymbalta
7/21/21-no recommendations
8/18/21- no recommendations regarding Cymbalta
9/21/21-no recommendations regarding Cymbalta
10/19/21-no recommendation regarding Cymbalta
11/16/21-no recommendations

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Review of Resident #17's medication administration records from June 2021 to November 2021 indicated he received his Cymbalta as ordered. There was no evidence of identified target behaviors and no evidence of monitoring for side effects.

Review of Resident #17's nursing notes from 6/1/21 to 11/30/21 did not include any documentation regarding any behaviors.

An observation and interview with Resident #17 was conducted on 11/30/21 at 9:41 AM. He lying in bed playing on a laptop. Resident #17 was complimentary of the facility and staff. He voiced no concerns.

An interview with the Director of Nursing (DON) was conducted on 11/30/21 at 1:32 PM. She stated she was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications. She reported the facility had two software programs with the capability to enter the monitoring of behaviors and side effects on the MAR under a "special requirement" tab, but apparently this was not being utilized by nursing.

An interview was conducted with the physician's assistant (PA) on 12/1/21 at 2:45 PM. She stated she depended on the nurses to tell her what behaviors were exhibited for any resident prescribed a psychotropic medications. She stated she was aware that target behaviors should be identified, documented and monitored and there should be side effect monitoring for any resident prescribed psychotropic medications.

An interview was conducted with NA #10 on

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12/2/21 at 9:10 AM. She stated Resident #17 was inappropriate with the female staff but she had not observed any crying, sadness, agitation or loss of appetite.

An interview was conducted with Nurse #1 on 12/2/21 at 9:15 AM. She stated Resident #17 did not exhibit any evidence of sadness, crying or changes in his appetite but he occasionally refused care but agreed with reapproach.

A telephone interview with the Consultant Pharmacist was conducted on 12/2/21 at 11:45 AM. The Consultant Pharmacist stated when doing her monthly review, it was difficult to review the MARs to ensure target behaviors and adverse side effects were monitored daily. She stated she referred to nursing notes and physician progress notes to monitor for specific behaviors, effectiveness and for side effects of the psychotropic medications prescribed for Resident #17.

An interview with the Administrator on 12/2/21 at 12:25 PM. He stated he was not aware that the facility was having any issues with psychotropic medications.

8. Resident #25 was admitted to the facility on 6/11/21 with multiple diagnoses including anxiety disorder.

The quarterly Minimum Data Set (MDS) assessment dated 9/17/21 indicated that Resident #25 has moderate cognitive impairment.

Resident #25 has a doctor's order dated 7/12/21 for Calcium Carbonate 500 milligrams (mgs) 1 tablet by mouth daily for 30 days.

Review of the Medication Administration Records

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(MARs) from July through December 2021 revealed that Calcium Carbonate was not discontinued after 30 days as ordered. Resident #25 continued to receive the Calcium Carbonate as of 12/1/21.

Review of the monthly drug regimen review (DRR) was conducted. The Pharmacy Consultant has conducted the DRR on 8/18/21, 9/21/21, 10/19/21 and 11/16/21. The reviews did not address the irregularity regarding the failure to discontinue the Calcium Carbonate as ordered.

Nurse #1, assigned to Resident #25, was interviewed on 12/1/21 at 12:15 PM. She reviewed the doctor's orders and verified that Calcium Carbonate was ordered for 30 days and should have been discontinued on 8/12/21 but it was not. She reported that the Nurse who transcribed the order to MAR did not put a stop date and therefore it was not discontinued. Nurse #1 stated that she would inform the doctor of the error.

The PA was interviewed on 12/1/21 at 3:40 PM. The PA reported that she was informed of the medication error on Resident #25 regarding the Calcium Carbonate. She stated that she expected the nurses to follow the order to prevent unnecessary medication. The PA added that she ordered to discontinue the Calcium Carbonate today.

The Pharmacy Consultant was interviewed on 12/2/21 at 9:35 AM. She reviewed the orders and verified that Calcium Carbonate was ordered for 30 days on 7/12/21 for Resident #25. She reviewed the monthly drug regimen reviews and reported that the irregularity was not identified

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and addressed with the DON nor the physician, it was missed.

The Director of Nursing (DON) was interviewed on 12/2/21 at 1:08 PM. She stated that she expected the Pharmacy Consultant to identify and to report drug irregularities as indicated.

9. Resident #6 was admitted to the facility on 6/16/21 with multiple diagnoses including depression and anxiety. The quarterly Minimum Data Set (MDS) assessment dated 8/11/21 indicated that Resident #6 has moderate cognitive impairment and has received an antianxiety and antidepressant medications for 7 days during the assessment period.

Resident #6 has doctor ' s orders for Paxil 40 milligrams (mgs) by mouth daily for depression on 6/16/21 and Klonopin 0.5 mgs by mouth at bedtime for anxiety on 8/1/21.

Review of Resident #6's medical records revealed no documentation of monitoring for the target behaviors and the side effects of the psychotropic medications.

Review of the monthly drug regimen reviews (DRR) for Resident #6 was conducted. The Pharmacy Consultant has completed the DRR for Resident #6 on 7/21/21, 8/19/21, 9/21/21, 10/19/21 and 11/16/21. The reviews did not address the need to monitor the side effects and the target behaviors.

Interview with the Director of Nursing (DON) was conducted on 11/30/21 at 1:32 PM. Th DON

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F 756	Continued From page 37 stated that she was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications. She reported that the facility has two software programs and has the capability to enter the monitoring of behaviors and side effects on the Medication Administration Record (MAR) under the special requirements, but apparently this special requirement was not being used by nursing. Interview with the Physician Assistant (PA) was conducted on 12/1/21 at 2:45 PM. The PA stated that she was aware that target behaviors should be identified, monitored, and documented and there should be side effects monitoring for any residents on psychotropic medications. Interview with the Pharmacy Consultant was conducted on 12/2/21 at 11:45 AM. The Pharmacy Consultant stated that she expected the staff to always monitor for adverse side effects of psychotropic medications. She reported that she looked for the target behaviors and the side effects monitoring in the physician progress notes, nursing notes and psychiatric notes if any. She added that she had recommended the need to monitor the behaviors in July and August 2021,but she was unable explain why she did not recommend the need to identify target behaviors and side effect monitoring for Resident #6 in her recommendations.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 757		12/30/21

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F 757	Continued From page 38 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and Physician Assistant (PA) and staff interview, the facility failed to discontinue a medication as ordered for 1 of 10 sampled residents reviewed for unnecessary medications (Resident #25). Findings included: Resident #25 was admitted to the facility on 6/11/21 with multiple diagnoses including anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 9/17/21 indicated that Resident #25 has moderate cognitive impairment. Resident #25 had a doctor's order dated 7/12/21 for Calcium Carbonate 500 milligrams (mgs) 1 tablet by mouth daily for 30 days.	F 757	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. The medication is question on Resident #25 was discontinued on December 1, 2021. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. On December 15, 2021 the Pharmacist Consultant conducted a thorough audit all	

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F 757	Continued From page 39 Review of the Medication Administration Records (MARs) from July through December 2021 revealed that Calcium Carbonate was not discontinued after 30 days as ordered. Resident #25 continued to receive the Calcium Carbonate as of 12/1/21. Nurse #1, assigned to Resident #25, was interviewed on 12/1/21 at 12:15 PM. She reviewed the doctor's orders and verified that Calcium Carbonate was ordered for 30 days and should have been discontinued on 8/12/21 but it was not. She reported that the Nurse who transcribed the order to MAR did not put a stop date and therefore it was not discontinued. Nurse #1 stated that she would inform the doctor of the error. The PA was interviewed on 12/1/21 at 3:40 PM. The PA reported that she was informed of the medication error on Resident #25 regarding the Calcium Carbonate. She stated that she expected the nurses to follow the order to prevent unnecessary medication. The PA added that she ordered to discontinue the Calcium Carbonate today. The Director of Nursing (DON) was interviewed on 12/2/21 at 1:08 PM. She stated that she expected the nurses to follow the doctor's order.	F 757	of resident's orders and noted five orders that needed to be discontinued. All five noted orders needing to be discontinued were discontinued on December 15, 2021. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. On December 15, 2021 all nurses were be re-educated by the Staff Development Nurse on proper order entry pertaining to order stop date entry which results in the discontinuation of the medication. Physician orders will be screened on a daily basis by the First Shift Nurse Manager and the Staff Development Nurse to determine orders requiring an order stop date and orders will be logged on the Order Entry Medication Stop Date Checklist and those will be verified for proper entry in AHT and verification and/or correction will be noted on Order Entry Medication Stop Date Checklist and followed up with entering nurse as needed. On December 15, 2021 the First Shift Nurse Manager and the Staff Development Nurse were educated by the Director of Nursing on the Order Entry Medication Stop Date Checklist and Physician order stop date order screening process. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE	

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F 757	Continued From page 40	F 757	SUSTAINED. The Director of Nursing or Designee will monitor the Order Entry Medication Stop Date Checklist as follows: 1. Monitor the Order Entry Medication Stop Date Checklist weekly 3 times a week for 4 weeks ; then 2. Monitor the Order Entry Medication Stop Date Checklist bi-weekly 3 times a week for 4 weeks; then 3. Monitor the Order Entry Medication Stop Date Checklist 4 times a month until resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and new system will be put into place by December 30, 2021.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		12/30/21

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F 758	Continued From page 41 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Pharmacy Consultant, facility Physician's Assistant and facility Nurse Practitioner, the facility failed to identify the need to monitor target behavioral symptoms, as well as the need to monitor residents for side effects of psychotropic medications (Residents #12, #14, #67, # 81, #69, #34, #17, #28 and #6). This was for 9 of 11 residents whose medications were reviewed. The findings included: 1) Resident #12 was originally admitted to the facility on 8/27/21 with a recent readmission date of 9/9/21. Her diagnoses included Alzheimer's disease and major depressive disorder. Resident #12's physician orders included an order for Sertraline (an antidepressant) 50 milligrams by mouth daily. The admission Minimum Data Set (MDS) assessment dated 9/3/21 indicated Resident #12 had severe cognitive impairment and displayed no behaviors. Her mood was coded with poor appetite or overeating 2 to 6 days during the 14 day look back period. Resident #12 received 7 days of an antidepressant. A review of Resident #12's care plan, with a start date of 9/7/21, revealed a focus area for the use of an antidepressant medication due to history of depression. The interventions included to monitor patterns of target behaviors, assess for adverse side effects, document, and report, and monitor for effectiveness of antidepressant medication.	F 758	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. On December 14, 2021 new orders entered for residents #12, #14, #67, #81, #69, #34, #17, #6, and #28 which include target behaviors/symptoms for each psychotropic medication including monitoring for potential adverse side effects. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. On December 15, 2021 the Pharmacist Consultant conducted an audit of psychotropic medications and of those residents who were audited found that orders for psychotropic medications contained target behaviors/symptoms and required monitoring for potential adverse side effects as required. The Pharmacist Consultant verified that the behavior type and adverse side are reflected on the electronic MAR. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR.	

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F 758	Continued From page 43 Review of the Pharmacy Consultant medication review notes for resident #12 from August 2021 to November 2021 did not reflect the need for monitoring targeted behaviors or side effects. A review of Resident #12's nursing progress notes from 8/27/21 to 11/27/21 included behaviors such as wandering, pilfering, cursing, and hitting staff as well as crying and tearfulness. Resident #12's Medication Administration Records (MARs) from 9/1/21 to present indicated she received Sertraline as ordered. There was no evidence of identified target behaviors or monitoring for side effects. An interview was conducted with the Director of Nursing (DON) on 11/30/21 at 1:32 PM. She stated Resident #12's target behaviors and side effect monitoring was documented if observed in the nursing notes and on the nursing acute sheets, which were not part of the medical record. She explained the facility had the capability to identify target behaviors and side effects when entering an order for a psychotropic medication into the electronic medical record (EMR) under the "special requirements" tab. If this was completed when the medication was entered in the EMR, it would appear on the resident's MAR, however she felt either this was not being done or the two software programs the facility used did not communicate with each other. The DON stated the physician reviewed all the psychotropic medications weekly with the Nurse Manager (NM) and was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications. On 11/30/21 at 3:15 PM, an interview was	F 758	On December 15, 2021 all nurses were educated by the Staff Development Nurse on proper psychotropic medication orders entry into AHT to include diagnosis, target behaviors/symptoms for each psychotropic medication including monitoring for potential adverse side effects. All psychotropic medication orders will include target behaviors/symptoms for each psychotropic medication including monitoring for potential adverse side effects. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Director of Nursing or Designee will review all psychotropic medication orders entered to ensure accuracy including diagnosis, target behaviors/symptoms for each psychotropic medication including monitoring for potential adverse side effects. The Director of Nursing or Designee will utilize the Alston Brook Psychotropic Medication Order Audit Log as follows: 1. Monitor the psychotropic medication orders 3 times a week for 4 weeks ; then 2. Monitor the psychotropic medication orders 3 times bi-weekly for 4 weeks; then 3. Monitor the psychotropic medication orders 4 times a month until resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance	

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F 758	Continued From page 44 conducted with the Nurse Manager (NM), who stated she was over the psychotropic medications and worked with the physician regarding the need for gradual dose reductions, but target behaviors and side effect monitoring was not discussed, as the nurses were only documenting these areas if observed. The NM stated she was not aware that psychotropics required identified target behaviors and the facility did not routinely monitor for side effects, but the nurse would contact the physician for any changes noted in the resident. The NM added the software system for charting had a tab called "special requirements" in which side effects and target behaviors could be identified but the two software programs did not communicate with each other. On 11/30/21 at 3:30 PM, Resident #12 was observed sitting up in a wheelchair in the common area talking with another resident. On 12/1/21 at 1:35 PM, an interview occurred with Nurse #2. She stated Resident #12 became easily agitated with other residents, would curse, and hit out at staff. Nurse #2 stated there was not a specific behavior or side effect monitored on the MAR or on the Physician orders, however if she observed or was told of any behaviors, it would be documented in the nursing progress notes and reported to the physician as needed. An interview was completed with Nurse Practitioner (NP) on 12/2/21 at 9:45 AM, who explained she relied on the nursing staff to report if Resident #12 was displaying any behaviors or side effects to the antidepressant medication. She further stated she was aware target behaviors should be identified, documented, and monitored and there should be side effect	F 758	Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and new system will be put into place by December 30, 2021.	

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monitoring for any resident prescribed psychotropic medications.

A telephone interview with the Pharmacy Consultant was conducted on 12/2/21 at 11:45 AM. She stated she expected the facility staff to always monitor for adverse side effects and she looked for the evidence of identified target behaviors and side effect monitoring in the physician notes, nursing notes and psychological service notes if applicable. The Pharmacy Consultant was unable explain why she did not recommend the need to identify target behaviors and side effect monitoring in her reviews.

The Administrator was interviewed on 12/2/21 at 12:25 PM and stated he was not aware the facility was having any issues with psychotropic medication monitoring.

2) Resident #14 was originally admitted to the facility on 10/3/19 with a readmission date of 4/9/21. Her diagnoses included a history of a stroke, and major depressive disorder.

Resident #14's physician orders included an order dated 4/9/21 for Sertraline (an antidepressant) 25 milligrams by mouth daily.

The annual Minimum Data Set (MDS) assessment dated 8/16/21 indicated Resident #14 was cognitively intact and displayed no behavior issues. Her mood was coded as feeling tired or having little energy 7 to 11 days during the 14 day look back period. Resident #14 received 7 days of an antidepressant.

Resident #14's active care plan revealed a focus

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area for history of crying spells and receives an antidepressant. The interventions included to monitor patterns of targeted behaviors, assess for adverse side effects, document, and report, and administer medication as ordered monitoring for effectiveness.

Review of the Pharmacy Consultant medication review notes for resident #14 from June 2021 to November 2021 did not reflect the need for monitoring targeted behaviors or side effects.

A review of Resident #14's nursing progress notes from 9/1/21 to 12/1/21 included a behavior of refusing medications at times.

Resident #14's Medication Administration Records (MARs) from 9/1/21 to present indicated she received Sertraline as ordered. The MAR did not list any targeted behaviors for staff to monitor nor side effects that may be displayed from the medication.

An interview was conducted with the Director of Nursing (DON) on 11/30/21 at 1:32 PM. She stated Resident #14's target behaviors and side effect monitoring was documented if observed in the nursing notes and on the nursing acute sheets, which were not part of the medical record. She explained the facility had the capability to identify target behaviors and side effects when entering an order for a psychotropic medication into the electronic medical record (EMR) under the "special requirements" tab. If this was completed when the medication was entered in the EMR, it would appear on the resident's MAR, however she felt either this was not being done or the two software programs the facility used did not communicate with each other. The DON

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stated the physician reviewed all the psychotropic medications weekly with the Nurse Manager (NM). She stated she was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications.

On 11/30/21 at 3:15 PM, an interview was conducted with the NM, who stated she was over the psychotropic medications and worked with the physician regarding the need for gradual dose reductions, but target behaviors and side effect monitoring was not discussed as the nurses were only documenting these areas if observed. The NM stated she was not aware that psychotropics required identified target behaviors. She stated the facility did not routinely monitor for side effect, but the nurse would contact the physician for any changes noted in the resident. The NM added the software system for charting had a tab called "special requirements" in which side effects and target behaviors could be identified but the two software programs did not communicate with each other.

On 12/1/21 at 12:30 PM, Resident #14 was observed completing her lunch meal. She was very engaging and had no concerns.

On 12/1/21 at 1:35 PM, an interview occurred with Nurse #2. She stated Resident #14 who was familiar with Resident #14 had episodes of crying or tearfulness. Nurse #2 stated there was there was not a specific behavior or side effect monitored on the MAR or on the Physician's order, however if she observed or was told of any behaviors, it would be documented in the nursing progress notes and reported to the physician as needed.

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An interview was completed with the facility Physician's Assistant (PA) on 12/1/21 at 2:45 PM, who explained she depended on the nursing staff to report if Resident #14 was displaying any behaviors or side effects to the antidepressant medication. She further stated she was aware target behaviors should be identified, documented, and monitored, as well as side effect monitoring for any resident prescribed psychotropic medications.

A telephone interview was completed with the Pharmacy Consultant on 12/2/21 at 11:45 AM. She stated she expected the facility staff to always monitor for adverse side effects and she referred to nursing notes, physician notes and psychological service notes, if applicable, for evidence of identified behaviors and side effects. The Pharmacy Consultant was unable to explain why she did not recommend the need to identify target behaviors and side effect monitoring in her reviews.

The Administrator was interviewed on 12/2/21 at 12:25 PM and stated he was not aware the facility was having any issues with psychotropic medication monitoring.

3) Resident #67 was admitted to the facility on 10/27/21 with diagnoses that included major depressive disorder, and Alzheimer's disease.

A review of Resident #67's physician orders included an order dated 10/27/21 for Citalopram (an antidepressant) 10 milligrams by mouth every evening.

The admission Minimum Data Set (MDS)

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assessment dated 11/3/21 indicated Resident #67 had severe cognitive impairment and displayed no behavior issues. Her mood was coded as feeling tired or having little energy 2 to 6 days during the 14 day look back period. Resident #67 received 7 days of an antidepressant.

A review of Resident #67's active care plan revealed a focus area for use of antidepressant medication due to history of recurrent major depression disorder. The interventions included to monitor patterns of targeted behaviors, assess for adverse side effects, document, and report, and administer medications as ordered.

Review of the Pharmacy Consultant medication review notes for resident #67 from October 2021 to November 2021 did not reflect the need for monitoring targeted behaviors or side effects.

A review of Resident #67's nursing progress notes from 10/27/21 to 12/1/21 included behaviors such as noncompliance and repetitive statements.

Resident #67's Medication Administration Records (MARs) from 10/27/21 to present indicated she received Citalopram as ordered. The MAR did not list any targeted behaviors for staff to monitor nor side effects that may be displayed from the medication.

On 11/30/21 at 9:30 AM, Resident #67 was observed sitting in her wheelchair at bedside. She was engaging but kept stating she had to get home since winter was coming and wanted to know how much longer things would take.

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An interview was conducted with the Director of Nursing (DON) on 11/30/21 at 1:32 PM. She stated Resident #67's target behaviors and side effect monitoring was documented if observed in the nursing notes and on the nursing acute sheets, which were not part of the medical record. She explained the facility had the capability to identify target behaviors and side effects when entering an order for a psychotropic medication into the electronic medical record (EMR) under the "special requirements" tab. If this was completed when the medication was entered in the EMR, it would appear on the resident's MAR, however she felt either this was not being done or the two software programs the facility used did not communicate with each other. The DON stated the physician reviewed all the psychotropic medications weekly with the Nurse Manager (NM). She stated she was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications.

On 11/30/21 at 3:15 PM, an interview was conducted with the NM, who stated she was over the psychotropic medications and worked with the physician regarding the need for gradual dose reductions, but target behaviors and side effect monitoring was not discussed as the nurses were only documenting these areas if observed. The NM stated she was not aware that psychotropics required identified target behaviors. She stated the facility did not routinely monitor for side effect, but the nurse would contact the physician for any changes noted in the resident. The NM added the software system for charting had a tab called "special requirements" in which side effects and target behaviors could be identified but the two software programs did not communicate with each other.

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On 12/1/21 at 1:50 PM, an interview occurred with Nurse #3 and Nurse Aide #8. They both stated Resident #67 became more agitated after 3:00 PM, wanting to go home, trying to find her car keys, or stating her husband was waiting for her. Nurse #3 stated there was not a specific behavior or side effect monitored on the MAR or on the Physician's orders, however if she observed or was told of any behaviors, it would be documented in the nursing progress notes and reported to the physician as needed.

An interview was completed with the facility Physician's Assistant (PA) on 12/1/221 at 2:45 PM, who explained she depended on the nursing staff to report if Resident #67 was displaying any behaviors or side effects to the antidepressant medication. She further stated she was aware target behaviors should be identified, documented, and monitored and there should be side effect monitoring for any resident prescribed psychotropic medications.

A telephone interview with the Pharmacy Consultant was conducted on 12/2/21 at 11:45 AM. She stated she expected the facility staff to always monitor for adverse side effects and she looked for the evidence of identified target behaviors and side effect monitoring in the physician notes, nursing notes and psychological service notes if applicable. The Pharmacy Consultant was unable explain why she did not recommend the need to identify target behaviors and side effect monitoring in her reviews.

The Administrator was interviewed on 12/2/21 at 12:25 PM and stated he was not aware the facility was having any issues with psychotropic

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medication monitoring.

4) Resident #81 was admitted to the facility on 11/8/21 with diagnoses that included congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).

A review of Resident #81's physician orders included orders dated 11/8/21 for Bupropion (an antidepressant) 100 milligrams (mg) by mouth every morning and Aripiprazole (an antipsychotic) 5mg by mouth twice a day.

The admission Minimum Data Set (MDS) assessment dated 11/15/21 indicated Resident #81 was cognitively intact and displayed no mood or behavior issues.

The active care plan for Resident #81 included a problem area for a history of anxiety and depression. The interventions included to administer medications as ordered, monitor patterns of targeted behaviors, and assess for adverse side effects, document, and report.

Review of the Pharmacy Consultant medication review notes for resident #81 from November 2021 did not reflect the need for monitoring targeted behaviors or side effects.

A review of Resident #81's nursing progress notes from 11/8/21 to 12/1/21 included no mood or behavior concerns.

Resident #81's Medication Administration Records (MARs) from 11/8/21 to present indicated he received Bupropion and Aripiprazole as ordered. The MAR did not list any targeted

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behaviors for staff to monitor nor side effects that may be displayed from the medications.

On 11/29/21 at 10:50 AM, Resident #81 was observed sitting in a wheelchair at bedside. He stated he was working with therapy in hopes of returning home. He denied any feelings of sadness and stated he only became anxious when he was having a hard time breathing but once he received his medications for shortness of breath the anxiety was gone.

An interview was conducted with the Director of Nursing (DON) on 11/30/21 at 1:32 PM. She stated Resident #81's target behaviors and side effect monitoring was documented if observed in the nursing notes and on the nursing acute sheets, which were not part of the medical record. She explained the facility had the capability to identify target behaviors and side effects when entering an order for a psychotropic medication into the electronic medical record (EMR) under the "special requirements" tab. If this was completed when the medication was entered in the EMR, it would appear on the resident's MAR, however she felt either this was not being done or the two software programs the facility used did not communicate with each other. The DON stated the physician reviewed all the psychotropic medications weekly with the Nurse Manager (NM). She stated she was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications.

On 11/30/21 at 3:15 PM, an interview was conducted with the NM, who stated she was over the psychotropic medications and worked with the physician regarding the need for gradual dose reductions, but target behaviors and side effect

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monitoring was not discussed as the nurses were only documenting these areas if observed. The NM stated she was not aware that psychotropics required identified target behaviors. She stated the facility did not routinely monitor for side effect, but the nurse would contact the physician for any changes noted in the resident. The NM added the software system for charting had a tab called "special requirements" in which side effects and target behaviors could be identified but the two software programs did not communicate with each other.

On 12/1/21 at 1:50 PM, an interview occurred with Nurse #3. She stated Resident #81 had not displayed any type of mood or behavior concerns. She further stated there was not a specific behavior or side effect monitored on the MAR or on the Physician orders, however if she observed or was told of any behaviors, it would be documented in the nursing progress notes and reported to the physician as needed.

An interview was completed with the facility Physician's Assistant (PA) on 12/1/221 at 2:45 PM, who explained she depended on the nursing staff to report if Resident #81 was displaying any behaviors or side effects to the antidepressant or antipsychotic medications. She further stated she was aware target behaviors should be identified, documented, and monitored and there should be side effect monitoring for any resident prescribed psychotropic medications.

A telephone interview with the Pharmacy Consultant was conducted on 12/2/21 at 11:45 AM. She stated she expected the facility staff to always monitor for adverse side effects and she looked for the evidence of identified target

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behaviors and side effect monitoring in the physician notes, nursing notes and psychological service notes if applicable. The Pharmacy Consultant was unable explain why she did not recommend the need to identify target behaviors and side effect monitoring in her reviews.

The Administrator was interviewed on 12/2/21 at 12:25 PM and stated he was not aware the facility was having any issues with psychotropic medication monitoring.

5. Resident #69 admitted on 9/15/20 with a diagnosis of vascular dementia with behavioral disturbance.

The quarterly Minimum Data Set (MDS) dated 11/1/21 indicated Resident #69 had severe cognitive impairments and he exhibited no behaviors during the 7 day look back period for the assessment. He was coded as taking as taking an antipsychotic on a routine basis.

Review of Resident #69's November 2021 Physician orders included the following: Seroquel 25 milligrams (mg) every morning and 25 mg every night at bedtime.

Review of Resident #69's medication administration records from June 2021 to November 2021 indicated he received his Seroquel as ordered. There was no evidence of identified target behaviors and no evidence of monitoring for side effects.

Review of Resident #69's nursing notes from 6/1/21 to 11/30/21 included the following behaviors: grabbing female staff, wandering into other residents rooms, pulling the fire alarm,

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removing brief, smearing feces and grabbing his roommates urinary catheter bag and refusing to release.

Observation on 11/29/21 at 1:18 PM, Resident #69 was in his room sitting in his wheelchair. He was cooperative and did not exhibit any signs of agitation, wandering or aggression.

An interview was conducted with the Director of Nursing (DON) on 11/30/21 at 1:32 PM. She stated Resident #69's target behaviors and side effects monitoring were documented by exception in the nursing notes and on the nursing acute sheets that were not part of the record. She stated the facility had the capability to identify target behaviors and side effects when entering a physician order for a psychotropic into the electronic medical record (EMR) under the "special requirements" tab so it would appear on the resident's MAR but that was apparently not being done or the two software programs the facility used, did not communicate with each other. The DON stated the Nurse Manger (NM) worked weekly with providers to discuss antipsychotic medications. She stated she was aware of the need for identifying targe behaviors and monitoring for side effects of psychotropic medications.

An interview was conducted with the NM on 11/30/21 at 3:15 PM. She stated she was over the psychotropic medications and worked the providers regarding the need for gradual dose reductions for antipsychotics. She stated target behaviors and side effects monitoring were not discussed because the nurses only documenting behaviors only by exception. The NM stated she was not aware that psychotropics required

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identified target behaviors. She stated the facility did no side effect monitoring but the nurse would contact the MD for any changes in the resident. The NM stated the software system for charting has a tab called "special requirements" in which side effects and target behaviors could be identified but the two software programs do not communicate with each other. She stated the nurses would not know unless they logged into the other program.

An interview was conducted with Nurse #4 on 12/1/21 at 8:30 AM. She stated Resident #69 exhibited wandering behaviors, exit seeking behaviors and inappropriately touched the female staff. Nurse #4 stated there were no identified target behaviors on the MAR or on the Physician orders. She also stated there were no side effect monitoring on the MAR or on the Physician orders. Nurse #4 stated when she observed a behaviors or was told about any behaviors, she documented it in a nursing note. She stated she was aware that there should be targeted behaviors to justify the continued use of an antipsychotic and that the side effect monitoring was very important for any resident talking an antipsychotic.

An interview was conducted with Nursing Assistant (NA) #9 on 12/1/21 at 9:00 AM. She stated she was very familiar with Resident #69. She stated the only behaviors she had observed was him wandering into other resident rooms and for some reason, he went around closing any door he saw open.

An interview was conducted with the PA on 12/1/21 at 2:45 PM. She stated she depended on the nurses to tell her what behaviors were

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exhibited for any resident prescribed a psychotropic medications. She stated she was aware that target behaviors should be identified, documented and monitored and there should be side effect monitoring for any resident prescribed psychotropic medications.

A telephone interview with the Consultant Pharmacist was conducted on 12/2/21 at 11:45 AM. The Consultant Pharmacist stated when doing her monthly review, it was difficult to review the MARs to ensure target behaviors and adverse side effects were monitored on a daily basis.

An interview with the Administrator on 12/2/21 at 12:25 PM. He stated he was not aware that the facility was having any issues with psychotropic medications.

6. Resident #34 was admitted 4/12/18 with of anxiety and depression.

Her quarterly Minimum Data Set (MDS) dated 9/30/21 indicated she was cognitively intact and she exhibited no behaviors in the 7 day look back period for the assessment. Resident #34 was coded for taking antianxiety and antidepressant medications.

Review of Resident #34's November 2021 Physician orders included the following: Xanax 0.25 milligrams (mg) every morning, afternoon and at bedtime and Wellbutrin 150mg three times a day.

Review of Resident #34's medication administration records from June 2021 to November 2021 indicated she received her Xanax and Wellbutrin as ordered. There was no

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evidence of identified target behaviors and no evidence of monitoring for side effects.

Review of Resident #34's nursing notes from 6/1/21 to 11/30/21 included the following behaviors: no documented behaviors in June 2021, August 2021, September 2021 and October 2021. Nursing notes dated 7/29/21 , 11/15/21, 11/19/21 and 11/22/21 read she was tearful.

An interview was conducted with the Director of Nursing (DON) on 11/30/21 at 1:32 PM. She stated Resident #34's target behaviors and side effects monitoring were documented by exception in the nursing notes and on the nursing acute sheets that were not part of the record. She stated the facility had the capability to identify target behaviors and side effects when entering a physician order for a psychotropic into the electronic medical record (EMR) under the "special requirements" tab so it would appear on the resident's MAR but that was apparently not being done or the two software programs the facility used, did not communicate with each other. The DON stated the Nurse Manger (NM) worked weekly with providers to discuss psychotropic medications. She stated she was aware of the need for identifying targe behaviors and monitoring for side effects of psychotropic medications.

An interview was conducted with the NM on 11/30/21 at 3:15 PM. She stated she was over the psychotropic medications and worked the providers. The NM stated during the weekly meetings, only the antipsychotics were discussed. She stated target behaviors and side effects monitoring were not discussed because the

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nurses only documenting behaviors only by exception. The NM stated she was not aware that psychotropics required identified target behaviors. She stated the facility did no side effect monitoring but the nurse would contact the MD for any changes in the resident. The NM stated the software system for charting has a tab called "special requirements" in which side effects and target behaviors could be identified but the two software programs do not communicate with each other. She stated the nurses would not know unless they logged into the other program.

An observation and interview was conducted on 12/1/21 at 10:40 AM. Resident #34 was in her room lying in bed. She stated she had not felt like herself lately and noted more confusion.

A telephone interview with the Consultant Pharmacist was conducted on 12/2/21 at 11:45 AM. The Consultant Pharmacist stated when doing her monthly review, it was difficult to review the MARs to ensure target behaviors and adverse side effects were monitored on a daily basis. She was unable to explain why she nor the facility identified the needed psychotropic medication monitoring.

An interview was conducted with NA #5 on 12/1/21 at 3:55 PM. She stated recently, Resident #34 has been accusing other residents of taking her things and clothing. NA #5 stated it was discovered that Resident #34 was throwing her clothes in the trash and staff had to go retrieve it. She stated she had not observed Resident #34 being tearful.

An interview was conducted with Nurse #5 on 12/2/21 at 9:05 AM. She stated she had not

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observed any evidence of agitation or crying but she had noted an increase in Resident #34 accusing other residents messing with her things. She stated it was felt that she was developing some dementia.

An interview with the NP was conducted on 12/1/21 at 9:44 AM. She stated she obtained her information about Resident #34 from the staff and her family. The NP stated the facility staff should monitor for adverse side effects for all medications to include psychotropics. The NP stated if the facility had a different software program, it was would be helpful but it was too much for the nurses to work in two different software programs and also the hard chart. The NP stated she felt the staff were overwhelmed with the events that have occurred during pandemic along with staff turnover and it resulted in some things being missed.

An observation of Resident #34 was conducted on 12/2/21 at 11:20 AM. She was lying in bed with her sister at the bedside. Her sister stated Resident #34 was nauseous this morning and the nurse had given her something for it. Resident #34's sister stated she started a new medication this morning and it may be making her nauseous.

An interview with the Administrator on 12/2/21 at 12:25 PM. He stated he was not aware that the facility was having any issues with psychotropic medications.

7. Resident #17 was admitted 10/20/20 with a diagnosis of depression.

His quarterly Minimum Data Set (MDS) dated 9/1/21 indicated he was cognitively intact and he

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exhibited no behaviors in the 7 day look back period for the assessment. Resident #17 was coded for taking antidepressant medications.

Review of Resident #17's November 2021 Physician orders included the following: Cymbalta 60 milligrams (mg) once daily.

Review of Resident #17's medication administration records from June 2021 to November 2021 indicated he received his Cymbalta as ordered. There was no evidence of identified target behaviors and no evidence of monitoring for side effects.

Review of Resident #17's nursing notes from 6/1/21 to 11/30/21 did not include any documentation regarding any behaviors.

An observation and interview with Resident #17 was conducted on 11/30/21 at 9:41 AM. He lying in bed playing on a laptop. Resident #17 was complimentary of the facility and staff. He voiced no concerns.

An interview was conducted with the Director of Nursing (DON) on 11/30/21 at 1:32 PM. She stated Resident #17's target behaviors and side effects monitoring were documented by exception in the nursing notes and on the nursing acute sheets that were not part of the record. She stated the facility had the capability to identify target behaviors and side effects when entering a physician order for a psychotropic into the electronic medical record (EMR) under the "special requirements" tab so it would appear on the resident's MAR but that was apparently not being done or the two software programs the facility used, did not communicate with each

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other. The DON stated the Nurse Manger (NM) worked weekly with providers to discuss psychotropic medications. She stated she was aware of the need for identifying targe behaviors and monitoring for side effects of psychotropic medications.

An interview was conducted with the NM on 11/30/21 at 3:15 PM. She stated she was over the psychotropic medications and worked the providers. The NM stated during the weekly meetings, only the antipsychotics were discussed. She stated target behaviors and side effects monitoring were not discussed because the nurses only documenting behaviors only by exception. The NM stated she was not aware that psychotropics required identified target behaviors. She stated the facility did no side effect monitoring but the nurse would contact the MD for any changes in the resident. The NM stated the software system for charting has a tab called "special requirements" in which side effects and target behaviors could be identified but the two software programs do not communicate with each other. She stated the nurses would not know unless they logged into the other program.

A telephone interview with the Consultant Pharmacist was conducted on 12/2/21 at 11:45 AM. The Consultant Pharmacist stated when doing her monthly review, it was difficult to review the MARs to ensure target behaviors and adverse side effects were monitored on a daily basis.

An interview was conducted with the PA on 12/1/21 at 2:45 PM. She stated she depended on the nurses to tell her what behaviors were exhibited for any resident prescribed a psychotropic medications. She stated she was

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aware that target behaviors should be identified, documented and monitored and there should be side effect monitoring for any resident prescribed psychotropic medications.

An interview was conducted with NA #10 on 12/2/21 at 9:10 AM. She stated Resident #17 was inappropriate with the female staff and loved it when a female bathed him. She stated she was not observed any crying, sadness, agitation or loss of appetite.

An interview was conducted with Nurse #1 on 12/2/21 at 9:15 AM. She stated Resident #17 did not exhibit any evidence of sadness, crying or changes in his appetite but he occasionally refused care but agreed with reapproach.

An interview with the Administrator on 12/2/21 at 12:25 PM. He stated he was not aware that the facility was having any issues with psychotropic medications.

8. Resident #28 was admitted to the facility on 6/28/17 with multiple diagnoses including major depressive disorder and anxiety. The annual Minimum Data Set (MDS) assessment dated 9/20/21 indicated that Resident #28's cognition was intact, and she has received an antianxiety and antidepressant medications for 7 days during the assessment period.

Resident #28 has doctor's orders for Clonazepam 0.125 milligrams (mgs) 1 tablet by mouth twice a day for anxiety and Lexapro 10 mgs - 1 and ½ tablet by mouth daily for depression on 9/23/21. On 11/9/21, Buspar 7.5 mgs 1 tablet by mouth 3 times a day for anxiety was added.

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Review of Resident #28's medical records revealed no documentation of monitoring of side effects and target behaviors.

An interview was conducted with the Director of Nursing (DON) on 11/30/21 at 1:32 PM. She stated that target behaviors and side effect monitoring were documented if observed in the nursing notes and on the nursing acute sheets, which were not part of the medical record. She explained the facility had the capability to monitor target behaviors and side effects when entering an order for a psychotropic medication into the electronic medical record (EMR) under the "special requirements" tab. If this was completed when the medication was entered in the EMR, it would appear on the resident's Medication Administration Records (MARs), however she felt either this was not being done or the two software programs the facility used did not communicate with each other. The DON stated the physician reviewed all the psychotropic medications weekly with the Nurse Manager (NM) and was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications.

On 11/30/21 at 3:15 PM, an interview was conducted with the Nurse Manager (NM), who stated she was over the psychotropic medications and worked with the physician regarding the need for gradual dose reductions, but target behaviors and side effect monitoring were not discussed, as the nurses were only documenting these areas if observed. The NM stated she was not aware that psychotropics required monitoring of target behaviors and the facility did not routinely monitor for side effects, but the nurse would contact the

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physician for any changes noted in the resident. The NM added the software system for charting had a tab called "special requirements" in which side effects and target behaviors could be monitored but the two software programs did not communicate with each other.

On 12/1/21 at 1:35 PM, an interview occurred with Nurse #2. Nurse #2 stated there was no specific behavior or side effect monitoring on the MAR, however if she observed or was told of any behaviors, it would be documented in the nursing progress notes and reported to the physician as needed.

An interview was completed with Nurse Practitioner (NP) on 12/2/21 at 9:45 AM, who explained she relied on the nursing staff to report if the resident was displaying any behaviors or side effects to the psychotropic medication. She further stated she was aware target behaviors should be identified, monitored and documented, and there should be side effect monitoring for any resident prescribed psychotropic medications.

The Administrator was interviewed on 12/2/21 at 12:25 PM and stated he was not aware the facility was having any issues with psychotropic medication monitoring.

9. Resident #6 was admitted to the facility on 6/16/21 with multiple diagnoses including depression and anxiety. The quarterly Minimum Data Set (MDS) assessment dated 8/11/21 indicated that Resident #6 has moderate cognitive impairment and had received an antianxiety and antidepressant medications for 7

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days during the assessment period.

Resident #6 has doctor's orders for Paxil 40 mgs. 1 tablet by mouth daily for depression on 6/16/21 and for Klonopin 0.5 mgs 1 tablet by mouth at bedtime for anxiety on 8/1/21.

Review of Resident #6 medical records revealed no documentation of monitoring of side effects and target behaviors.

An interview was conducted with the Director of Nursing (DON) on 11/30/21 at 1:32 PM. She stated that target behaviors and side effect monitoring were documented if observed in the nursing notes and on the nursing acute sheets, which were not part of the medical record. She explained the facility had the capability to monitor target behaviors and side effects when entering an order for a psychotropic medication into the electronic medical record (EMR) under the "special requirements" tab. If this was completed when the medication was entered in the EMR, it would appear on the resident's Medication Administration Records (MARs), however she felt either this was not being done or the two software programs the facility used did not communicate with each other. The DON stated the physician reviewed all the psychotropic medications weekly with the Nurse Manager (NM) and was aware of the need for identifying target behaviors and monitoring for side effects of psychotropic medications.

On 11/30/21 at 3:15 PM, an interview was conducted with the Nurse Manager (NM), who stated she was over the psychotropic medications and worked with the physician regarding the need for gradual dose reductions, but target behaviors

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F 758	Continued From page 68 and side effect monitoring were not discussed, as the nurses were only documenting these areas if observed. The NM stated she was not aware that psychotropics required target behavior monitoring and the facility did not routinely monitor for side effects, but the nurse would contact the physician for any changes noted in the resident. The NM added the software system for charting had a tab called "special requirements" in which side effects and target behaviors could be monitored but the two software programs did not communicate with each other. On 12/1/21 at 1:35 PM, an interview occurred with Nurse #2. Nurse #2 stated there was no specific behavior or side effect monitored on the MAR, however if she observed or was told of any behaviors, it would be documented in the nursing progress notes and reported to the physician as needed. An interview was completed with Nurse Practitioner (NP) on 12/2/21 at 9:45 AM, who explained she relied on the nursing staff to report if the resident was displaying any behaviors or side effects to the psychotropic medication. She further stated she was aware target behaviors should be identified, monitored and documented, and there should be side effect monitoring for any resident prescribed psychotropic medications. The Administrator was interviewed on 12/2/21 at 12:25 PM and stated he was not aware the facility was having any issues with psychotropic medication monitoring.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		12/30/21

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F 759	Continued From page 69 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review and review of the manufacturer's specification, observation, and staff interview, the facility failed to have a medication error rate of less than 5% as evidenced by 2 of 29 opportunities resulting in a medication error rate of 6.9% for 2 of 4 residents observed during medication pass (Residents #5 & #27). Findings included: 1. Resident #5 was admitted to the facility on 10/29/19. On 5/13/21, the resident has a doctor's order for senna (used to treat constipation) 8.6 milligrams (mgs) 1 tablet by mouth daily. Resident#5 was observed during the medication pass on 12/1/21 at 8:00 AM. The Medication Aide (Med. Aide) was observed to prepare and to administer senna with laxative 50 mgs/8.6 mgs 1 tablet by mouth to the resident. The Med. Aide was interviewed on 12/1/21 at 9:05 AM. She reported that she always administers senna with laxative to Resident #5 as she was instructed to give. She stated that she didn't know that there was a senna and a senna plus. The Director of Nursing (DON) was interviewed on 12/2/21 at 1:08 PM. She stated that she expected nursing including the Med Aides to	F 759	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. On December 3, 2021 the medication aide in question was re-educated by the Staff Development Nurse on the proper administration of a hand held inhaler and the difference between Senna and Senna Plus. Medication Aide was then observed by the Staff Development Nurse to have correctly administered the hand held inhaler for resident #27 and was observed administering correct dose of Senna to resident #5. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. The medication aide was re-educated on December 3, 2021 by the Staff Development Nurse as to the 5 rights of giving medication and the Staff Development Nurse conducted a Competency Assessment on Metered Dose Inhaler. The Pharmacist Consultant conducted a Med Pass Review on December 15, 2021 for medication aide in	

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F 759	Continued From page 70 follow doctor's orders. 2. The manufacturer's specification for Symbicort indicated "if your prescribed dose is 2 puffs, wait at least one minute between them" Resident #27 was admitted to the facility on 6/14/21. On 10/27/21, the resident has a doctor's order for Symbicort (used to treat chronic obstructive pulmonary disease (COPD)) 80-4.5 milligrams (mgs) inhaler - 2 puffs twice a day. Resident #27 was observed during the medication pass on 12/1/21 at 8:21 AM. The Med Aide was observed to prepare and to administer 2 puffs of Symbicort to Resident #27. The Med Aide waited 10 seconds between puffs. The Med Aide was interviewed on 12/1/21 at 9:05 AM. The Med Aide stated that she was supposed to wait 2-3 minutes between puffs, but she did not. The Director of Nursing (DON) was interviewed on 12/2/21 at 1:08 PM. She stated that she expected nursing including the Med Aides to follow the manufacturer's specification in administering the inhalers.	F 759	question with 0% error rate. In addition the Pharmacist Consultant conducted Med Pass Reviews on two addition nurses with 0% error rate which included residents with hand held inhaler. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. The Pharmacist Consultant will conduct random monthly Med Pass Reviews throughout facility. Timers were placed on all medication carts as a means of monitoring appropriate time period between inhaler administrations. On December 15, 2021 all nurses and medication aides were re-educated on proper Medication Administration by the Staff Development Nurse and RN Weekend Nurse Manager. The facility implemented a system where the Staff Development Nurse and RN Weekend Nurse Manager will randomly complete a Med-Pass Review checklist to ensure proper Medication Administration. On December 15, 2021 the Staff Development Nurse and RN Weekend Nurse Manager were educated on the implemented system change. All education was required prior to assuming scheduled work assignment. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED.	

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F 759	Continued From page 71	F 759	The Director of Nursing or Designee will review and monitor the Alston Brook Med-Pass Review Checklist by completing an Alston Brook Med-Pass Review QA Sheet to ensure systemic changes are maintained as follows: 1. Monitor the Med-Pass Review Checklist weekly for 4 weeks 1 Nurse and 1 Med-aide; then 2. Monitor the Med-Pass Review Checklist bi-weekly for 4 weeks1 Nurse and 1 Med-aide; then 3. Monitor the Med-Pass Review Checklist monthly 1 Nurse and 1 Med-aide until resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and new system will be put into place by December 30, 2021.	
F 947 SS=B	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must	F 947		12/30/21

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F 947	Continued From page 72 be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide Nursing Assistants (NAs) with annual dementia training for 5 of 5 sampled Nursing Assistants reviewed for required in-service training (NAs #1, #2, #3, #4 and #5). The findings included: NA #1's date of hire was 8/7/13. Review of NA #1's Education/in-service records indicated no record of Dementia training since 1/22/2020. NA #2's date of hire was 5/12/98. Review of NA #2's Education/in-service records indicated no record of Dementia training since 1/22/2020. NA #3's date of hire was 7/1/15. Review of NA #3's Education/in-service records indicated no record of Dementia training since 1/22/2020. NA #4's date of hire was 8/20/19. Review of NA #4's Education/in-service records indicated no record of Dementia training since 1/22/2020.	F 947	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. There were no residents directly affected. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. On December 8, 2021 all nurse aides were re-trained on understanding Dementia and Symptoms by the Staff Development Nurse and provided with handouts for cues and helps needed in dealing with residents with dementia diagnosis. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC	

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F 947	Continued From page 73 NA #5's date of hire was 6/12/18. Review of NA #5's Education/in-service records indicated no record of Dementia training since 1/22/2020. During an interview on 12/1/21 at 10:30 AM, the Staff Development Coordinator (SDC) stated she had recently taken over the position as SDC in July 2021 and confirmed she had not completed any type of dementia training since this time except for new hires. On 12/1/21 at 10:45 AM, the Director of Nursing (DON) confirmed dementia training had not occurred since January 2020 due to staff turn-overs in staff development in the past 2 years. The DON stated it was her expectation for all active aides be up to date with dementia training.	F 947	CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. The Annual Training Calendar was updated to include Dementia training to ensure annual training is conducted within the authorized time line requirements. Monthly schedule of all scheduled training will be posted on the Employee's Communication Board located by time clock in the break room. On December 15, 2021 the Staff Development Nurse was educated by the Director of Nursing on updating the Annual Training Calendar and posting month training schedule on the Employee's Communication Board located by time clock in the break room. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Director of Nursing or Designee will review and monitor the Alston Brook Annual Training Calendar and Employee Communication Board utilizing the Annual Training Requirements QA Form as follows: 1. Monitor the Alston Brook Annual Training Calendar and Employee Communication Board weekly for weekly for 4 weeks; then 2. Monitor the Alston Brook Annual Training Calendar and Employee Communication Board bi-weekly for 4 weeks e; then 3. Monitor the Alston Brook Annual	

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F 947	Continued From page 74	F 947	Training Calendar and Employee Communication Board monthly until resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and new system will be put into place by December 30, 2021.	