STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345072	A. BUILDING _____ B. WING _____	C 01/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RIVERS NURSING AND REHABILITATION CENTER	1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540

(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 The survey team entered the facility on 01/10/22 to conduct a Recertification survey. The survey team was onsite 01/10/22 through 01/13/22. Additional information was obtained offsite on 01/14/22. Therefore, the exit date was 01/14/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QRZH11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 01/10/22 to conduct a recertification survey and complaint investigation. The survey tam was onsite 01/10/22 through 01/13/22. Additional information was obtained offsite on 01/14/22. Therefore, the exit date was 01/14/22. Event ID#QRZH11. 18 of the 18 complaint allegations were not substantiated.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a	F 565		2/11/22

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

Electronically Signed | 01/27/2022

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F 565	Continued From page 1 resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviewed and staff and resident interviews, the facility failed to resolved grievances that were reported in resident council meetings for 4 of 6 months reviewed (July 2021, September 2021, October 2021, and November 2021). Findings included: Record review of Resident Council Meeting minutes for the months of July 2021, September 2021, October 2021, and November 2021 all revealed concerns about call light times. There was no attached resolution of these grievances. During an interview on 1/11/21 at 9:30 AM, Resident #2 revealed he and his roommate attend resident council meeting every month. He further indicated that staff does not address	F 565	On 1/25/2022, a Resident Council meeting was held by the Administrator to address actions initiated in response to unresolved resident council grievances. On 1/24/22, a 100% interview of alert and oriented residents was initiated by the Social Worker utilizing a Resident Council Audit Tool in regards to ensuring any concerns voiced during Resident Council Meetings are being addressed. All areas of concern were addressed by the Administrator. Questionnaires were completed by 1/25/22 A 100% staff inservice was initiated by the Administrator regarding answering call lights and timeliness of call light response. This was in response to Resident Council	

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F 565	Continued From page 2 concerns brought up in the meetings. During an interview on 1/12/21 at 10:40 AM, the activities director revealed they do not provide written resolutions to concerns brought up by the Resident Council group but will follow up with individual concerns. During an interview on 1/14/21 at 1:15 PM, the Administrator revealed individuals' concerns were addressed in writing but not concerns from the group.	F 565	concerns voiced during the July, September, October and November, 2021 meetings. The Resident Council was notified of the actions taken and resolution during the Resident Council meeting on 1/25/22. Inservice was completed on 1/28/22 Systemic Changes The Activity Director will bring any concerns voiced during the Resident Council meeting to the Cardinal IDT meeting on the day following the Resident Council meeting. The Activity Director and/or Activity Assistant will complete a Grievance Form for all concerns and forward to the Administrator who will forward it to the appropriate Department Head. The grievance will be investigated and resolved per policy and a written response will be provided at the next Resident Council meeting and attached to the meeting minutes. On 1/25/22 the Administrator completed an inservice with all Department Heads (DON, Social Worker, Maintenance Director, Dietary Manager, Accounts Receivable, Unit Managers, MDS Nurse, Activity Director and Rehab Director) regarding the Resident Council Grievance Process. QA Monitoring 10% of all alert and oriented residents will be interviewed by the Social Worker utilizing the Resident Council Audit Tool to ensure all Resident Council concerns are being addressed. This will be done weekly x 4 weeks and monthly x one	

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F 565	Continued From page 3	F 565	month. The Administrator will review and initial the Resident Council Audit Tools to ensure completion and all areas of Resident Council issues and/or concerns have been addressed. The Administrator will forward the Resident Council Audit Tool to the Executive QA Committee monthly x 2 months. The Executive QA Committee will review the Resident Council Audit Tool monthly x 2 months to determine trends and/or issues that may need further interventions put into place and to determine the need e for further and/or frequency of monitoring.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		2/11/22

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F 623	Continued From page 4	F 623		

discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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F 623	Continued From page 5 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written notification to the resident representative of the reason for discharge to the hospital and failed to provide a	F 623	On 1/25/22 a 100% audit of all residents who were transferred and/or discharged from the facility from December 1, 2021 through 1/14/22 was completed by the	

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F 623	Continued From page 6 copy of the notice to the Ombudsman for 2 of 5 sampled residents (Resident #35 and Resident #73) reviewed for hospitalization. The findings included: 1. Resident #35 was initially admitted to the facility on 5/15/18 with the last readmission on 1/7/22. The most recent comprehensive Minimum Data Set (MDS) dated 11/17/21 indicated Resident #35 was cognitively impaired Review of Resident #35's medical record revealed hospital stays from 10/27/21 through 10/31/21 and 1/2/22 through 1/7/22. During an interview on 1/14/22 at 10:44 AM, facility Administrator stated she was not aware that a letter was supposed to be sent to the resident representative regarding the reason a resident was being discharged to the hospital. The administrator communicated the resident representative was usually notified of transfer by telephone call and documented in resident's record. She indicated the Social Worker was supposed to send a log of admissions and discharges to the Ombudsman monthly. An interview was conducted with Social Worker (SW) on 1/14/22 at 1:44 PM. The SW indicated she was not aware she was supposed to send the Ombudsman a copy of notification of a resident discharge to hospital. A follow up interview was conducted with facility Administrator on 1/14/22 at 1:56 PM. The Administrator stated she thought they were doing	F 623	Administrator to ensure a Notice of Transfer and Discharge was provided to the resident and/or responsible party and to ensure the notice included the Resident's Appeal Rights; the Regional Ombudsman contact information and that written notification of transfer/discharge was provided to the Regional Ombudsman. Any issues and/or concerns were addressed by the Administrator. Systemic Changes An Inservice with the Social Worker, Accounts Receivable Manager and Admissions Director was conducted by the Administrator on 1/24/22 regarding Transfer and Discharge Notices with emphasis on notification of Responsible Party and the Regional Ombudsman The Admissions Director will notify the Regional Ombudsman of any transfers/discharges as soon as possible after discharge or, at least, on a monthly basis. The Accounts Receivable Manager will provide residents and/or the responsible party the resident's appeal rights, and the Regional Ombudsman contact information per the Notice of Transfer and Discharge Form. Quality Assurance Monitoring: 100% audit of all Transfers and Discharges will be completed by the Admissions Director weekly x 4 weeks and monthly x 1 month utilizing the Transfer and Discharge Audit Tool. This audit is to ensure notice requirements for all transfer or discharges have been met including written notification to Regional	

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F 623	Continued From page 7 what they were supposed to do regarding notification of resident discharge to hospital. She stated that they called resident representative but did not provide a written notification to resident representative. Social worker was supposed to send monthly notifications of discharges to ombudsman but had not sent it in. Administrator stated going forward she would ensure a written notification of reason for discharge to hospital was provided to resident representative and a copy of notice was provided to the Ombudsman. 2. Resident #73 was admitted to the facility on 5/4/20. The most recent comprehensive Minimum Data Set (MDS) dated 10/27/21 indicated Resident #73 was cognitively intact. Review of Resident #73's medical record revealed hospital stays from 11/27/21 through 11/29/21, 12/1/21 through 12/7/21, and 12/10/21 through 12/11/21. During an interview on 1/14/22 at 10:44 AM, facility Administrator stated she was not aware that a letter was supposed to be sent to the resident representative regarding the reason a resident was being discharged to the hospital. The administrator communicated the resident representative was usually notified of transfer by telephone call and documented in resident's record. She indicated the Social Worker was supposed to send a log of admissions and discharges to the Ombudsman monthly. An interview was conducted with Social Worker (SW) on 1/14/22 at 1:44 PM. The SW indicated she was not aware she was supposed to send	F 623	Ombudsman per CFR (s): 483.15. The Administrator will review and initial the Transfer and Discharge Audit Tools to ensure completion and all issues have been addressed. The Administrator will forward the Transfer and Discharge Audit Tools to the Executive QA Committee monthly x 2 months. The Executive QA Committee will review the Transfer and Discharge Audit Tools monthly x 2 months to determine trends and/or issues that may need further interventions put into place and to determine for further and/or increased frequency of monitoring.	

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F 623	Continued From page 8 the Ombudsman a copy of notification of a resident discharge to hospital. A follow up interview was conducted with facility Administrator on 1/14/22 at 1:56 PM. The Administrator stated she thought they were doing what they were supposed to do regarding notification of resident discharge to hospital. She stated that they called resident representative but did not provide a written notification to resident representative. Social worker was supposed to send monthly notifications of discharges to ombudsman but had not sent it in. Administrator stated going forward she would ensure a written notification of reason for discharge to hospital was provided to resident representative and a copy of notice was provided to the Ombudsman.	F 623		
F 641 SS=D	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 interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of level II Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents (Resident # 71) identified as PASRR Level II. Findings included: Resident #71 was admitted to the facility on 5/03/12 and most recently readmitted on 12/21/21 after hospitalization with multiple diagnoses that included schizophrenia and depression.	F 641	Resident #71's Minimum Data Set dated 3/31/21 was modified by the MDS Nurse on 1/12/22 to show a Level II PASRR An audit of all other Level II PASRR's was initiated on 1/25/22 to ensure all are coded accurately on the most recent MDS. All issues were corrected by the MDS Nurse. Audit to be completed by 1/26/22 Systemic Changes The Social Worker will discuss all new Level II PASSRs during the daily Cardinal IDT meeting and ensure PASSR level is	2/11/22

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F 641	Continued From page 9 Record review indicated Resident #71 had a Preadmission Screening and Resident Review (PASRR) Level II Determination Notification dated 1/29/21. The annual MDS assessment dated 3/31/21 was answered "No" to question A1500 which asked if Resident #71 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or intellectual disability or a related condition. An interview was conducted on 1/11/22 at 3:00 PM with the Administrator regarding PASRR II documentation for Resident #71. The Administrator provided a copy of the Level II PASRR Review for Resident #71. An interview was conducted on 1/12/22 at 1:15 PM with the Minimum Data Set Nurse 1 (MDS Nurse #1) and Minimum Data Set Nurse 2 (MDS Nurse #2) regarding PASRR II documentation. MDS Nurse #1 stated the PASRR II documentation was available but not to them; therefore, it did not get coded in Resident #71 ' s annual MDS assessment. An interview was conducted on 1/14/22 at 11:20 AM with the Administrator. The Administrator explained she had been notified by the MDS Nurses that the PASRR II was not coded on Resident #71 ' s annual assessment dated 03/31/21 and the coding was being corrected. The Administrator stated all PASRR II residents should be coded on their annual MDS assessments.	F 641	documented accurately in the Electronic Health Record. MDS Nurses were inserviced by the Facility Nurse Consultant on 1/25/22 regarding ensuring all PASSRs are coded accurately on the most recent MDS. QA Monitoring The Medical Records Manager will monitor 10% of all Admission, Annual and Significant change in condition MDS's, weekly x 4 weeks and monthly x one month to ensure accuracy of PASSR coding. Any issues will be reported to and addressed by the MDS Nurse. The Administrator will review and initial the MDS List Form to ensure completion and all areas of concerns have been addressed. The Administrator will forward the MDS List Form to the Executive QA Committee monthly x 2 months. The Executive QA Committee will review the MDS List Form monthly x 2 months to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or increased frequency of monitoring.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On	F 756		2/11/22

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F 756	Continued From page 10 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 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	F 756		

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F 756	Continued From page 11 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the physician received the Pharmacy Consultant's recommendations to include a stop date for psychotropic medications for 1 of 3 residents reviewed for unnecessary psychotropic medications (Resident #59). The findings included: Resident #59 was admitted to the facility on 09/30/19 with diagnoses that included mood disorder, dementia with behavioral disturbance. Review of Resident #59's physician orders revealed an order dated 11/15/21 for Haloperidol Lactate 5 milligrams (mg) intramuscular every 6 hours PRN for agitation. The end date indicated was "indefinite." Review of Resident #59's physician orders revealed an order dated 11/16/21 entered by the psychology service Physician Assistant (PA) for Haloperidol Lactate 5 mg intramuscular every 12 hours PRN for breakthrough agitation and aggression. The end date indicated was "indefinite." Review of Resident #59's physician orders revealed an order dated 11/16/21 entered by the psychology service's PA for Quetiapine Fumarate (an antipsychotic medication) 50 mg tablet every 6 hours as needed for breakthrough agitation or insomnia. The end date indicated was "indefinite." Resident #59's quarterly Minimum Data Set (MDS) dated 11/29/21 indicated severe cognitive	F 756	The physician reviewed and signed the Pharmacy Consultant recommendation form for Resident #59 on 1/14/22 with the following change in orders: • The order for Haloperidol Lactate 5 milligrams (mg) intramuscular every 6 hours prn for agitation was discontinued on 1/14/22. • The order for Haloperidol Lactate 5mg intramuscular every 12 hours prn for breakthrough agitation and aggression was clarified with an end date of 1/28/22. • The order for Quetiapine Fumerate 50mg tablet every 6 hours as needed for breakthrough agitation or insomnia was discontinued on 1/14/22. Other Residents A 100% audit of the Consultant Pharmacy Recommendations from 11/30/21 to 12/31/21 was conducted by the DON on 1/26/22. This was to ensure that all Consultant Pharmacy Recommendations had been addressed by the Physician. All issues or concerns were addressed by the Director of Nursing. Systemic Changes On 1/25/22, The DON and Unit Coordinators were inserviced by the Facility Nurse Consultant regarding ensuring all Pharmacy recommendations are forwarded and addressed by the physician. The Director of Nursing will complete monthly reconciliations of Pharmacy Consultant Recommendation and forward the audit to the Administrator monthly for	

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F 756	Continued From page 12 impairment. He required extensive assistance with most activities of daily living. The MDS indicated he received an antipsychotic medication daily with physical and verbal behaviors occurring in 1 to 3 of 7 days reviewed. A Consultant Pharmacist's Medication Regimen Review (MRR) dated 11/30/21 provided recommendations to provide a stop date for the PRN Haloperidol Lactate and Quetiapine Fumarate. The "follow-through" column was blank. A Physician Communication Form dated 12/31/21 signed by the consultant Pharmacist provided recommendations to limit the PRN antipsychotic to 14 days and to discontinue the duplicate Haloperidol Lactate order. The bottom of the form provided check boxes and a signature line which were blank. During an interview on 1/14/22 at 9:00 AM, the Pharmacist Consultant revealed she had made recommendations to indicate a stop date for fourteen days for Resident #59's psychotropic medications in November and December 2021. She revealed she emailed her recommendations on a Physician Communication Form to the Director or Nursing (DON) and she distributes them. The recommendations sheets were uploaded into the electronic medical record when they had a response and signature by the physician. During an interview on 1/14/22 at 9:40 AM, the psychology services PA revealed she had not received the pharmacist's recommendations until that morning. She indicated the recommendations were normally emailed to the	F 756	review. QA Monitoring A 10% audit of all Consultant Pharmacist Recommendations will be completed by the QI Nurse weekly x 4 weeks and monthly x 1 month utilizing the Pharmacy Recommendation Audit Tool. This audit is to ensure all Pharmacy Recommendations have been forwarded to and addressed by the Physician The Administrator will review and initial the Pharmacy Recommendation Audit Tools to ensure completion and all areas of issues and/or concerns have been addressed. The Administrator will forward the Pharmacy Recommendation Audit Tools to the Executive QA Committee monthly x 2 months. The Executive QA Committee will review monthly x 2 months to determine trends and/or issues that may need further interventions put into place and to determine for further and/or frequency of monitoring.	

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F 756	Continued From page 13 DON by pharmacy then placed in her mailbox. She had not had any for several months. During an interview on 1/14/21 at 12:10 PM, the Administrator revealed that the pharmacy recommendations were sent to the PA that morning and they were working to address the issue. She stated she did not know what happened to the recommendations as the DON had been out for several weeks.	F 756		
F 758 SS=D	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; (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;	F 758		2/11/22

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F 758	Continued From page 14 §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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure physician's orders for psychotropic medications to be administered as needed (PRN) were time limited in duration for 1 of 3 residents (Resident #59) reviewed for unnecessary medications. The findings included: Resident #59 was admitted to the facility on 09/30/19 with diagnoses that included mood disorder, dementia with behavioral disturbance. A Care Plan focused on psychotropic drugs use dated 10/20/21 included a goal for improvement of mood and behavior with interventions to	F 758	Resident #59's psychotropic medications were reviewed by the M.D. with changes as follows: • The order for Haloperidol Lactate 5 milligrams (MG_ intramuscular every 6 hours prn for agitation was discontinued on 1/14/22 The Haloperidol Lactate 5 mg intramuscular every 12 hours prn for breakthrough agitation and aggression was clarified with an end date of 1/28/22 The order for Quetiapine Fumarate 50 mg table every 6 hour as needed for breakthrough agitation or insomnia was discontinued on 1/14/22.	

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F 758	Continued From page 15 administer medications per physician's orders, notify the physician of significant changes to Resident #59's mood or behavior, and psychological services as needed. Review of Resident #59 physician's orders revealed an order dated 11/15/21 for Haloperidol Lactate 5 milligrams (mg) intramuscular every 6 hours PRN for agitation. The end date indicated was "indefinite." Further review of Resident #59 physician's orders revealed an order dated 11/16/21 entered by the psychology service's physician's assistant (PA) for Haloperidol Lactate 5 mg intramuscular every 12 hours PRN for breakthrough agitation and aggression. The end date indicated was "indefinite." Further review of Resident #59's physician's orders revealed an order dated 11/16/21 entered by the psychology service's PA for Quetiapine Fumarate (an antipsychotic medication) 50 mg tablet every 6 hours as needed for breakthrough agitation or insomnia. The end date indicated was "indefinite." Resident #59's quarterly Minimum Data Set (MDS) dated 11/29/21 indicated severe cognitive impairment. He required extensive assistance with most activities of daily living. The MDS indicated he received an antipsychotic medication daily with physical and verbal behaviors occurring in 1 to 3 of 7 days reviewed. Two physician communication forms dated 11/30/21 and 12/31/21 provided recommendations from the pharmacist to limit duration of Haloperidol Lactate and Quetiapine	F 758	Other Residents A 100% audit of all residents receiving prn psychotropic medications was conducted on 1/25/22 by the Director of Nursing to ensure all prn psychotropic medications had end dates and all issues were addressed. Systemic Changes 100% education was provided to licensed and medical providers by the Director of Nursing on 1/26/22 regarding requirements of ensuring that an end date must be included with all prn psychotropic orders. The Director of Nursing will complete a monthly prn order review utilizing the Order Listing Report to ensure all psychotropic medications have an end date and will address concerns as indicated. QA Monitoring QI Nurse will do a weekly order review of prn psychoactive medications to ensure there is a stop date weekly x 4 weeks and monthly x 1 month. Any issues will be reported to the Director of Nursing and addressed. The Administrator will review and initial the Pharmacy Recommendation Audit Tools to ensure completion and all areas of issues and/or concerns have been addressed. The Administrator will forward the Pharmacy Recommendation Audit Tools to the Executive QA Committee monthly x 2 months. The Executive QA Committee will review monthly x 2 months to determine trends and/or issues that may need further interventions put into place and to determine for further and/or	

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F 758	Continued From page 16 Fumarate to fourteen days. The communication forms did not indicate a response from the physician. During an interview on 1/14/22 at 9:00 AM, the pharmacist revealed she had made recommendations to indicate a stop date for fourteen days for Resident #59's psychotropic medications. During an interview on 1/14/22 at 9:40 AM, the psychology services PA revealed Resident #59 refused medications at times and the PRN orders were to address behaviors. She indicates she was aware of the order needing a stop date and "must have missed it." She further revealed she had received the pharmacist's recommendations and they were working to get stop dates on appropriate medications. During an interview on 1/14/21 at 12:10 PM, the Administrator revealed she was aware that PRN psychotropic medications needed to be limited in duration and the facility was currently working to resolve the issue.	F 758	frequency of monitoring.	