STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 07/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	**604 STOKES STREET EAST AHOSKIE, NC 27910**

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F 000	INITIAL COMMENTS A complaint investigation was conducted on 7/29/20 to 7/30/20. Two of the sixteen allegations were substantiated without a deficiency.	F 000		
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; §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	F 758		8/14/20

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

Electronically Signed | 08/11/2020

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F 758	Continued From page 1 §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, observation, staff, pharmacy, and physician interviews, the facility failed to monitor the side effects and behavior of a resident on scheduled Trazadone (antidepressant) and Lorazepam (antianxiety) for 1 of 1 sampled resident, reviewed for psychotropic medications (Resident # 5). Findings included: Resident #5 was readmitted to the facility on 1/2/20 with diagnoses of epilepsy, Alzheimer's disease, anxiety disorder, pseudobulbar effect, dementia with behavioral disorder, and a history of cerebral infarction. Documentation on the quarterly minimum data set assessment dated 7/6/20 revealed Resident #5 was severely cognitively impaired with no moods or behaviors in the assessment period. Documentation on the care plan, dated as last reviewed on 7/7/20, revealed a focus area for	F 758	F758 1. RESIDENT AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: Resident #18 was seen by Shae Partners Psych Services on 8/06/2020 and medication regimen reviewed with new orders given. Monitoring and documentation of behaviors associated with psychotropic medication was implemented on 8/11/2020. 2. OTHER RESIDENTS AT RISK: An audit of current residents receiving psychotropic medication will be conducted by the Director of Nursing or designee to ensure behaviors are being monitored and documented in the medical record/EMAR according to the diagnosis associated with the psychotropic medication. This audit will be completed by 8/12/2020.	

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F 758	Continued From page 2 resident #5 for a behavior problem relative to yelling out loudly continuously without the ability to explain why. Interventions included monitoring/documenting side effects and effectiveness, intervening as necessary to protect the rights and safety of others, and documentation of behavior and potential causes. Documentation on the same care plan had a focus area for the resident's use of antianxiety medication relative to behavior management due to an anxiety disorder and "yelling out." Interventions were to give the medication as ordered, monitor for side effects of the medication, and report to the medical doctor. Documentation on the care plan had an additional focus area for antidepressant medication relative to depression. Interventions included to give the medication as ordered, monitor/document side effects and effectiveness every shift. Documentation in the physician orders for Resident #5 revealed an order for Lorazepam 1 milligram (mg) 1 tablet via G-tube (gastrostomy tube) two times a day for anxiety initiated on 1/17/20. Documentation in the MAR (medication administration record) for January 2020 to July 30, 2020 revealed Resident #5 received the Lorazepam 1 mg as ordered. Documentation in the physician orders for Resident #5 revealed that on 3/30/20 the medication Quetiapine Fumarate, an antipsychotic, was discontinued and the medication Trazadone (antidepressant) 50 mg 1 tablet via G-tube one time a day at bedtime related to anxiety was initiated. Review of the MAR for March 2020 to July 30, 2020 revealed Resident #5 received the Trazadone 50 mg as ordered starting on 3/30/20.	F 758	3. SYSTEMIC MEASURES IMPLEMENTED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR INCLUDE: On 8/10/2020 a re-education of current licensed nurses was be provided by the Director of Nursing or designee. The re-education was regarding the need to monitor and document in the clinical record behaviors associated with the diagnosis related to the administration of psychotropic medication. The re-education will be completed by 8/13/2020. The Director of Nursing/designee will audit 10 residents receiving psychotropic medications 2 times weekly for 4 weeks, weekly times 4 weeks and monthly times 1 month to ensure behaviors are being monitored and documented appropriately. Negative findings will be corrected if noted. 4. MONITORING The results of all audits will be reviewed by the Quality Assurance Performance Improvement Committee to determine the effectiveness of the plan. Additional interventions will be developed and implemented as needed to ensure sustained compliance.	

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Documentation in the physician orders revealed the diagnosis of major depressive disorder was added for Resident #5 on 4/7/20.

Documentation in a nurse practitioner note dated 4/8/20 revealed Resident #5 was seen for "yelling out." The 4/8/20 nurse practitioner note added an order for Trazadone 25 mg once daily in the morning via the G-tube for behaviors. Review of the physician orders and the MAR for April 2020 to July 30, 2020 revealed Resident #5 received the Trazadone 25 mg as ordered starting on 4/14/20.

Documentation in the nursing progress notes from January 2020 to July 30, 2020 did not reveal any behaviors or monitoring of behaviors. Documentation in physician progress notes dated 3/21/20, 5/29/20, and 7/4/20 did not reveal any concerns regarding side effects from medications or behaviors. The medication administration records from March 2020 to July 30, 2020 did not reveal any monitoring of behaviors or the side effects of Lorazepam or Trazadone.

An observation was made of Resident #5 on 7/29/20 at 9:58 AM. Resident #5 was reclining in bed hollering and yelling at a level that could be heard five doors down from her room. A nurse aide was observed to pass the room of Resident #5 but did not enter the room.

An observation was made of Resident #5 on 7/29/20 from 3:55 PM to 4:55 PM. Resident #5 was reclining in bed very tearful calling out "Ma Ma" repeatedly at a level that could be heard five doors down from her room. Multiple staff members were observed to pass the room of

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Resident #5 but did not enter the room.

An interview was conducted with the Director of Nursing (DON) on 7/30/20 at 8:50 AM. The DON stated that Resident #5 would holler and yell sporadically and that if it became a problem the nurses would slip notes under her door to let her know. The DON stated that nurses do monitor Resident #5 for her behaviors but that there was no specific order for them to do so. The DON revealed that the electronic medical record had a template for behavior monitoring but that it had not been used for Resident #5. The DON indicated that sometimes Resident #5 could be consoled and sometimes not. The DON acknowledged that there was no written documentation of the monitoring of the behavior of Resident #5 for the effectiveness of interventions or medications.

An observation was made of Resident #5 on 7/30/20 at 9:23 AM. Resident #5 was reclining in bed tearfully crying and yelling. Resident #5 stated, "I want my child to read and write. Can you teach her? I want her to be a good child." Resident #5 stopped crying after expressing her desire to the surveyor.

An interview was conducted with Nurse #1 on 7/30/20 at 9:36 AM. Nurse #1 revealed that sometimes Resident #5 would calm down when she was hollering but sometimes not. Nurse #1 indicated that Resident #5 could be confused at times and other times had the ability to hold a conversation. Nurse #1 also indicated that there was a place in the electronic medical record to document a change or an increase in behaviors for residents. Nurse #1 stated that she was not assigned to care for Resident #5 very often and

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that there was no set nurse who cared for Resident #5 on a regular basis.

An interview was conducted with NA (nurse aide) #3 on 7/30/20 at 10:53 AM. NA #3 stated she was familiar with Resident #5 and was usually assigned to the area where Resident #5 resided. NA #3 indicated that sometimes she was able to get Resident #5 to stop hollering if she attended to her immediate care needs, but that it depended on what kind of day the resident was having and if Resident #5 had her medications. NA #3 stated that if other residents were complaining about Resident #5 hollering, she would ask the nurse to see if anything could be done to help.

An interview was conducted with the physician for Resident #5 on 7/30/20 at 12:10 PM. The physician stated that the nurse practitioner who initiated an order for the Trazadone 25 mg given one time a day in the morning for behaviors was consulting on an acute situation and was not under his service. The physician stated that the nurses verbally let him know of any problems or concerns with Resident #5 and he was not made aware of any concerns recently.

An interview was conducted with the pharmacy consultant for facility on 7/30/20 at 12:21 PM. The pharmacist stated that she expected the facility to monitor the behaviors and side effects of the medications for behaviors. The pharmacist stated that she looked for this monitoring and documentation in the progress notes and on the MAR. The pharmacist stated that it was unusual to give Trazadone in the morning but that she would expect for the nursing staff to document in the notes if they saw excessive drowsiness due to the medication Trazadone.

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