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	175369	A. BUILDING _____ B. WING _____	01/31/2023

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 02/10/23.	F 000		
F 689 SS=D	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: The facility had a census of 31 residents. The sample included 12 residents with five reviewed for falls. Based on observation, interview and record review the facility failed to provide adequate supervision for Resident (R) 29 who fell when she was left unattended in the shower room and R35 who fell while unsupervised in an unlocked treatment room. This deficient practice placed R29 and R35 at risk for injuries from falls. Findings included: - R29's Electronic Medical Record (EMR) documented diagnoses of dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/10/2023

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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The "Quarterly Minimum Data Set" (MDS), dated 11/04/22, documented a Brief Interview for Mental Status (BIMS) score of six. The MDS documented R29 required supervision for eating, extensive assistance of two staff for transfers, bed mobility, toileting, dressing, and did not walk. R29 used a wheelchair and balance unsteady and required human assistance to stabilize during transfers. The MDS documented R29 had two or more non-injury falls since the prior MDS, received antianxiety medication seven days, and a bed alarm was used daily.

The "Fall Care Plan," dated 11/10/22, directed staff to use a silent alarm to monitor attempts to self-transfer from bed to recliner without assistance and not to leave R29 in her wheelchair when alone in her room. The paln directed staff to try to keep R29 in the commons area when she was not sleeping or with someone in her room, place a fall mat beside her bed, gripper socks, and low bed. The plan directed to use a gait belt and walker, assist with walking to or from the bathroom. The 01/15/23 update directed staff to not leave R29 unattended in the shower room.

The "Fall Risk Assessments," dated 10/24/22, 12/18/22, and 01/16/23 all indicated R29 a high fall risk.

The "Fall Note," dated 01/15/23 at 10:37 AM, documented staff took R29 to the bathroom in the shower room and then left to get or check something. Staff returned to the shower room and found R29 by the shower room door, where she had slid down to the floor because she "needed to get somebody." No injuries were noted.

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On 01/30/23 at 12:56 PM, observation revealed R29 in a recliner in the living room, feet elevated, glasses on, and looking around. Further observation at 01:30 PM, Certified Medication Aide (CMA) S woke R29 and asked if she could take her to her room. CMA S transferred R29 to her wheelchair, asked her if she needed to go to the bathroom, and assisted R29 to toilet. CMA S then assisted R29 to bed, placed the call light in reach, bed low, and a pressure alarm was on.

On 01/26/23 at 01:22 PM, CMA S stated when staff see R29 trying to get out of bed, staff toilet her and assist her to her wheelchair and have her sit in the living room.

On 01/31/23 at 01:45 PM, Administrative Nurse D verified staff should not have left R29 alone and unsupervised in the shower room.

The facility's "Fall Prevention" policy, dated 05/2015, stated various strategies would be implemented to minimize fall risk. A fall risk assessment would be completed at admission, quarterly, with any significant change and after a fall if the resident not previously identified at risk. Based on the resident assessment and their individual needs, interventions would be implemented to minimize the risk of falls and documented on the care plan.

The facility failed to provide adequate supervision when staff left R29 alone in the shower room and she fell. This deficient practice placed R29 at risk for injury from falls.

- R35's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease with early onset (a specific brain disease marked

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by symptoms of dementia that gradually get worse over time), psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).

The "Annual Minimum Data Set" (MDS), dated 04/15/22, documented short, long term memory problems with severely impaired decision making. The MDS documented R35 had hallucinations (seeing or hearing things that are not here), delusions (belief in something that is clearly not real), and wandered daily. The MDS documented R35 required supervision for walking in the corridor, extensive assistance of one staff for walking in her room, hygiene, and extensive assistance of two staff for transfers, dressing, eating and toileting. R35's balance was unsteady and required assistance to regain balance. R35 had one minor injury fall since the prior MDS and received antipsychotic (medications used to treat major mental disorders) and antianxiety medications seven days of the lookback period.

The "Care Area Assessment" (CAA), dated 04/15/22, documented R35 had a history of falls and her balance varied from steady to unsteady. The CAA documented R35's vision was impaired, and her cognition was severely impaired due to Alzheimer's disease.

The "Fall Care Plan," dated 04/15/22, directed staff to ensure R35 had gripper socks on, gripper strips in front of her bed, a fall mat in place, bed alarm, pressure alarm in the recliner, low bed, and staff were to leave the shower room doors

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closed when not in use. The care plan did not address the 01/05/22 fall in the treatment room until 01/25/22 with the statement the care plan was reviewed and remained appropriate.

The "Fall Note," dated 01/05/22 at 06:00 AM, documented at 06:00 AM, R35 went into the treatment room and staff heard "help me, help me" and found R35 sitting on the floor on her buttocks with her head toward the door, and her feet toward the sink in the treatment room. The nurse noted a bruise on her left side forehead. Staff assisted R35 up and obtained R35's vital signs. The physician and family were notified.

The "Social Services Note," dated 1/18/22, stated R35 continued to wander the halls.

01/26/23 at 12:00 PM, Social Services X stated R35 had poor cognition, bad eyesight and did not want to wear her glasses. R35 would run into things, walked with head down often, and fell occasionally. Social Services X stated staff could not restrain R35, staff constantly looked for her and watched the cameras for her. R35 was very mobile and quick.

On 01/26/23 at 02:03 PM, Administrative Nurse D stated at that time of the fall, 01/05/22, the treatment room was enclosed, and staff had to go through the nutrition room which was left open. Administrative Nurse D stated staff had not closed the treatment room door and R35 went in and she tripped over the weight scale. Administrative Nurse D stated she educated staff and placed signage to ensure the door to the treatment room locked and had maintenance staff change the door lock to a keypad. Administrative Nurse D stated the nurse on duty

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F 689	Continued From page 5 did not write a witness statement. On 01/31/23 at 08:52 AM, Licensed Nurse (LN) G verified the treatment room had a key lock at the time of the fall and staff were to close and lock the door. She verified R35 had "fiddled" with the doorknob of the treatment room at times. On 01/31/23 at 01:45 PM, Administrative Nurse D verified staff should have ensured the treatment room door was closed and locked when leaving the area. The facility's "Fall Prevention" policy, dated 05/2015, stated various strategies would be implemented to minimize fall risk. A fall risk assessment would be completed at admission, quarterly, with any significant change and after a fall if the resident not previously identified at risk. Based on the resident assessment and their individual needs, interventions would be implemented to minimize the risk of falls and documented on the care plan. The facility failed to provide adequate supervision for R35, who was unsupervised when she entered an unlocked treatment room and fell, placing R35 at risk for injury.	F 689		
F 756 SS=D	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.	F 756		

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§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 requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure the Consultant Pharmacist identified and reported to the Director of Nursing, facility medical director, and physician, the lack of

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a 14 day stop date for Resident (R)11 and R13's as needed (PRN) psychotropic (a medication that affects mood and/or thought) or rationale for continued use. This placed the residents at risk for inappropriate use of a psychotropic medication with side effects.

Findings included:

- R11's Electronic Medical Record (EMR) recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental, uncertainty and irrational fear), and depression (mood disorder characterized by persistent sadness).

R11's "Quarterly Minimum Data Set" (MDS), dated 11/18/22, documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R11 required supervision with transfer, dressing, toilet use, , and required limited assistance of one staff for locomotion on and off the unit and hygiene. The MDS documented R11 received an antidepressant medication for all seven of the look back days.

The "Psychotic Drug Use Care Area Assessment" (CAA), dated 03/18/22, documented R11 received Wellbutrin (antidepressant) daily for major depressive disorder and as needed Ativan (psychotropic antianxiety medication) for anxiety.

The "Mood Care Plan," dated 12/02/22 recorded the resident displayed signs and symptoms of depression, such as feeling down, depressed and bad about herself, and tired. The resident had chronic pain that affected her mood and at times was verbally aggressive towards staff. Staff administered Ativan as needed for her persistent

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anxiety after non-pharmacological interventions have been attempted.

The "Physician's Order," dated 10/24/22, directed the staff to administer Ativan 0.5 milligrams (mg), administer one half tablet or 0.25 mg twice a day as needed for anxiety. The order lacked a stop date.

Review of the "Medication Administration Record" in the EMR revealed the resident last received the Ativan 0.25mg on 01/24/23 for anxiety from a bloody nose, with documented relief from the anxiety.

Review of the "Medication Regimen Reviews" lacked evidence the Consultant Pharmacist identified the need for the as needed Ativan 14 day stop date.

On 01/25/23 at 04:20 PM, observation revealed the resident sat in a recliner in her room with a bedside table in front of her and the activity director painting her fingernails. Certified Medication Aide (CMA) R administered the resident's morning medications to her.

On 01/31/23 at 09:40 AM, Administrative Nurse D verified the resident received Ativan, with a physician order date of 10/14/22. Administrative Nurse D verified the facility failed to obtain the 14 days stop date or reason for continued use with the appropriate rational. Administrative Nurse D verified the Consultant Pharmacist failed to recommend a 14 day stop date for use of the residents as needed Ativan.

The "Antipsychotic Medication Use" policy dated October 2017 recorded antipsychotic medication

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therapy shall be used as appropriate with the proper assessment, diagnosis and physician or mental health expert oversight. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The PCP would identify, evaluate and document, with input from other disciplinary and consultants as needed, symptoms that may warrant the use of antipsychotic medications. All residents with an order for antipsychotic medications would be assessed for ongoing use. The assessment would include proper diagnosis, AIMS testing, behavior monitoring, gradual dose reduction and care plan use. A monthly drug regimen review would be completed on all residents by the consulting pharmacist, and appropriate recommendations for dose reduction are made to the physician.

The facility's "Pharmacy Services- Role of the Consulting Pharmacist" policy, dated February 2018 documented the facility would contract the services of the Consulting Pharmacist. The Consulting Pharmacist shall provide consultation on all aspects of pharmacy services in the facility, including identify pertinent resources and references about medications and their proper use and monitoring in the population. Help the facility evaluate and optimize their medication administration and documentation process. Identifying pertinent resources and references about medications and their proper use and monitoring in the population. Regular review of the emergency medication supply and provide facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review.

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The facility's Consultant Pharmacist failed to recommend to the facility Director of Nursing (DON), medical director, and physician the need for a 14 day stop date or rationale for continued use of PRN Ativan. This placed the resident at risk for inappropriate use of an as needed psychotropic medication with side effects.

- R13's Electronic Medical Record (EMR) documented diagnoses of dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).

The "Annual Minimum Data Set" (MDS), dated 11/25/22, documented a Brief Interview for Mental Status (BIMS) score of two, indicating severely impaired cognition. The MDS documented R13 demonstrated physical, verbal and other behaviors which placed resident and others at risk physically, interfered with her care, and disrupted the environment. R13 required extensive staff assistance for eating, hygiene, dressing, toilet use, bed mobility, transfers and received antipsychotic (medication used to treat psychosis) and antianxiety medication seven days of the lookback period.

The "Psychotropic Medication Care Area Assessment" (CAA), dated 11/25/22, documented R13 had various mental health disorders and received psychotropic medications for these conditions. The assessment stated R13 had behaviors at times, such as crying, throwing food, aggression during cares.

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The "Medication Care Plan," dated 12/01/22, directed staff to talk to R13 when she was sad or anxious. If R13 was wandering and agitated, offer a drink or snack, like Cola and chocolate. The care plan directed staff to apply Ativan (antianxiety drug) cream as needed for anxiety. Utilize PRN Ativan if non-medication approaches are ineffective to relieve anxiety. May use oral or topical. Monitor adverse effects: speech pattern changes, loss of strength, over-sedation, gait changes, irritability, increased sweating, dizziness.

The "Physician Order," dated 10/02/19, directed staff to administer Ativan 0.5 milligrams (mg), three times daily (TID), as needed (PRN) for anxiety. The order lacked a stop date.

The "Physician Order," dated 10/13/21, directed staff to administer Ativan cream, 1 mg, topically, PRN every six hours, for anxiety. The order lacked a stop date.

The "Medication Administration Record" (MAR) documented the PRN Ativan was administered almost daily, sometimes three times daily for behaviors of anxious, crawling on floor, crying, hitting at staff, or combative.

The "Consultant Pharmacist Review," dated 06/13/2022, documented a risk versus benefit documentation was due for the PRN use of Ativan. The physician response documented her current status warrants need to continue medications and monitoring to continue. The documentation lacked a request for a stop date for the use of the PRN Ativan.

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The "Consultant Pharmacist Reviews," 07/18/22 through 01/24/23 documented no suggestions at this time.

On 01/26/23 at 09:01 AM, observation revealed Certified Medication Aide (CMA) T administered medications to R13 in her room. CMA T crushed the pills, including Ativan, and mixed with chocolate pudding. R13 accepted medication easily without problems.

On 01/26/23 at 07:56 AM, CMA T stated R13 can become upset with staff or anybody at times, due to multiple personalities and severe dementia.

On 01/31/23 at 01:45 PM, Administrative Nurse D verified the lack of a stop date for the PRN Ativan and stated the Consultant Pharmacist had not notified her of the need for one.

The "Antipsychotic Medication Use" policy dated October 2017 recorded antipsychotic medication therapy shall be used as appropriate with the proper assessment, diagnosis and physician or mental health expert oversight. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective.The PCP would identify, evaluate and document, with input from other disciplinary and consultants as needed, symptoms that may warrant the use of antipsychotic medications. All residents with an order for antipsychotic medications would be assessed for ongoing use. The assessment would include proper diagnosis, AIMS testing, behavior monitoring, gradual dose reduction and care plan use. A monthly drug regimen review would be completed on all residents by the consulting pharmacist, and appropriate

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F 756	Continued From page 13 recommendations for dose reduction are made to the physician. The facility's Consultant Pharmacist failed to recommend to the facility Director of Nursing (DON), medical director, and physician the need for a 14 day stop date or rationale for continued use of PRN Ativan. This placed the resident at risk for inappropriate use of an as needed psychotropic medication with side effects.	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		

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§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:
The facility had a census of 31 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observations, interview and record review, the facility failed to ensure a 14- day stop date for Resident (R)11 and R13 who received as needed (PRN) psychotropic (medication that affects mood and/or thoughts) that lacked a 14 day stop date or rationale for continued use. This placed the affected residents at risk for unintended affects related to psychotropic drug medications.

Findings included:

- R11's Electronic Medical Record (EMR) recorded diagnoses of dementia (progressive

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mental disorder characterized by failing memory, confusion), anxiety (mental, uncertainty and irrational fear), and depression (mood disorder characterized by persistent sadness).

R11's "Quarterly Minimum Data Set" (MDS), dated 11/18/22, documented a Brief Interview for Mental Status (BIMS) score of fourteen, indicating intact cognition. R11 required supervision with transfer, dressing, toilet use, , and required limited assistance of one staff for locomotion on and off the unit and hygiene. The MDS documented R11 received an antidepressant medication for all seven of the look back days.

The "Psychotic Drug Use" Care Area Assessment" (CAA), dated 03/18/22, documented R11 received Wellbutrin (antidepressant) daily for major depressive disorder and as needed Ativan (psychotropic antianxiety medication) for anxiety.

The "Mood Care Plan," dated 12/02/22 recorded the resident displayed signs and symptoms of depression, such as feeling down, depressed and bad about herself, and tired. The resident had chronic pain that affected her mood and at times was verbally aggressive towards staff. Staff administered Ativan as needed for her persistent anxiety after non-pharmacological interventions have been attempted.

The "Physician's Order," dated 10/24/22, directed the staff to administer Ativan 0.5 milligrams (mg), administer one half tablet or 0.25 mg twice a day as needed for anxiety. The order lacked a stop date.

Review of the "Medication Administration Record"

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in the EMR revealed the resident last received the Ativan 0.25mg on 01/24/23 for anxiety from a bloody nose, with documented relief from the anxiety.

On 01/25/23 at 04:20 PM, observation revealed the resident in a recliner in her room with a bedside table in front of her and the activity director painting her fingernails and Certified Medication Aide (CMA) R administered the resident's morning medications to her.

On 01/31/23 at 09:40 AM, Administrative Nurse D verified the resident received Ativan, with a physician order date of 10/14/22. Administrative Nurse D verified the facility failed to obtain the 14 days stop date or reason for continued use with the appropriate rational.

The "Antipsychotic Medication Use" policy dated October 2017 recorded antipsychotic medication therapy shall be used as appropriate with the proper assessment, diagnosis and physician or mental health expert oversight. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective.The PCP would identify, evaluate and document, with input from other disciplinary and consultants as needed, symptoms that may warrant the use of antipsychotic medications. All residents with an order for antipsychotic medications would be assessed for ongoing use. The assessment would include proper diagnosis, AIMS testing, behavior monitoring, gradual dose reduction and care plan use. A monthly drug regimen review would be completed on all residents by the consulting pharmacist, and appropriate recommendations for dose reduction are made to

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the physician.

The facility failed to ensure R11 was free of the use of unnecessary psychotropic drugs when they failed to obtain a stop date for the use of PRN Ativan, placing R11 at risk for adverse effects from the continued use of those medications.

- R13's Electronic Medical Record (EMR) documented diagnoses of dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).

The "Annual Minimum Data Set" (MDS), dated 11/25/22, documented a Brief Interview for Mental Status (BIMS) score of two, indicating severely impaired cognition. The MDS documented R13 demonstrated physical, verbal and other behaviors which placed resident and others at risk physically, interfered with her care, and disrupted the environment. R13 required extensive staff assistance for eating, hygiene, dressing, toilet use, bed mobility, transfers and received antipsychotic (medication used to treat major mental disorders), and antianxiety medication seven days of the lookback period.

The "Psychotropic Medication Care Area Assessment" (CAA), dated 11/25/22, documented R13 had various mental health disorders and received psychotropic medications for these conditions. The assessment stated R13 had

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behaviors at times, such as crying, throwing food, aggression during cares.

The "Medication Care Plan," dated 12/01/22, directed staff to talk to R13 when she was sad or anxious. If R13 was wandering and agitated, offer a drink or snack, like cola and chocolate. The care plan directed staff to apply Ativan (antianxiety drug) cream as needed for anxiety. Utilize PRN Ativan if non-medication approaches were ineffective to relieve anxiety. May use oral or topical. Monitor adverse effects: speech pattern changes, loss of strength, over-sedation, gait changes, irritability, increased sweating, dizziness.

The "Physician Order," dated 10/02/19, directed staff to administer Ativan 0.5 milligrams (mg), three times daily (TID), as needed (PRN) for anxiety. The order lacked a stop date.

The "Physician Order," dated 10/13/21, directed staff to administer Ativan cream, 1 mg, topically, PRN every six hours, for anxiety. The order lacked a stop date.

The "Medication Administration Record" (MAR) documented the PRN Ativan was administered almost daily, sometimes three times daily, for behaviors of anxious, crawling on floor, crying, hitting at staff, or combative.

The "Consultant Pharmacist Review," dated 06/13/2022, documented a risk versus benefit documentation was due for the PRN use of Ativan. The physician response documented her current status warrants need to continue medications and monitoring to continue. The documentation lacked a request for a stop date

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for the use of the PRN Ativan.

On 01/26/23 at 09:01 AM, observation revealed Certified Medication Aide (CMA) T administered medications to R13 in her room. CMA T crushed the pills, including Ativan, and mixed with chocolate pudding. R13 accepted medication easily without problems.

On 01/26/23 at 07:56 AM, CMA T stated R13 can become upset with staff or anybody at times, due to multiple personalities and severe dementia.

On 01/31/23 at 01:45 PM, Administrative Nurse D verified the lack of a stop date for the PRN Ativan and stated the Consultant Pharmacist had not notified her of the need for one.

The "Antipsychotic Medication Use" policy dated October 2017 recorded antipsychotic medication therapy shall be used as appropriate with the proper assessment, diagnosis and physician or mental health expert oversight. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The PCP would identify, evaluate and document, with input from other disciplinary and consultants as needed, symptoms that may warrant the use of antipsychotic medications. All residents with an order for antipsychotic medications would be assessed for ongoing use. The assessment would include proper diagnosis, AIMS testing, behavior monitoring, gradual dose reduction and care plan use. A monthly drug regimen review would be completed on all residents by the consulting pharmacist, and appropriate recommendations for dose reduction are made to the physician.

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F 758	Continued From page 20 The facility failed to ensure R13's drug regimen was free of unnecessary psychotropic drugs when they failed to obtain a stop date for the use of PRN Ativan beyond the 14-day requirement, placing R13 at risk for unnecessary side effects from the continued use.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 31 residents. The	F 761		

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sample included 12 residents. Based on observation, record review and interview, the facility failed to discard expired medications in the emergency drug treatment kit/box located in the medication room. This placed residents at risk for ineffective medications.

Findings included:

- On 01/29/23 at 08:40 AM, observation during the initial tour revealed the emergency medication kit/box, had an expiration date, 12/22 written on the top of the kit/box.

On 01/31/23 at 09:50 AM, Administrative Nurse D verified the emergency treatment kit had numerous expired medications. Administrative Nurse D verified the pharmacist had not been on site to identify the expired medications, however the nurses should identify the expired kit during use and said she would contact the local pharmacy to get replacement medications.

The facility's "Emergency Drug Kit" policy, dated 4/2021, documented a supply of drugs typically used in emergencies shall be maintained at each nurse's station. An emergency drug kit contains the drugs and biologicals that are essential to providing emergency treatment. A kit is available at the nurse's station and is stored in the medication room. An inventory listing is maintained of the content of the kit. The pharmacist shall inspect the emergency medical kit monthly and record the findings on the record maintained with each kit. Medications and supplies used from the emergency kit must be replaced upon the next routine drug order. Indicated on the drug order form that the supply is needed to replenish the kit. Drugs removed from

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F 761	Continued From page 22 the emergency kit must be entered on the emergency medication administration log. The lock tag for the kit must be recorded when removed- who opened, and the reason the kit was opened, and date. The facility failed to ensure expired medications were remoevd and replaced, placing the residents at risk for use of an ineffective medication.	F 761		