STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 12/4/23 to 12/7/23. The following common abbreviations are used throughout this document: DON: Director of Nursing ADON: Assistant Director of Nursing MDS: Minimum Data Set RN: Registered Nurse CNA: Certified Nursing Assistant IP: Infection Preventionist Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		1/11/24

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

Electronically Signed | 12/29/2023

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F 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure care plans were implemented for 1 of 3 sample residents (#100) with falls. The findings were: 1. Review of the significant change MDS assessment dated 5/11/23 showed resident #100	F 656	1) Resident #100 had her care plan reviewed immediately to ensure appropriate interventions were in place. Education of the CNA involved was completed immediately after the incident and at the time of the investigation/RCA-root cause analysis. Education focused on the importance of	

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F 656	Continued From page 2 had a brief interview for mental status (BIMS) score of 3 out 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia and anxiety disorder. Further review showed the resident required extensive physical assistance of 2 or more people for transfers and extensive physical assistance of 1 person for toileting and personal hygiene. Review of the self-care deficit care plan last revised on 8/10/23 showed interventions which included "...Transfer: I recently sustained major injury post fall and am now an extensive/total assist of two staff members at all times. Staff may use sara lift [sit-to-stand type mechanical lift] for transfer with two person assist or staff can pivot transfer me as tolerated by me..." Review of the mobility deficit care plan last revised on 8/10/23 showed and intervention of "...Transfer: I am no longer able to transfer independently with my four wheeled walker. I am currently using a wheelchair related to recent injury..." which was revised on 5/11/23. Review of the care plan titled "I am a high risk for falls r/t [related to] memory impairment and history of falls" care plan last revised on 5/17/23 showed interventions which included "...Ensure that I am wearing appropriate footwear (specify and describe correct client footwear i.e. brown leather shoes, tartan bedroom slippers, black non-skid socks) when up ambulating..." The following concerns were identified: a. Review of a progress note dated 11/11/23 and timed 7:41 PM showed the resident had a fall that day at 6:30 PM, had been assisted to the bathroom by 1 staff member without a mechanical lift or gait belt, and the resident was not wearing any footwear. Further review showed the resident had complaints of bilateral knee pain. b. Review of a root cause analysis provided	F 656	following the care plan, specifically knowing the transfer status of the resident and those interventions that are standard for all residents: ie non skid socks or shoes with transferring as well as the appropriate transfer technique. Education was sent out to all staff regarding the use of gait belts for any resident with more than a stand by assist for transfer. 2) All residents have the potential to be affected by not following and implementing the care plan. The IDT will evaluate all care plans to ensure appropriate and resident centered and targeted interventions are in place specifically related to transfer status, and fall prevention. Education of all staff will be accomplished by the completion date related to care plans and the importance of implementation and the consequences of not following the plan. Random audits will be completed by IDT to assess staff knowledge of the care plans, where to find them and if they are following. These audits will be conducted monthly with quarterly reporting to both QAPI and Quality Council. 3) The facility currently utilizes an RCA format with IDT to review falls with major injury. We will implement a more extensive format to include a broader based plan of correction to evaluate the possibility of systemic concerns throughout the facility. At that time we can identify potential issues with the development and implementation of the care plan and act proactively in correcting	

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F 656	Continued From page 3 by the administrator on 12/6/23 showed "[Resident] s/p [status post] fall on 11/11/2023 at 1830 [6:30 PM], assisted fall. [S/he] was transferred to ER. [S/he] X-ray [sic] results stated comminuted periprostehetic [sic] fractures distal right femur with displacement of the right total knee prosthesis and boney fragments posteriorly and comminuted displaced periprostehetic [sic] fracture distal left femoral shaft with the prosthesis and distal femur displaced medially. Large joint effusion and prepatellar swelling" Under the section "describe what happened" the document showed "[Resident name] was being assisted with toileting by the CNA, resident was trying to sit on the toilet, and slid off the toilet and onto the floor. Legs were bent under and to the side of [him/her], assessment completed noted deformity to right knee prior to moving, 911 called to sent [sic] to ER." Further review showed the "statement of cause" included the resident was not wearing socks or shoes, a gait belt was not used, the staff member was not aware of the resident's transfer status, and the resident's care plan was not followed. c. Interview with CNA #1 on 12/6/23 at 6:07 PM confirmed she assisted resident #100 to the bathroom without assistance on 11/11/23, a gait belt or mechanical lift was not used, and the resident was not wearing any footwear. 2. Interview with the infection preventionist, DON, restorative nurse, MDS coordinator, nurse manager #1, and the administrator on 12/7/23 at 8:37 AM revealed resident #100 was able to transfer with a sit-to stand type mechanical lift transfer or a gait belt stand and pivot procedure; however, the resident required 2 staff members for all transfers. Further interview revealed staff were expected to use a gait belt for all physically	F 656	a possible issue. Review of the policy titled, "Care Plan: Initiating Individualized Patient/Resident Care Plans" to assess for possible revisions will be completed by date specified below. 4) In addition to the random audits in 2) above, will also review the RCAs in insure compliance with follow up dates. Audits to be done by IDT monthly with quarterly reporting to QAPI, and QC.	

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F 656	Continued From page 4 assisted transfers, were expected to identify the resident's transfer status prior to transfer, and were expected to follow the resident's care plan when assisting residents. 3. Review of the policy titled "Care Plan: Initiating Individualized Patient/Resident Care Plans" last revised on August 2020 showed "Nurses caring for the patient/resident are responsible for ensuring that the multi-disciplinary plan of care is implemented and updated as appropriate..."	F 656		
F 689 SS=G	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 medical record review, staff interview, and policy and procedure review, the facility failed to implement interventions to ensure resident safety for 1 of 3 sample residents (#100) reviewed for falls. This failure resulted in actual harm to resident #100 who sustained fractures and was hospitalized. The findings were: 1. Review of the significant change MDS assessment dated 5/11/23 showed resident #100 had a brief interview for mental status (BIMS) score of 3 out 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia and anxiety	F 689	1) Resident #100 had her care plan reviewed immediately to ensure appropriate interventions were in place. Education of the CNA involved was completed immediately after the incident and at the time of the investigation/RCA-root cause analysis. Education focused on the importance of following the care plan, specifically knowing the transfer status of the resident and those interventions that are standard for all residents: ie non skid socks or shoes with transferring as well as the appropriate transfer technique. Education	1/11/24

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F 689	Continued From page 5 disorder. Further review showed the resident required extensive physical assistance of 2 or more people for transfers and extensive physical assistance of 1 person for toileting and personal hygiene. Review of the self-care deficit care plan last revised on 8/10/23 showed interventions which included "...Transfer: I recently sustained major injury post fall and am now an extensive/total assist of two staff members at all times. Staff may use sara lift [sit-to-stand type mechanical lift] for transfer with two person assist or staff can pivot transfer me as tolerated by me..." Review of the mobility deficit care plan last revised on 8/10/23 showed and intervention of "...Transfer: I am no longer able to transfer independently with my four wheeled walker. I am currently using a wheelchair related to recent injury..." which was revised on 5/11/23. Review of the care plan titled "I am a high risk for falls r/t [related to] memory impairment and history of falls" care plan last revised on 5/17/23 showed interventions which included "...Ensure that I am wearing appropriate footwear (specify and describe correct client footwear i.e. brown leather shoes, tartan bedroom slippers, black non-skid socks) when up ambulating..." The following concerns were identified: a. Review of a progress note dated 11/11/23 and timed 7:41 PM showed the resident had a fall that day at 6:30 PM, had been assisted to the bathroom by 1 staff without a mechanical lift or gait belt, and the resident was not wearing any footwear. Further review showed the resident had complaints of bilateral knee pain. b. Review of a progress note dated 11/11/23 and timed 11:15 PM showed the emergency room nurse contacted the facility to notify them of the resident transfer by helicopter flight to Billings due to bilateral displaced femur fractures.	F 689	was sent out to all staff regarding the use of gait belts for any resident with more than a stand by assist for transfer. 2) All residents have the potential to be affected by not following and implementing the care plan. The IDT will evaluate all care plans to ensure appropriate and resident centered and targeted interventions are in place specifically related to transfer status,and fall prevention. Education of all staff will be accomplished by the completion date related to the use of gait belts for all residents requiring more than a stand by assist. Random audits will be completed by IDT to assess compliance with gait belt use and immediate correction for non compliance. These audits will be conducted monthly with quarterly reporting to both QAPI and Quality Council. 3) The facility currently utilizes an RCA format with IDT to review falls with major injury. We will implement a more extensive format to include a broader based plan of correction to evaluate the possibility of systemic concerns throughout the facility. At that time we can identify potential issues with the fall preventions in place and their appropriateness as well as staff compliance with those preventions. Review of the "Gait Belt" procedure will be reviewed and updated by completion date. 4) The random audits in 2) above will be done by IDT monthly with quarterly	

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F 689	Continued From page 6 c. Review of a progress note dated 11/13/23 and timed 3:51 PM showed the resident's representatives had decided a non-operative care approach with a focus on comfort. Further review showed the resident was placed on comfort measures and was being medically stabilized for return to the facility at an unknown date. d. Review of a progress note dated 11/28/23 and timed 9:15 AM showed the resident was given Morphine IR (pain medication) 15 mg and transferred to the facility without immobilizers and with a Foley catheter present. e. Review of a progress note dated 11/28/23 and timed 11:36 AM showed the resident returned to the facility with "several new wounds" which included 2 skin tears, 2 "deep tissue" injuries on his/her left buttocks/coccyx, a "deep tissue" injury to his/her right gluteal fold, and a "deep tissue" injury to his/her right mid back. f. Review of a progress note dated 12/6/23 and timed 3:46 PM showed the resident was pronounced deceased at 11:55 AM. g. Review of a root cause analysis provided by the administrator on 12/6/23 showed "[Resident] s/p [status post] fall on 11/11/2023 at 1830 [6:30 PM], assisted fall. [S/he] was transferred to ER. [S/he] X-ray [sic] results stated comminuted periprostehetic [sic] fractures distal right femur with displacement of the right total knee prosthesis and boney fragments posteriorly and comminuted displaced periprostehetic [sic] fracture distal left femoral shaft with the prosthesis and distal femur displaced medially. Large joint effusion and prepatellar swelling" Under the section "describe what happened" the document showed "[Resident name] was being assisted with toileting by the CNA, resident was trying to sit on the toilet, and slid off the toilet and onto the floor. Legs were bent under and to the	F 689	reporting to QAPI, and QC.	

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F 689	Continued From page 7	F 689		

side of [him/her], assessment completed noted deformity to right knee prior to moving, 911 called to sent [sic] to ER." Further review showed the "statement of cause" included the resident was not wearing socks or shoes, a gait belt was not used, the staff member was not aware of the resident's transfer status, and the resident's care plan was not followed.

2. Interview with CNA #1 on 12/6/23 at 6:07 PM confirmed she assisted resident #100 to the bathroom without assistance on 11/11/23, a gait belt or mechanical lift was not used, and the resident was not wearing any footwear. Further interview revealed the resident attempted to stand without assistance, fell to the ground, and reported pain in his/her legs.

3. Interview with the infection preventionist, DON, restorative nurse, MDS coordinator, nurse manager #1, and the administrator on 12/7/23 at 8:37 AM revealed resident #100 was "very independent" prior to a fall on 4/19/23 which resulted in a fibula fracture. Following the 4/19/23 fall, the resident had a decline in ability and required a mechanical lift for transfers. During the 2 months prior to the 11/11/23 fall, the residents was able to transfer with a sit-to stand type mechanical lift transfer or a gait belt and stand and pivot procedure; however, the resident required 2 staff members for all transfers. They confirmed the resident declined after the fall on 11/11/23 and passed away on 12/6/23. Further interview revealed staff were expected to use a gait belt for all physically assisted transfers, were expected to identify the resident's transfer status prior to transfer, and follow the resident's care plan when assisting residents.

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F 689	Continued From page 8 4. Review of the "Gait Belt" procedure last revised May 2010 showed "...1. A gait belt must be used by all nursing staff in the following situations: a. When transferring residents who are cooperative, able to bear weight, partially independent. b. When assisting a patient/resident to the floor, or off of the floor if a fall occurred. c. When ambulating with patient/resident who requires a minimum of stand by assistance..." 5. Review of the policy titled "Care Plan: Initiating Individualized Patient/Resident Care Plans" last revised on August 2020 showed "Nurses caring for the patient/resident are responsible for ensuring that the multi-disciplinary plan of care is implemented and updated as appropriate..."	F 689		
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;	F 758		1/11/24

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F 758	Continued From page 9 §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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure as needed (PRN) orders for psychotropic medications were limited to 14 days for 1 of 5 sample residents (#42) and failed to ensure appropriate target symptoms were identified and monitored, and gradual dose reductions were performed for 1 of 5 sample residents (#4) reviewed for unnecessary medications. The findings were:	F 758	1) Resident #42 had her order for Ativan updated for an every 14 day stop date immediately. Subsequently, discussion with pharmacy and provider to provide a specific clinical indication on the order and in the clinical record for use of the Ativan with muscle spasms beyond a 14 day stop date. This discussion is ongoing to follow the intent of the regulation and provide the appropriate monitoring of the medication	

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F 758	Continued From page 10 1. Review of the quarterly MDS assessment dated 10/24/23 showed resident #42 had a brief interview for mental status score (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included non-alzheimer's dementia. Further review showed the resident had behaviors of delusions and hallucinations and received an antidepressant medication. The following concerns were identified: a. Review of the physician's orders showed the resident received an order for Ativan (antianxiety) 0.5 mg as needed one time per day for body spasms on 11/21/23 and no stop date or physician's rationale was indicated. b. Observation of the medication administration on 12/6/23 at 8:45 AM showed RN #1 administered Ativan 0.5 milligrams (mg) by mouth, 15 days after the Ativan order was obtained. c. Review of the November 2023 medication administration record (MAR) showed the Ativan 0.5 mg order was started on 11/21/23 and administered to the resident on 11/30/23. Review of the December 2023 MAR showed the Ativan 0.5 mg was administered to the resident on 12/6/23. d. Interview with RN #1 on 12/7/23 at 8:30 AM revealed she was unaware PRN Ativan should not exceed a 14 day duration and confirmed she administered the medication to the resident on 12/6/23. Interview with the RN on 12/7/23 at 8:50 AM revealed she spoke with the resident's physician and the physician was aware of a 14 day rule; however, the physician had not received a notice to change the order as of that time. e. Interview with the DON and nurse manager #1 on 12/7/23 at 9:35 AM revealed there was no	F 758	for the indication for this resident. Resident #4 will have her care plan modified to identify specific targeted symptoms for the use of sertraline and her trazadone. In addition her behavior monitor will more accurately reflect the targeted symptoms we are looking for in relation to the Trazodone. The provider will be contacted to provide the rationale section behind the clinical contraindication for dosage reduction rather than just checking the box reflecting that choice. 2) This has the potential to affect all residents who are currently prescribed psychotropic medications. GDR forms will be evaluated and reformatted for the providers to provide more complete clinical rationale and resident specific targeted symptoms for each psychotropic medication prescribed. Education will be given to providers regarding this regulation and the requirements needed by completion date. Education will also be provided to all nursing staff regarding the 14 day rule for antipsychotics, the GDR process as well as the specific targeted symptoms identified for each resident's antipsychotic or psychotropic medication by the completion date. 3) MDS coordinator in collaboration with the IDT will conduct monthly audits of the GDR forms as well as the antipsychotic medication orders to insure the 14 day rule is followed and that clinical rationale is provided. Those audits will be reported quarterly to QAPI and subsequently Quality Council. Social Services coordinator will review the CPs of those	

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POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 11 evidence a request was sent to the physician for a stop date or a physician rationale for the long term use of the as needed Ativan order. 2. Review of the quarterly MDS assessment dated 11/14/23 showed resident #4 had a BIMS score of 8 out 15, which indicated moderate cognitive impairment, and diagnoses which included anxiety disorder and depression. Further review showed the resident had a patient health questionaire-9 (PHQ-9) score of zero, which indicated no depression symptoms, and no behaviors were exhibited. Review of the physician orders showed the resident received sertraline (anti-depressant) 150 mg by mouth daily for depression related to other specified anxiety and trazadone (anti-depressant) 75 mg by mouth at bedtime for insomnia. The following concerns were identified: a. Review of the care plan last revised on 11/30/22 showed "I'm having psychosocial well-being problem [sic] r/t [related to] s/s [signs and symptoms] of depression" and interventions which included "Monitor/document/report PRN [as needed] adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs [problems], movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt [weight] loss, n/v [nausea/vomiting], dry mouth, dry eyes...Not being able to see or hear very well is hard and makes me sad. Please be patient with me and speak up when talking...Social services to monitor my mood/behavior every quarter and as needed..." Further review showed no specific	F 758	residents to insure specific targeted symptoms and interventions are indicated with appropriate behavior monitors in place for each medication.	

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F 758	Continued From page 12	F 758		

target symptoms were identified for the use of sertraline or trazadone.

b. Review of the "I use two antidepressant medications r/t [related to] depression and insomnia" care plan last revised on 5/31/23 showed interventions which included "Monitor/document/report PRN [as needed] adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs [problems], movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt [weight] loss, n/v [nausea/vomiting], dry mouth, dry eyes...Not being able to see or hear very well is hard and makes me sad. Please be patient with me and speak up when talking...Social services to monitor my mood/behavior every quarter and as needed..." and no specific target symptoms were identified for the use of sertraline or trazadone. Further review showed "follow guidelines for GDR [gradual dose reduction] attempts unless contraindicated by my physician.

b. Review of the physician orders for December 2023 showed "...Behaviors-Monitor for the following: (specify) itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care. For antidepressant use." There was no evidence of behavior monitoring related to the use of trazadone.

c. Review of a pharmacy services communication dated 5/3/23 showed "...This note is in reference to you resident, [resident's name],

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F 758	Continued From page 13	F 758		

who is currently on the anxiolytic/hypnotic medication trazadone 75 mg po [by mouth] at bedtime for insomnia. Please review and indicate below if you think we could trial a lower dose or if [s/he] should remain where [s/he] is at..." A facility RN added "In talking with [resident's name] [s/he] doesn't want any changes to this as [s/he] feels this helps [him/her] sleep at night and feels the current dose is effective..." Further review showed the physician marked a box which stated "I consider a dosage reduction to be clinically contraindicated;" however, the rationale section was not completed.

d. Review of a pharmacy services communication dated "5/3/236/2/22" and signed by the physician on 7/25/23 showed "This note is in reference to your resident, [resident's name] who is currently on Sertraline 100 mg daily for depression. Please review and indicate below if you think we could trial a lower dose or if [s/he] should remain where [s/he] is..." A facility RN added "In talking with [resident's name] [s/he] feels this medication is helping [him/her] and [s/he] doesn't want any changes made to it. Also [resident's name]'s Sertraline was increased to 150 mg [by mouth] daily on 5/25/23. No changes are requested at this time." Further review showed the physician marked a box which stated "I consider a dosage reduction to be clinically contraindicated;" however, the rationale section was not completed.

e. Interview with the DON, infection preventionist, MDS coordinator, social services/recreation coordinator, and nurse manager on 12/7/23 at 9:36 AM revealed the pharmacy sends the communication to the nursing facility, it was reviewed and updated, and sent to the doctor. Staff members talk to the resident and evaluate how they feel about the

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F 758	Continued From page 14	F 758		

medication and add the information to the communication. The revealed the target symptoms the resident displayed were tearfulness and negative self-talk. They revealed the resident used trazadone for insomnia and had the insomnia related to a response in changes resulted in difficulty sleeping because s/he gets upset; however, they did not monitor the resident's difficulty sleeping or specific sleeping patterns and they confirmed the care plan indicated insomnia may be an adverse reaction of anti-depressant therapy. Further interview confirmed the facility did not monitor resident specific identified target symptoms for the use of psychotropic medications or the medication effectiveness, and confirmed the physician did not provide a resident specific rationale for not performing a gradual dose reduction.

3. Review of the policy titled "Monthly Resident Drug Regimen Review" dated October 2017 showed "...Management of Psychotropic Drugs and Gradual Dose Reductions (GDR)...C. Each resident must be evaluated by the attending physician to determine whether a GDR is clinically contraindicated. If a GDR is clinically contraindicated the physician is required to document this specifically in the medical record...B. Antidepressants 1...After the first year, a tapering should be attempted annually, unless clinically contraindicated. The tapering may be considered clinically contraindicated if: 2. The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale why an attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder, or 3. The resident's target

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F 758	Continued From page 15 symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rationale for why an attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder..." Further review showed "...III, Orders for psychotropic drugs "as needed" or "PRN" A. All PRN orders for antidepressants, anxiolytics, or hypnotics will have a limited duration of 14 days. PRN orders for these medications will be discontinued 14 days from the date written. 1. If the resident's primary care providers believes [sic] a PRN order for longer than 14 days is needed or appropriate, the physician can extend the order beyond 14 days by documenting their rationale on the order and the resident's medical record..."	F 758		