STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056157	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alvarado Care Center	1154 S.Alvarado St Los Angeles, CA 90006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberate, aggressive, or violent behavior with the intention to cause harm) for one of two sampled residents (Resident 1), when on 6/26/2024 Resident 2 hit Resident 1 on the nose causing pain and redness to the nose. Resident 1 was subjected to abuse and psychosocial (mental health) harm by Resident 2, while under the care of the facility. Findings: A review of Resident 2's admission record indicated the facility admitted the resident on 1/19/2024 with diagnoses including Parkinson's disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), psychosis (a mental disorder, collection of symptoms that affect the mind, where there has been some loss of contact with reality) and anxiety disorder. A review of Resident 2's Behavior Problem Care Plan, initiated 3/7/2024, indicated the resident had psychosis manifested by sudden outburst of anger. The goal was for Resident 2 to utilize acceptable methods of communicating needs and the interventions included to assist the resident in developing more appropriate methods of coping, interacting, and for caregivers to provide opportunity for positive interaction or attention. A review of Resident 2's Change in Condition (COC) form, dated 3/14/2024, indicated Resident 2 had an episode of physical aggression towards staff. Resident 2 hit the staff member on the chest. A review of the Activities, Cognitive Stimulation and Social Interaction care plan, developed 3/14/2024, indicated the resident was dependent upon staff for these activities. The care plan interventions indicated all staff were to converse with Resident 2 while providing care and Resident 2 needed one to one bedside/in-room visits and activities if unable to attend out of room events. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056157	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alvarado Care Center	1154 S.Alvarado St Los Angeles, CA 90006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	According to a review of Resident 2's History and Physical (H&P), dated 4/19/2024, the resident was recently discharged from hospital due to confusion and agitation and was transferred to the hospital due to 5150 danger to self (the number of the section of the Welfare and Institutions Code, which allows an adult who is experiencing a mental health crisis to be involuntarily detained for a 72- hour psychiatric hospitalization when evaluated to be a danger to others, to himself or herself, or gravely disabled). The H&P indicated the resident was currently diagnosed with major depression (a common and serious medical illness severe low mood, sadness and despair), psychotic features (collection of symptoms that affect the mind, where there has been some loss of contact with reality), and was being followed by psychiatry(a medical practitioner specializing in the diagnosis and treatment of mental illness). The H&P further indicated Resident 2 lacked capacity to make medical decisions. A review of Resident 2's Minimum Data Set (MDS, an assessment and care planning tool) dated 4/27/2024, indicated the resident's cognitive skills of daily decision were intact. The MDS indicated Resident 2 did not have physical or verbal behavioral symptoms directed towards others, which was a discrepancy compared to the Behavior Problem Care Plan, initiated 3/7/2024 and the COC dated 3/14/2024. A review of Resident 2's Nursing Home Visit note, dated 5/6/2024, indicated the resident was seen for a psychiatric consultation (a medical practitioner specializing in the diagnosis and treatment of mental illness) at the request of the primary physician to assess the resident's behaviors and to review any psychotropic medications (a group of drugs that doctors may prescribe to treat a variety of brain conditions). The note indicated Resident 2 was having sudden outbursts of anger, inability to sleep, and episodes of aggressive behavior towards staff. A review of Resident 2's COC form, dated 5/14/2024 at 1:30 AM, indicated Resident 2 was noted grabbing and spitting on staff members. Resident 2's behavior care plan was not updated to reflect the resident's behavior of grabbing and spitting at staff. A review of Resident 2's Nursing Home Visit note, dated 6/6/2024, indicated Resident 2 continued to have sudden outbursts of anger. The note indicated the recommendation for a decrease in the resident's psychotropic medication dose was contraindicated because the benefits outweighed the risks for the resident and a reduction was likely to impair the resident's function and /or cause instability. A review of Resident 2's COC form, dated 6/26/2024 at 6:15 PM, indicated Resident 2 had physical aggression towards a roommate (Resident 1). The form indicated Resident 2 hit Resident 1's face, as Resident 2 was angry due to the roommate being very slow and Resident 2 needed to go to the restroom right away. The COC form indicated the psychiatrist ordered Resident 2 to transfer out of the facility on a 5150. A review of the Physician's Orders, dated 6/26/2024 (after the altercation), indicated the following: - monitor Resident 2 for 72 hours due to physical aggression - transfer Resident 2 on 5150 (which allows an adult who is experiencing a mental health crisis to be involuntarily detained for a 72- hour psychiatric hospitalization when evaluated to be a danger to others, or to himself or herself, or gravely disabled) due to physical aggression towards another resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056157	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alvarado Care Center	1154 S.Alvarado St Los Angeles, CA 90006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	- place Resident 2 on one-to-one observation (used to reduce the risk and incidence of harm to the resident). A review of Resident 1's Admission Record indicated the facility admitted the resident on 5/31/2024 with diagnoses including schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms) and depression. According to a review of Resident 1's History and Physical, dated 6/1/2024, the resident had the capacity to understand and make decisions. A review of Resident 1's MDS dated [DATE], indicated the resident's cognitive skills of daily decision were intact. The MDS indicated Resident 1 had little interest or pleasure in doing things and Resident 1 was feeling down, depressed or hopeless. The MDS also indicated the resident required partial to substantial assistance with oral hygiene, toileting hygiene, showering/bathing, and dressing. A review of Resident 1's Resident Grievance/Complaint Investigation Report dated 6/24/2024 (two days before the altercation) indicated Resident 1 reported not getting along with his roommate (Resident 2). The report indicated Resident 1 and his roommate were offered a room change and both refused. A review of Resident 1's COC form, dated 6/26/2024 at 6:15 PM, indicated Resident 1 received physical aggression, the resident's nose was red, and staff applied an ice pack. The COC indicated the physician ordered Resident 1 to receive an x-ray. A review of the Physician's Orders, dated 6/26/2024, indicated to transfer Resident 1 to a general acute care hospital (GACH) for further evaluation of nasal pain and redness, Resident 1 was to receive a stat (immediate) x-ray of the face due to nasal pain and redness, and was to have a psychiatrist and psychologist consultation. According to a review of Resident 1's Telemedicine Visit note, dated 6/27/2024, the resident was recently involved in a physical altercation with another resident (Resident 2), in which Resident 1 was the victim. The note indicated Resident 1 continued to verbalize feelings of depression and the psychiatrist increased the resident's dose of Luvox (fluvoxamine - a medication used to treat unwanted repeated thoughts). During an interview on 7/10/2024 at 9:20 AM, Resident 1 stated while sitting in a wheelchair in their shared room (on 6/26/2024), Resident 2 walked past. Resident 1 stated Resident 2 then turned back around and hit Resident 1 in the face three times. During a phone interview on 7/10/2024 at 10:03 AM, Certified Nursing Assistant (CNA) 1 stated she heard Resident 2 screaming and yelling at Resident 1 on 6/26/2024. Resident 1 stated, Get away from me, to Resident 2. CNA 1 stated then she observed Resident 2 hit Resident 1 in the face twice. CNA 1 stated she then went to inform the charge nurse. CNA 1 stated Resident 2 tended to be 'grumpy'. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056157	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alvarado Care Center	1154 S.Alvarado St Los Angeles, CA 90006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/10/2024 at 10:24 AM, Licensed Vocational Nurse (LVN) 1 stated about two weeks ago (on 6/26/2024), while administering medications, RN Supervisor (RNS) 2 stated Resident 1 and Resident 2 had a physical altercation. LVN 1 stated upon assessing Resident 1, Resident 1 had a small area of redness on the nose. LVN 1 stated Resident 1 stated it was painful but refused pain medication. LVN 1 further stated Resident 2 was placed on one-to-one observation. LVN 1 stated Resident 2 had a history of being verbally aggressive towards staff. On 7/10/2024 at 10:49 AM, during an interview, RNS 2 stated that on 6/26/2024 around 6 PM, RNS 2 heard a loud noise, and Resident 1 reported, I was too slow to move out of his way, I think he became impatient, so he hit me twice. RNS 2 stated Resident 2 had a red area on the nose and law enforcement was notified. RNS 2 stated law enforcement determined Resident 2 did not qualify for 5150 transfer and Resident 1 was moved to a different room. RNS 2 further stated Resident 2 had a sudden outburst of anger toward staff in the past and if you did not give Resident 2 attention he would become angry. During an interview on 7/10/2024 at 12:07 PM, RNS 1 stated we have to remind Resident 2 to use his call light instead of screaming. During a concurrent review of Resident 2's COC Evaluation, dated 5/14/2024, where Resident 2 was noted to spit on staff, RNS 1 stated the care plan for this incident of Resident 2 being physically aggressive with staff was initiated on 6/26/2024 (over one month later from the COC evaluation). RNS 1 further stated when Resident 2 was readmitted from the GACH on 7/3/2024 (after the altercation with Resident 1), the resident's dose of Seroquel (an antipsychotic medication that treats several kinds of mental health conditions) was increased from 25 milligrams (mg) to 50 mg. During a concurrent interview and record review on 7/10/2024 at 1:55 PM, Resident 1's Resident Grievance / Complaint Investigation Report, dated 6/24/2024, was reviewed. The Social Services Director (SSD) stated Resident 1 made a grievance against Resident 2 prior to the physical altercation (on 6/24/24). The SSD stated Resident 1's grievance against Resident 2 was regarding Resident 2's TV being too loud and Resident 2's extended time in the restroom. The SSD stated when speaking to Resident 2 regarding Resident 1's complaint, Resident 2 refused to move and stated they would work the situation out. During an interview on 7/10/2024 at 4:09 PM, the Administrator (ADM) stated she was in the building when the altercation between Resident 1 and Resident 2 occurred. The ADM stated she completed an investigation into the incident, and it was determined Resident 2 hit Resident 1. A review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, dated 10/1/2023, indicated the residents have the right to be free from abuse and neglect, or mistreatment. The policy indicated the facility was committed to protecting residents from abuse by anyone including staff, other residents, visitors, and others. A review of the facility's P&P titled, Resident - Resident Altercations, dated 10/1/2023, indicated the facility acts promptly and conscientiously to prevent and address altercations between residents. The policy indicated the facility staff monitors residents for aggressive or inappropriate behavior toward other residents, separates the residents and institute measures to calm the situation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056157	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alvarado Care Center	1154 S.Alvarado St Los Angeles, CA 90006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43851 Based on interview and record review, the facility failed to developo a care plan (a document outlining a detailed approach to care customized to an individual resident's need) for psychotropic (a medication that affects behavior, mood, thoughts, or perception) medication for one of four sampled residents (Resident 2). This deficient practice had the potential to result in Resident 2 not receiving the appropriate care and to experience adverse (harmful) side effects which could result in injury. Findings: A review of Resident 2's Admission Record indicated the facility admitted the resident on 7/18/2024 with diagnoses including unspecified psychosis (a mental disorder characterized by a disconnection from reality) schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living). A review of Resident 2's Physician's Orders dated 7/18/2024, indicated the resident was to receive the following: -Paroxetine (Paxil, a medication used to treat depression) 50 milligrams (mg) one time a day for depression manifested by feelings of sadness. -Quetiapine Fumarate (Seroquel, a medication used to treat psychosis) 200 mg by mouth at bedtime for psychosis manifested by unusual behavior. -Risperidone (Risperdal, a medication used to treat the symptoms of schizophrenia) 3 mg every 12 hours for schizoaffective disorder manifested by sudden changes in mood. A review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 7/25/2024, indicated the resident was cognitively intact (had the ability to think, understand, reason, and make decisions) and had active diagnoses of depression, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and psychotic disorder. The MDS indicated Resident 2 was taking antipsychotic (medication used to manage psychosis), and antidepressant (medication used to treat depression) medication. A review of Resident 2's Medication Administration Record dated 8/1 - 8/31/2024, indicated Resident 2 received the following medications: -22 doses of Paxil 50 mg from 8/1/2024 - 8/22/2024 -21 doses of Seroquel 200 mg from 8/1/2024 - 8/22/2024 -43 doses of Risperdal 3 mg from 8/1/2024 - 8/22/2024 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056157	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alvarado Care Center	1154 S.Alvarado St Los Angeles, CA 90006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a review of Resident 2's care plans, the resident did not have a care plan initiated for Paxil, Seroquel, or Risperdal. During a concurrent interview and record review on 8/22/2024 at 1:40 PM, Resident 2's care plan and physician's orders for Paxil, Seroquel, and Risperdal were reviewed with Registered Nurse Supervisor (RNS) 1. RNS 1 confirmed that Resident 2 did not have a developed care plan for Paxil, Seroquel, or Risperdal. RNS 1 stated, I don't know what happened, it is supposed to be care planned. RNS 1 stated care plan should be developed for any psychotropic medication and that not creating a care plan for psychotropic medication could potentially cause injury to Resident 2 because staff would not know what medication the resident was receiving or the side effects to monitor. The Director of Nursing (DON) was not available for interview. During a concurrent interview and record review on 8/22/2024 at 2:08 PM, Resident 2's care plan and physician's orders for Paxil, Seroquel, and Risperdal were reviewed with the Administrator. The Administrator confirmed Resident 2 did not have a developed care plan for Paxil, Seroquel, or Risperdal. During a review of the facility's policy and procedure titled, Care Planning, implemented 10/1/2023, indicated a Comprehensive Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs. Each resident's Comprehensive Care Plan will describe the following: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; any services that would be required, but are not provided due to the resident's exercise of rights, which includes the right to refuse treatment; any specialized services including rehabilitative service as a result of PASARR recommendations. If the facility disagrees with the PASARR findings, rationale will be notated in the resident's medical record; the resident's goals for admission and desired outcomes; and discharge plans as appropriate. The Comprehensive Care Plan must be completed within 7 days after completion of the Comprehensive Admission Assessment and must be periodically reviewed and revised by a team of qualified persons after each assessment, including the comprehensive and quarterly review assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056157	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alvarado Care Center	1154 S.Alvarado St Los Angeles, CA 90006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 43851 Based on interview and record review, the facility failed to obtain informed consent (a communication between a patient and physician that results in the patient's authorization or agreement to undergo a specific medical intervention or treatment) for an increase in the dosage of Fluvoxamine Maleate [a medication used to treat depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living), with side effects that include nausea, diarrhea, tremors, seizures, fast heartbeat, insomnia (trouble sleeping), and restlessness] for one of four sampled residents (Resident 1). This deficient practice had the potential to result in Resident 1 not being informed about the medications Resident 1 was receiving and had the potential to cause the resident to experience adverse (harmful) side effects of the medication. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 5/31/2024 with a diagnoses including depression. A review of Resident 1's Physician's Order dated 5/31/2024, indicated Resident 1 was to receive Fluvoxamine Maleate 50 milligrams (mg) by mouth at bedtime for depression manifested by feelings of sadness. A review of Resident 1's Consent 3.0 document dated 5/31/2024, indicated Resident 1 consented to receive the anti-depressant medication Fluvoxamine Maleate 50 milligrams (mg) by mouth at bedtime. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 6/13/2024, indicated Resident 1 was cognitively intact (had the ability to think, understand, reason, and make decisions), had a diagnosis of depression, and was taking antidepressants (medication used to treat depression). According to a review of Resident 1's Psychiatric (psychiatrist, a medical doctor who specializes in mental health) Note dated 6/27/2024, the resident was seen for a psychiatric consultation. The note indicated Resident 1's dosage of Fluvoxamine maleate was to be increased to 100 mg at bedtime. A review of Resident 1's Physician's Order dated 6/27/2024, indicated the resident was to receive Fluvoxamine Maleate 100 mg by mouth at bedtime for depression manifested by feelings of sadness. A review of Resident 1's Medication Administration Record (MAR) dated 8/1/2024 - 8/31/2024, indicated the resident received 20 doses of Fluvoxamine Maleate from 8/1/2024 to 8/21/2024. There was no Consent 3.0 document that indicated Resident 1 consented to receive Fluvoxamine Maleate 100 mg by mouth at bedtime. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056157	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alvarado Care Center	1154 S.Alvarado St Los Angeles, CA 90006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/22/2024 at 1:40 PM, Resident 1's physician's order for Fluvoxamine Maleate 100 mg dated 6/27/2024 and Consent 3.0 document dated 5/31/2024 were reviewed with Registered Nurse Supervisor (RNS) 1. RNS 1 stated Resident 1 was currently receiving Fluvoxamine Maleate 100 mg by mouth at bedtime. RNS 1 stated Resident 1 was previously taking 50 mg of Fluvoxamine Maleate 50, but the dose was increased on 6/27/2024 to 100 mg. RNS 1 verified that Resident 1 provided consent to receive Fluvoxamine Maleate 50 mg as indicated on the Consent 3.0 document dated 5/31/2024. RNS 1 further stated that there was no consent obtained from Resident 1 for the increase in the dose of Fluvoxamine Maleate to 100 mg. RNS 1 stated the informed consent should have been obtained from Resident 1 for the increase to 100 mg of Fluvoxamine Maleate. RNS 1 stated there was a potential for Resident 1 to not have been informed of the change in dosage and for Resident 1 to experience adverse side effects if informed consent was not obtained from the resident. The Director of Nursing (DON) was not available for interview on 8/22/2024. During a concurrent interview and record review on 8/22/2024 at 2:08 PM, Resident 1's physician's order for Fluvoxamine Maleate 100 mg dated 6/27/2024 and Consent 3.0 document dated 5/31/2024 were reviewed with the Administrator. The Administrator confirmed Resident 1 did not have a consent for Fluvoxamine Maleate 100 mg. The Administrator stated they only saw the consent for Fluvoxamine Maleate 50 mg. A review of the facility's policy and procedure titled, Psychotherapeutic Drug Management, dated 10/1/2023, indicated when changing the dosage of psychotherapeutic medications, the Attending Physician/LHP must obtain informed consent for changes in dosage of a psychotherapeutic medication. An updated informed consent is needed even if the medication change is from within the same class (Ex: SSR, antipsychotic, etc.).