STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225476	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alliance Health at Maples	90 Taunton Street Wrentham, MA 02093

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34145 Based on record review and interview, the facility failed to ensure the Resident Representative was notified of a change in treatment for one Resident (#77), out of a total sample of 26 residents. Specifically, the facility failed to notify the Resident Representative when the Nurse Practitioner ordered the discontinuation of anticoagulant (medication that prevents blood from clotting) therapy following a fall resulting in a subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain). Findings include: Review of the facility's policy titled Condition: Significant Change in, last revised 5/20/22, indicated but was not limited to: Policy: professional staff will communicate with physician, resident, and family regarding changes in condition. -Purpose: to provide timely communication of resident status change which is essential to Quality Care Management. -Process: The physician, resident and/or responsible party will be promptly notified by the nurse in the event of a condition change. -Order changes given by the physician will be carried out, including emergency transport if necessary, by the nurse -This notification including date, time and by whom, shall be documented in the clinical record by appropriate personnel. Resident #77 was admitted to the facility in May 2024 following an extended hospitalization and had an activated Health Care Proxy. The Resident was administered the anticoagulant medication Lovenox for treatment of a splenic infarct (occurs when the blood supply to the spleen is compromised, resulting in tissue ischemia and eventual necrosis). (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 5/16/24, indicated Resident #77 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15, and was administered anticoagulant medication. Review of the May 2024 Physician's Orders included but was not limited to: -Enoxaparin (anticoagulant) syringe 40 milligrams (mg)/0.4 milliliters (mL) subcutaneously (under the skin) twice a day for two months (5/9/24-7/9/24). According to the National Institute of Health (2023), anticoagulants may increase the risk of intracranial hemorrhage associated with falling. Review of the medical record indicated Resident #77 sustained a fall on 6/1/24 and was sent to the emergency room for evaluation. Review of emergency room Physician documentation, dated 6/1/24, indicated the computed tomography (CT) scan of the brain, revealed a finding of a trace right frontal subarachnoid hemorrhage. Review of Nursing Notes, dated 6/3/24, indicated the Nurse Practitioner gave an order to discontinue Lovenox due to the Resident's subarachnoid hemorrhage. Further review of the medical record failed to indicate Resident #77's Resident Representative was notified of the discontinuation of anticoagulant therapy. During an interview on 7/17/24 at 10:55 A.M., Resident #77's Resident Representative said he was not notified by anyone that the order for Lovenox was discontinued. During an interview on 7/17/24 at 11:20 A.M., Unit Manager #2 said she spoke to the Nurse Practitioner and received the order to discontinue Lovenox. She said she usually documents when she notifies Resident Representatives of any changes, but she may have missed telling the Resident's Representative the medication was discontinued.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 46562 Based on record review and staff interview, for one Resident (#88), of three closed records reviewed, the facility failed to document the recapitulation of the Resident's stay that included his/her course of illness/treatment. Findings include: Review of the facility's policy titled Discharge Planning Process, dated 6/11/24, indicated but was not limited to: Upon discharge the facility will complete a discharge summary which will include a recapitulation (the recapitulation of stay shall be a concise summary of the resident's stay and course of treatment while in the facility) and a final summary which included the resident's status at the time of discharge. The discharge summary shall include a description of the resident's: -course of illness, treatment, and/or therapy since entering the facility Resident #88 was admitted to the facility in April 2024 with the following diagnoses: fracture of right femur (bone in the upper leg/thigh) and history of fall. Review of the medical record indicated Resident #88 was discharged to an Assisted Living Facility (ALF) on 6/25/24. Review of Resident #88's discharge paperwork, titled Discharge Summary, indicated the following information was left blank: -date and time of admission -date and time of discharge -admitting diagnosis -brief history of nursing home stay -condition at time of discharge (physical and mental) -discharge to -final diagnosis -prognosis -date -physician signature (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/24 at 4:00 P.M., Unit Manager #2 said when a resident is being discharged , she prints the Continuity of Care Document including their medication list and the last time administered. Unit Manager #2 said no additional assessments or observations are completed on paper or electronically. Unit Manager #2 said she then reviews the information with the resident and/or resident representative, faxes the information to the receiving facility or Visiting Nurse Agency and puts a copy in the Resident's medical record. During an interview on 7/16/24 at 4:31 P.M., Social Worker #2 said a once a discharge date and plan is established, the facility sets up any necessary outpatient services. Social Worker #2 said when the resident is discharged the discharge paperwork including the discharge plan of care and discharge summary was sent to the primary care provider, receiving facility, and/or outpatient services. Social Worker #2 said the discharge plan of care was completed electronically. Social Worker #2 said Resident #88's discharge plan of care was not completed at the time of discharge. During an interview on 7/16/24 at 4:28 P.M., the Director of Nurses (DON) and Regional Clinical Specialist #1 said the physician did not complete the discharge summary and recapitulation. The Regional Clinical Specialist #1 said she believed the physician had roughly 30 days to complete the recapitulation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on record review and interview, the facility failed to ensure staff provided adequate supervision to one Resident (#77), out of a total sample of 26 residents, who was identified as a high fall risk and received anticoagulant medication (medication that prevents blood from clotting). Specifically, the facility failed to ensure staff provided adequate supervision and/or implemented adequate interventions in an effort to prevent five falls in one month, one of which resulted in the Resident being transferred to the hospital emergency department for evaluation, and he/she was diagnosed with a subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain). Findings include: Review of the facility's Fall Management Program, dated as last revised 10/13/22, indicated but was not limited to the following: -Policy: To identify, prevent, and treat residents at risk for negative outcomes based on their clinical comorbidities, functional status, cognitive status, and other risk factors that compromise their well-being through a systematic approach. -Purpose: To utilize resident related data to determine which residents are at risk. To minimize resident falls through a systematic approach, implementing individualized interventions based on the resident's assessment, clinical condition, comorbidities, and other related factors. -Procedure: The facility will utilize all resident related information made available on admission to determine resident-at-risk for Fall Status. -A fall risk assessment will be conducted on each resident upon admission, with the quarterly Minimum Data Set (MDS) cycle, when a significant change in status occurs, annually and after a fall. -Residents identified at high risk for falls (score of 10 or higher on the assessment) will have an appropriate fall prevention care plan developed, implemented, and revised as necessary. -Develop a new care plan or update the existing care plan as applicable with new interventions to prevent reoccurrence. -Morning team review will include clinical record review, care plan and Certified Nursing Assistant (CNA) care card update. Interdisciplinary care plans will be revised with a new dated intervention following a resident fall to ensure that all appropriate interventions to minimize recurrence have been included. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #77 was admitted to the facility in May 2024 following an extended hospitalization after having two falls at home and a urinary tract infection The Resident had diagnoses including encephalopathy (any brain disease that alters brain function or structure), history of repeated falls, syncope (dizziness) and collapse, muscle weakness and difficulty in walking. Medications included antipsychotic, antidepressant, anticoagulant, and anti-seizure medication (also used for nerve pain). Review of the MDS assessment, dated 5/16/24, indicated Resident #77 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15, demonstrated inattention and wandering, and required partial to moderate assistance for all walking, and was administered anticoagulant medication. The MDS also indicated Resident #77 had falls prior to admission and had two falls since admission to the facility. Review of May 2024 Physician's Orders included but was not limited to: -Enoxaparin (anticoagulant) syringe 40 milligrams (mg)/0.4 milliliters (mL) subcutaneously (under the skin) twice a day for two months (5/9/24-7/9/24) According to the National Institute of Health (2023), anticoagulants may increase the risk of intracranial hemorrhage associated with falling. Review of a fall risk assessment, dated 5/10/24, indicated Resident #77 had balance problems while walking and had a fall risk score of 10, indicating a high risk for falls. The assessment indicated referrals to Physical Therapy (PT) and Occupational Therapy (OT) were appropriate. Review of the comprehensive care plan for falls, initiated 5/9/24, indicated: Problem: Resident has a history of falling related to weakness and confusion Goal: Resident will remain free from injury (target: 2/28/24) Approach: -Analyze Resident's fall to determine pattern/trend -Give Resident verbal reminders not to ambulate/transfer without assistance -Keep call light in reach at all times -Keep personal items and frequently used items within reach -Leave nightlight on in room -Obtain PT consult for strength training, toning, positioning, transfer training, gait training, mobility devices -Occupy Resident with meaningful distractions: music, companion, crafts -Provide an environment free of clutter (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the CNA Care Card (undated) indicated but was not limited to: -Mobility/Ambulation: Walks with supervision, monitoring (close supervision) -Mobility device: Encourage rolling walker (RW) -Behaviors: Wanders, anxious, resistive to care -Fall Risk: Yes Review of the medical record and Accident/Incident Report and Investigation Form-Falls indicated Resident #77 sustained five falls between 5/9/24 and 6/1/24, one of which (6/1/24) resulted in a subarachnoid hemorrhage. Fall #1 (5/9/24 at 3:40 P.M.): -Review of the medical record indicated Resident #77 fell off a chair in his/her room witnessed by his/her Health Care Proxy (HCP). No injuries were noted. Interventions/recommendations identified to prevent further occurrence included redirection, encourage diversional activities and therapy to improve gait and balance. Review of the OT Evaluation and Plan of Treatment, dated 5/9/24, indicated, but was not limited to: -The patient presents with impairments in balance, gross motor coordination and mobility resulting in limitations and/or participation restrictions in the areas of mobility and self-care. Review of the PT Evaluation and Plan of Treatment, dated 5/10/24, indicated but was not limited to: -The patient presents status post lengthy admission to hospital (one month) with decreased strength in bilateral lower extremities, decreased activity tolerance and decreased standing balance. -Patient with decreased safety awareness demonstrating much confusion. Resident #77's baseline level of functional mobility was partial/moderate assistance (the patient can perform 50% of the mobility task while the caregiver assists with 50%) to walk between 10 feet and 150 feet with no assistive device. -Long term goal: safely ambulate 350 feet using no assistive device on level surfaces with supervision or touching assistance with ability to right self to achieve/maintain balance to increase independence within facility (target: 6/20/24). -Plan of treatment included PT sessions five to six times a week for six weeks (5/10/24 - 6/20/24). Review of an Interdisciplinary Team (IDT) Risk Note, dated 5/23/24, indicated but was not limited to: team reviewed the Resident's fall from 5/9/24 with the following interventions in place: therapy for gait and balance, and encourage diversional activities of choice. Resident very restless and pacing. Medications reviewed and restarted Gabapentin (treats nerve pain) for his/her restless legs. IDT will continue to monitor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Fall #2 (5/26/24 at 9:30 A.M.) -Review of the medical record indicated Resident #77 had a fall in the unit hallway witnessed by a nurse. A Nursing Note, dated 5/26/24, indicated the Nurse saw the Resident walking down the hallway, lose his/her balance and fall. The Nurse indicated she was administering medications some distance away from the Resident and was unable to reach the Resident. No injuries were noted. Fall #3 (5/28/24 at 7:05 A.M.) -Review of the medical record indicated Resident #77 had an unwitnessed fall in the unit hallway. The report indicated a Nurse was at the medication cart and turned around and saw the Resident on the floor. No injuries were noted. Interventions/recommendations identified to prevent further occurrence indicated medication review by the Physician, continue to encourage the Resident to be in supervised area and provide distraction-encourage activity. Review of the PT progress note, dated 5/28/24, indicated Resident #77 had an unwitnessed fall with a recommendation to continue supervision for all mobility. Fall #4 (5/29/24 at 9:30 A.M.) -Review of the medical record indicated Resident #77 had an unwitnessed fall in the unit hallway. The report indicated the Resident's ambulation status was supervised; however, the fall was unwitnessed, and staff found the Resident on the floor in front of the nurse's desk. No injuries were noted. Interventions/recommendations identified to prevent further occurrence indicated to keep hallway clear of obstacles, monitor Resident when in hallway, and attempt to encourage Resident to sit and rest. Review of the medical record indicated Resident #77 was seen by his/her Physician on 5/29/24 and some medications were adjusted. The Physician assessed the Resident using a rolling walker, and said the Resident is to be encouraged to use the walker. Review of an Interdisciplinary Referral and Rehab Screen, dated 5/30/24, indicated but was not limited to a recommendation for staff to provide supervision at all times and to walk with the Resident due to his/her fall risk and decreased safety awareness. The care plan for falls was updated on 5/30/24 with intervention to monitor the Resident for fatigue and offer him/her a chair. Review of an IDT Risk Note, dated 5/31/24, indicated but was not limited to: team reviewed the Resident's falls from 5/9/24, 5/26/24 and 5/29/24 with the following interventions in place: therapy for gait and balance, and encourage diversional activities of choice. Resident very restless and pacing. Physician reviewed medications and made adjustments and said to encourage the Resident to use walker when he/she is ambulating. IDT will continue to monitor. Fall #5 (6/1/24 at 7:45 A.M.) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Review of the medical record indicated Resident #77 was walking in the dayroom without his/her walker and tripped on a walker and fell as he/she was exiting the dayroom. The report indicated the fall was witnessed by Nurse #8. Nurse #8's statement indicated she placed the Resident's walker outside the dayroom to give to the Resident when he/she came out of the room, and she was at the medication cart at the time of the fall. Further review of the incident report indicated four investigation/witness statements from CNAs working on the unit at the time of the fall. None of the CNAs indicated they observed the fall or provided close supervision (according to the fall care plan) while he/she ambulated in the dayroom and failed to indicate any staff encouraged the Resident to use the walker for ambulation as indicated by the Physician on 5/29/24. Further review of the medical record indicated Resident #77 complained of pain to his/her right hip and was sent to the emergency room for evaluation. Review of emergency room Physician documentation, dated 6/1/24, indicated but was not limited to Resident #77 being evaluated after sustaining a fall at the facility with a question of a head strike. Imaging of the pelvis and both hips were negative for fracture. However, on the computed tomography (CT) scan of the brain, there was a finding of a trace right frontal subarachnoid hemorrhage. A repeat scan performed four hours later confirmed the presence of a subarachnoid hemorrhage and that it was unchanged from the initial scan. Review of a CT scan of the brain performed during a prior hospitalization , dated 4/11/24, failed to indicate Resident #77 had a subarachnoid hemorrhage or any other type of bleeding in the brain. The care plan for falls was updated on 6/2/24 with interventions to occupy Resident with meaningful distractions (repeated intervention); PT notified and recommends not using walker- he/she does not recognize the device; provide close supervision for safety as needed (6/3/24). Review of the CNA Care Card failed to indicate it was updated to reflect PT's recommendation to not use a walker as the Resident does not recognize it. Review of a Physician's Progress Note, dated 6/3/24, indicated the Resident had a recent fall with subarachnoid hemorrhage. Continue fall precautions, supportive care, monitor for any motor or sensory deficits, follow up with neurology as needed. Review of an IDT Risk Note, dated 6/6/24, indicated but was not limited to: team reviewed the Resident's falls from 5/9/24, 5/11/24, 5/26/24, 5/29/24, and 6/1/24 with the following interventions in place: therapy for gait and balance, and encourage diversional activities of choice. Resident very restless and pacing. Physician reviewed medications and made adjustments and encouraged resident to use walker when he/she is ambulating. On 6/3/24, Resident was assigned a CNA with very close supervision at all times. IDT will continue to monitor. Review of a Nursing Note, dated 6/3/24, indicated but was not limited to Resident #77 was placed on 1:1 supervision with a CNA and a gait belt worn every shift to prevent any falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Rehabilitation Director and Physical Therapist #1 on 7/16/24 at 7:42 A.M., the Rehab Director said Resident #77 has had a lot of falls since admission and can be impulsive and uncooperative. The Rehab Director reviewed PT documentation and said supervision by staff means when the Resident is up and ambulating, the resident should always have someone right there with him/her. Physical Therapist #1 said she agreed with the Rehab Director and said supervision of the Resident is when someone has eyes on the Resident and standing right with him/her to assist. During an interview on 7/16/24 at 9:31 A.M., CNA #3 said Resident #77 used to walk around the unit independently, and after the Resident fell and was sent to the hospital, he/she has been on a 1:1. She said now she walks alongside the Resident with her hand ready on the gait belt if he/she needs to be redirected or guided to turn or avoid obstacles so he/she doesn't trip. During an interview on 7/16/24 at 9:50 A.M., CNA #4 said she has worked with Resident #77 as his/her 1:1 a few times. She said the Resident has never fallen while she was his/her 1:1, but he/she has fallen with other CNAs. She said she saw the Resident fall at the nursing station (5/29/24) and she did not see a CNA supervising him/her. During an interview on 7/16/24 at 10:30 A.M., Nurse #8 said Resident #77 wanders constantly and has had a lot of falls since being admitted to the facility. She said on 6/1/24 (fall with injury), she didn't actually see the Resident fall (contrary to the incident report). She said she heard a noise, turned around and saw the Resident on the floor and no CNA was with him/her. She said after that fall, she was glad that they put him/her on a 1:1 because she was so nervous the Resident would fall and get hurt. During an interview on 7/16/24 at 10:48 A.M., CNA #2 said when Resident #77 was first admitted to the unit, he/she was very confused, unsteady with walking and impulsive. He said the Resident needed someone watching him/her 24/7. During an interview with the Director of Nursing (DON) and Regional Clinical Specialist #2 on 7/16/24 at 11:10 A.M., they said Resident #77's ambulation status is very different than his/her last admission. They said the Resident is very impulsive and gets up and walks in a moment's notice. Regional Clinical Specialist #2 and the DON said close/constant supervision of the Resident was not practical and they did not implement 1:1 supervision until the Resident returned from the hospital after sustaining a subarachnoid hemorrhage from the fall on 6/1/24. During an interview on 7/17/24 at 10:55 A.M., Resident #77's Responsible Person (RP) said Resident #77 was taken to the emergency roiagnom on [DATE] after having a fall and was told by the doctor that there was some bleeding in his/her head. He said the Resident had CT scans of his/her head before, and the Resident never had any bleeding in his/her brain before. He said the Resident has had several falls since admission to the facility and is relieved he/she now has a 1:1 to keep him/her safe.

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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. 48695 Based on records reviewed and interviews, the facility failed to ensure for two Residents (#13 and #15), out of five residents selected for unnecessary medication review, that each Resident's drug regimen was free from unnecessary psychotropic medications. Specifically, the facility failed to ensure: 1. For Resident #13, an Abnormal Involuntary Movement Scale (AIMS) assessment (a clinical outcome checklist completed by a healthcare provider to assess the presence and severity of adverse outcomes, such as abnormal movements of the face, limbs, and body) was completed timely in accordance with standards of practice; and 2. For Resident #15, as needed (prn) antidepressant medication was limited to 14 days, or extended beyond 14 days with a documented clinical rationale for its continued use and identified a clinical indication for use. Findings include: Review of the facility's policy titled Psychotropic Medication Management, last revised 5/15/2022, indicated but was not limited to: - Policy: Each resident's drug regimen will be free from unnecessary drugs. Administration of psychoactive medications will focus on the individual needs of the resident and will be prescribed only when necessary and clinically indicated to treat specific conditions and symptoms as diagnosed and documented. Psychoactive medication management will include implementation of behavioral interventions, gradual dose reduction, and adequate monitoring that complies with Federal and State guidelines. - Protocol: - Obtain Physician order for each psychoactive medication. Ensure that supportive diagnosis and target behaviors are documented and clearly identify the use of the medication is necessary and warranted. - Perform a baseline AIMS assessment upon initiation of any Antipsychotic medication and every six months thereafter. - Review should include verification that adequate indications for use of the psychotropic medication exist, the medications are not being used for extended duration, and residents are free from duplicate therapy and being monitored for adverse consequences, per current professional standards of practice and in accordance with Federal and State guidelines. (continued on next page)

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Alliance Health at Maples	90 Taunton Street Wrentham, MA 02093

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	- PRN (as needed) orders for psychotropic drugs are limited to 14 days (except as noted before) if the prescribing MD or practitioner believes it is appropriate for the PRN to be extended beyond 14 days. The MD will document his/her rational in the resident's medical record and indicate the duration for the PRN order. Review of the facility's policy titled Abnormal Involuntary Movement Scale (AIMS), last revised 8/5/23, indicated but was not limited to: - Policy: The AIMS examination will be administered to all residents when antipsychotic medications are prescribed at time of baseline and every six months thereafter. A psychiatric service provider, or licensed nursing/social service staff member may administer this examination. - Procedure: - Perform the AIMS examination according to the guidelines provided on the Abnormal Involuntary Movement Scale. Review of the National Library of Medicine (NLM), dated 5/15/23, indicated but was not limited to: - The AIMS is administered every three to six months to monitor the patient for the development of TD (tardive dyskinesia, is a syndrome characterized by abnormal involuntary movements of the patient's face, mouth, trunk, or limbs. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10292174/) 1. Resident #13 was admitted to the facility in April 2022 with diagnoses including major depressive disorder, psychosis, and unspecified dementia. Review of Resident #13's Minimum Data Set (MDS) assessment, dated 5/15/24, indicated that the Resident had short- and long-term memory problems as evidenced by staff interview. Further review of the MDS indicated Resident #13 was receiving an antipsychotic medication on a regular basis. Review of Resident #13's current Physician's Orders indicated but were not limited to: - Quetiapine (antipsychotic medication) 50 milligrams (MG) tablet. Give one tablet twice daily (start date 7/20/24). Review of Resident #13's Medication Administration Records (MAR) for May, June, and July indicated he/she received Quetiapine per physician's orders. Review of Resident #13's current Care Plan indicated but was not limited to: - Problem: Psychotropic Drug Use Resident is receiving psychotropic medication (Edited: 05/22/2024) - Goal: Resident will have no side effects to medication noted through next review. (Edited: 05/20/2024) - Intervention: AIMS assessment every 6 months (Created: 04/25/2023) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's medical record indicated his/her last AIMS was completed 9/5/2023. During an interview on 7/16/24 at 1:04 P.M., Unit Manager #3 said that AIMS assessments are either done by the Psychiatric Nurse Practitioner or by the Psychologist, but she would also do the AIMS assessment if she needed to do it. Unit Manager #3 reviewed Resident #13's medical record and said that Resident #13 last had an AIMS assessment completed 9/5/23. Unit Manager #3 said she was unaware of when Resident #13's next AIMS assessment was due. During an interview on 7/16/24 at 1:17 P.M., the Director of Nursing (DON) said AIMS assessments were to be completed every six months. The DON said Resident #13 last had his/her AIMS assessment completed on 9/5/23 and it was due to be completed again in March of 2024, but it was not. 34145 2. Resident #15 was admitted to the facility in May 2021 with diagnoses including dementia with behavioral disturbance, restlessness and agitation, paranoid personality disorder, and anxiety. Review of the MDS assessment, dated 5/30/24, indicated Resident #15 was unable to complete the Brief Interview for Mental Status (BIMS), had both long- and short-term memory problems, and received antipsychotic and antidepressant medication daily. Review of the medical record indicated but was not limited to the following Physician's orders: -Trazodone (antidepressant) 50 mg, give 25 milligrams (gm) every six hours prn, re-evaluate on 9/15/23 (9/2/23) -Trazodone 50 mg, give 25 mg every six hours prn, then re-evaluate on 10/2/23 (9/18/23) -Trazodone 50 mg, give 25 mg every six hours prn, then re-evaluate on 10/20/23 (10/6/23) -Trazodone 50 mg, give 25 mg every six hours prn for 14 days, then re-evaluate (11/3/23) -Trazodone 50 mg, give 25 mg every six hours prn, then re-evaluate in six months on 5/17/24 (11/20/23) -Trazodone 50 mg, give 25 mg every 6 hours prn. Re-eval with MD on 8/16/24 (5/19/24-8/16/24) The prn orders for Trazodone failed to indicate an indication for its use. Review of MARs from September 2023 through July 2024 indicated prn Trazodone was administered as follows: -September 2023 through February 2024: not administered -March 2024: 3/13, 3/14, 3/18, 3/23, 3/28 -April 2024: 4/2 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-May 2024: 5/13 -June 2024 and July 2024: not administered Review of the entire medical record failed to indicate the prn orders for Trazodone from September 2023 through July 2024 were re-evaluated and a clinical rationale for its continued use was documented in the medical record by either the Physician (MD) or Nurse Practitioner (NP). During an interview on 7/11/24 at 9:11 A.M., the Staff Development Coordinator (SDC) reviewed Resident #15's medical record and said there was no documentation from the MD or NP that indicated an evaluation and clinical rationale for the continued use of prn Trazodone. During an interview on 7/15/24 at 1:30 P.M., Unit Manager (UM) #2 reviewed Resident #15's medical record and said there was no documentation from the MD or NP to indicate a clinical rationale for continued use of Trazodone. She said the prn Trazodone orders are supposed to include indications for its use, but they don't. UM #2 said she would contact the Physician regarding the prn Trazodone order. Review of a Nursing Note, dated 7/15/24, indicated UM #2 spoke with Resident #15's Physician about the prn Trazodone order. The note indicated Resident #15 had not used the prn Trazodone over the last month, had no restlessness or agitation and may discontinue the prn Trazodone order. No further documentation was provided to the survey team by the exit conference on 7/17/24 at 2:00 P.M.