STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305087	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Community	93 Water Village Road Ossipee, NH 03864

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. 43408 Based on interview and record review, it was determined that the facility failed to ensure residents receiving antipsychotic medications had appropriately identified behaviors for the continued use of antipsychotic medications for 2 of 5 residents reviewed for unnecessary medications in a final survey sample of 20 residents. (Resident identifiers are #61 and #86). Findings include: Review on 9/12/24 of the facility's policy titled, Medication - Psychoactive, last revised 1/31/20, revealed: .1. The attending physician or consulting psychiatrist will do a comprehensive assessment of a resident according to OBRA requirements for dose reduction. Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless contraindicated, in an effort to discontinue these drugs. A progress note documenting the decision with supporting rationale shall be written by the physician. 2. 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 .6. The medication administration nurse/ LN [Licensed Nurse] will be responsible for documenting frequency of targeted behaviors and side effects of antipsychotic, hypnotic and anxiolytics medications, on the psychoactive flow record . Review on 9/12/24 of the facility's policy titled, Behavior Monitoring, initiated 8/8/18, revealed: .It is the policy to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental and psycho-social well being. Behaviors monitoring and documentation will be appropriate to allow the healthcare provider the ability to target acceptable behaviors and provide the necessary behavioral health care and services. Procedure: 1. Behavior Monitoring Flowsheets/notes are completed for all residents presenting behaviors. Documentation is to be completed by a Licensed Nurse. All other staff should report behaviors immediately to the Licensed Nurse . Resident #86 Review on 9/12/24 of Resident #86's physician orders revealed the following order: Seroquel Oral Tablet (Quetiapine Fumarate) Give 12.5 mg [milligram] by mouth at bedtime for psychosis, with a start date of 2/8/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review on 9/12/24 of Resident #86's medical record revealed there were no identified target behaviors or psychotic symptoms monitored to support the use of an antipsychotic medication. Resident #86 was not receiving psychiatric services. Resident #86 did not have a care plan for behavior monitoring or any non pharmological interventions. Interview on 9/12/24 at approximately 11:30 a.m. with Staff A (Nurse Practitioner) and Staff B (Director of Nursing) confirmed the above findings. Resident #61 Observation on 9/10/24 at approximately 9:30 a.m. of Resident #61 revealed them to be in bed with eyes closed, not responding to verbal stimuli and with bilateral hand contractures. Review on 9/10/24 of Resident #61's physician orders revealed an order for Abilify 2mg once a day for unspecified psychosis that was started on 12/6/21. Review on 9/11/24 of Resident #61's medical record revealed the last documented behavior was on 8/22/22. Further review of Resident #61's medical record revealed that there was no care plans for behavior monitoring or any non pharmological interventions. Review on 9/11/24 of Resident #61's Psychiatry notes for January and April 2024 revealed no active behaviors. Further review of Resident #61's psychiatry notes revealed a note dated 4/15/24 that stated Gradual Dose Reduction (GDR) clinically contraindicated for one year as decrease in these medications can worsen patient's clinical condition. Interview on 9/12/24 at approximately 9:00 a.m. with Staff C (Licensed Practical Nurse) revealed Resident #61 was on end of life care, was unable to stand and was dependant on staff for all activities of daily living. Staff C stated they were unaware of any current or recent behaviors for Resident #61. Interview on 9/12/24 at approximately 9:21 a.m. with Staff B confirmed the last known or documented behavior for Resident #61 was 8/22/22. 28881