STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asheboro Rehabilitation and Healthcare Center	400 Vision Drive Asheboro, NC 27203

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record reviews, observations and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of range of motion (Resident #21), medications and PASRR (Pre-Admission Screening and Resident Review- Resident #36). This was for 2 of 21 residents reviewed. The findings included: 1. Resident #21 was admitted to the facility on [DATE] with diagnoses that included right foot drop and diabetes type 2. An orthopedic progress note dated 6/26/24 indicated that Resident #21 had contractures present to the left and right lower extremity. A quarterly MDS assessment dated [DATE] indicated Resident #21 had intact cognition and was coded with limited range of motion to one side of the upper and lower extremity. An interview occurred with the MDS Nurse on 9/4/24 at 9:49 AM. She reviewed the MDS assessment dated [DATE] and indicated it was an oversight not to have coded Resident #21 with limited range of motion to both lower extremities. On 9/4/24 at 1:00 PM, an observation occurred with Resident #21 who was unable to move her right leg at all, the leg remained in a straight position. She had a contracture to the left leg which she was unable to straighten out and right foot drop was also present. On 9/6/24 at 9:14 AM, the Administrator was interviewed and stated it was his expectation for the MDS assessments to be coded accurately. 46725 2a. Resident #36 was admitted to the facility on [DATE] with diagnosis that included major depressive disorder and schizophrenia. Review of Resident #36's physician orders included an order initiated on 11/6/23 for an antipsychotic medication to be given two times daily. (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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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	A review of the July 2024 Medication Administration Record revealed Resident #36 was administered antipsychotic medication daily. An annual Minimum Date Set (MDS) assessment dated [DATE] indicated Resident #36's cognition was cognitively impaired. The medications section was coded that she did not receive antipsychotic medication during the 7 -day look back period. On 9/5/24 at 3:28 PM, an interview occurred with the MDS nurse. She explained she had completed the medication section of the MDS and did not code the antipsychotic medication usage section correctly and that it was an oversight. b. A review of the PASRR Level II determination notice dated 3/1/24 indicated Resident #36 was approved for a Level II PASRR. A review of the Resident 36's annual MDS assessment dated [DATE] indicated Resident #36 had a diagnosis of Schizophrenia but was not considered by the state level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability or a related condition On 9/5/24 at 12:30 PM, an interview occurred with the Social Worker, and she explained that the facility received notification of the change from a Level I to a Level II PASRR in March 2024 but did not code it correctly on the annual MDS. She further indicated that it was an oversight. An interview was completed on 9/6/24 at 9:23 AM with the Administrator and he indicated that the MDS assessments should accurately reflect the resident's status.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725 Based on record review and staff interviews the facility failed to revise a smoking care plan to reflect a resident's level of supervision needed for smoking for 1 of 3 residents (Resident #77) reviewed for smoking. The findings included: Resident #77 was originally admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction. Review of Resident #77's quarterly smoking assessment dated [DATE] revealed the resident was a safe smoker and did not require supervision. Review of Resident #77's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively impaired and required extensive assistance for most activities of daily living (ADL). Review of Resident #77's care plan revised on 7/5/24 revealed the resident required supervision when smoking. An interview with the MDS coordinator on 9/4/24 at 9:28 am revealed Residents #77's care plan should have reflected the resident being an independent smoker and edited when the smoking assessment was completed on 5/8/24. An interview conducted with the Administrator on 9/6/24 at 9:23 am revealed Resident #77's care plan should have been revised to reflect the resident was an independent smoker. The Administrator further revealed resident care plans reflect the residents care and concerns and were expected to be updated.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record review and staff interviews, the facility failed to transcribe the correct medication administration route for 1 of 1 resident reviewed for gastric feeding tube (Resident #45). The findings included: Resident #45 was admitted to the facility on [DATE] with diagnoses that included traumatic brain injury, history of a stroke, dysphagia (difficulty swallowing) and presence of a feeding tube. An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #45 had severe cognitive impairment and received all nutrition and fluids via a feeding tube. Review of the active care plan, last reviewed 7/16/24, revealed Resident #45 required tube feeding for all nutrition and fluids. The active September 2024 physician orders included an order dated 6/20/24 for Guaifenesin Liquid 100 milligrams per 5 milliliters. Give 20 milliliters by mouth three times a day for cough/congestion. All other medications were written to be provided through the gastric feeding tube. The physician orders indicated Resident #45 was to have nothing by mouth (NPO). On 9/5/24 at 10:18 AM, an interview was conducted with Nurse #1 who was working the medication cart for Resident #45's hall and had administered her medications earlier. The nurse confirmed Resident #45 did not receive any medications by mouth and she had not provided her morning dose of Guaifenesin by mouth. Nurse #1 acknowledged the Medication Administration Record (MAR) read for Guaifenesin to be provided by mouth, which was inaccurate as all medications were provided via the gastric feeding tube. The Assistant Director of Nursing (ADON) was interviewed on 9/5/24 at 2:14 PM. She reviewed Resident #45's physician orders and confirmed the route for Guaifenesin was entered as oral instead of via gastrostomy tube (G-tube/feeding tube). She further explained when entering the medication into the electronic medical system the default route was oral, and she felt it was an oversight that the nurse failed to change the route to G-tube. The ADON stated it was her expectation for all medication administration routes to be entered correctly when the order was received and verified. A phone interview occurred with Nurse #2 on 9/6/24 at 10:13 AM. She was the nurse that verified the Guaifenesin order for Resident #45 on 6/20/24. Nurse #2 explained that she verified the order after it had been entered by the Nurse Practitioner in the Electronic Medical System but failed to change the medication route to gastrostomy tube. She stated the default route was by mouth.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record review and interviews with staff, Pharmacy Consultant and Nurse Practitioner, the Pharmacy Consultant failed to identify the facility's need to identify target behavioral symptoms, to monitor those symptoms as well as the need to monitor residents for side effects of psychotropic medications (Residents #73, #82 and #68). This was for 3 of 5 residents reviewed for unnecessary medications. The findings included: 1. Resident #73 was originally admitted to the facility on [DATE] with a recent readmitted [DATE]. Her diagnoses included bipolar disorder, depression, anxiety disorder and unspecified psychotic disorder. A review of Resident #73's medical record revealed the following hospitalization for mental health concerns: 2/10/24 through 2/12/24 was seen for suicidal ideations. 3/27/24 through 4/23/24 was seen for bipolar disorder severe with psychotic features. A review of Resident #73's physician orders included an order dated 4/25/24 for Fluphenazine (an antipsychotic medication) 5 milligrams (mg) one tablet by mouth twice a day. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #73 was cognitively intact and displayed no behavior issues. Her mood was coded with feeling down, depressed or hopeless 7 out of 10 days during the 14-day look back period. Resident #73 received an antipsychotic medication. Review of the Pharmacy Consultant medication review notes for Resident #73 from 6/25/24, 7/12/24 and 8/15/24, did not reflect the need for monitoring targeted behaviors and side effects for the use of an antipsychotic medication. A psychiatric progress note dated 8/6/24 indicated Resident #73 endorsed having more episodes of depression, irritability and anxiety. A review of Resident #73's nursing progress notes from 2/1/24 to 9/3/24 included behaviors such as crying, suicidal thoughts, agitation, and restlessness. Resident #73's Medication Administration Records (MAR) from 6/1/24 to 9/3/24 indicated she received Fluphenazine as ordered. The MAR did not list any targeted behaviors or side effects for staff to monitor. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Nurse Practitioner #1 occurred on 9/4/24 at 2:09 PM and stated she would have expected the Pharmacy Consultant to have caught the missing target behaviors and side effect monitoring for Resident #73's antipsychotic medication. A telephone interview was conducted with the Pharmacy Consultant on 9/5/24 at 3:20 PM. She stated she didn't normally review the MARs but reviewed the physician and psychiatric progress notes as well as the nursing notes each month during her medication review. The Pharmacy Consultant stated she understood why target behaviors and side effect monitoring was important in a resident with a history of suicidal thoughts. The Pharmacy Consultant was unable to explain why she did not recommend the need to identify target behaviors and side effect monitoring for Resident #73 in her recommendations. 31227 2. Resident # 82 was admitted on [DATE] with cumulative diagnoses of depression anxiety, dementia with behavioral disturbances, unspecified psychosis and affective mood disorder. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #82 had moderate cognitive impairment, exhibited no behaviors and was coded for the use of an antipsychotic and an antidepressant. Review of Resident #82 September 2024 Physician orders included the following order dated 4/23/24: Seroquel (antipsychotic) Extended Release 24 hour 50 milligrams give one tablet by mouth in the afternoon for dementia with mood/psychotic disturbances. Another order dated 8/1/24 read Sertraline (antidepressant) 50 milligrams give one tablet by mouth at bedtime for dementia with behaviors, depression and anxiety. Review of the medication administration records (MARs) from November 1, 2023 to September 2024 included an order that was not included on the monthly Physician orders that read: Is resident free from side effects of psychotherapeutic medications? (if no, document side effects in progress note every shift-Order Date 11/10/2023. There was no documented evidence of targeted clinical behavior identification and no clarification of what side effects the staff were to monitor with regard to the antipsychotic versus the antidepressant. A review of a Pharmacist Medication Regime Review dated 11/20/23 read there were no irregularities and no recommendations. This review was completed by the previous Consultant Pharmacist. A review of Pharmacist Medication Regime Review dated 12/15/23 read to see the monthly report for any noted irregularities. This review was completed by the previous Consultant Pharmacist. The monthly pharmacy reports were requested from the Assistant Director of Nursing (ADON) on 9/4/24 but there was nothing listed on the December pharmacy report and the ADON was not able to locate any pharmacy recommendations dated 12/15/23. A review of a Pharmacist Medication Regime review dated 1/19/24 read there were no irregularities and no recommendations. This review was completed by the previous Consultant Pharmacist. A review of a Pharmacist Medication Regime review dated 2/23/24 read there were no irregularities and no recommendations. This review was completed by the current Consultant Pharmacist. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a Pharmacist Medication Regime review dated 3/15/24 read there were no irregularities and no recommendations. This review was completed by the current Consultant Pharmacist. A review of a Pharmacist Medication Regime review dated 4/24/24 read there were recommendations and to see the monthly report. This review was completed by the current Consultant Pharmacist. Review of the monthly pharmacy report read her recommendation was to add a stop date of 5/20/24 to the use of Resident #82's as needed (prn) antipsychotic because they must be limited to 14 days and reevaluated. A review of a Pharmacist Medication Regime review dated 5/29/24 read there were no irregularities and no recommendations. This review was completed by the current Consultant Pharmacist. A review of a Pharmacist Medication Regime review dated 6/28/24 read there were no irregularities and no recommendations. This review was completed by the current Consultant Pharmacist. A review of a Pharmacist Medication Regime review dated 7/13/24 read there were recommendations and to see the monthly report. Review of the monthly pharmacy report read her recommendation was to attempted a gradual dose reduction on Resident #82's antidepressant. This review was completed by the current Consultant Pharmacist. A review of a Pharmacist Medication Regime review dated 8/16/24 read there were no irregularities and no recommendations. This review was completed by the current Consultant Pharmacist. An interview was completed with Resident #82 on 9/3/24. She was sitting up in her reclining chair dressed for the day. She was very pleasant and engaging in a conversation regarding her jewelry. There were no observed extrapyramidal symptoms such as movement dysfunction, rigidity, jerking or tremors associated with prolonged use of an antipsychotic medications and no drowsiness, dizziness, insomnia or headaches symptoms associated with antidepressants. An interview was completed on 9/4/24 at 1:54 PM with the ADON who was acting as the Director of Nursing (DON) while she was away. She stated the Consultant Pharmacist reviewed Resident #82's medications for irregularities, accuracy and completeness every month and there was no documentation from the Consultant Pharmacist stating the need to identify her target clinical behaviors or specific side effect monitoring for different psychotropic medications. The ADON stated either the DON or herself reviewed the monthly pharmacy reports and recommendations for all the residents and there was nothing in the monthly reports going back to November 2023 that mentioned anything about the missing monitoring needed on Resident #82. An interview was completed on 9/4/24 at 2:09 PM with NP #1. She stated she would have expected the Consultant Pharmacist to have caught the missing monitoring and since it had been happening since November 2023, she was concerned for all the residents prescribed psychotropic medications. NP #1 stated when residents in their 90's are prescribed antipsychotics and other psychotropics, they require close monitoring for target clinical behaviors to determine if the identified behaviors improved or not and to see if the resident remains free from adverse side effects. An interview was completed on 9/5/24 at10:30 AM with Nursing Assistant (NA) #1. She stated she had worked with Resident #82 a long time and she was never known her to exhibit any sort of negative behaviors. NA #1 stated Resident #82 was always cooperative and pleasant with her. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was completed on 9/5/24 at 10:40 AM with Nurse #3. She stated at one time sometime after her admission, it was suspected she was sundowning(late-day confusion) but Resident #82's behaviors have been under control for months. A telephone interview was attempted with the previous Consultant Pharmacist but at the time of exit, she had not returned surveyor's calls. A telephone interview was completed on 9/5/24 at 3:20 PM with the Consultant Pharmacist. She stated when she completes her monthly medication review, she does not normally review the MARs to see if there have been any behaviors but rather she reviews Physician, NP, nursing and Psychiatric notes. She stated after reviewing Resident #82's MARs and only seeing a box to check for behaviors and no side effect monitoring at all, she understood what the missing monitoring was and why target clinical behaviors were important to identify to determine worsening or improvement. She stated both antidepressants and antipsychotics have different side effects and both should be clear on what potential adverse side effects to monitor. She stated she started in February 2024 and that she should have identified this irregularity and acted on it before the now. An interview was completed on 9/5/24 at 3:50 PM with the Administrator. He stated the Consultant Pharmacist had been reviewing Resident #82's medications monthly for irregularities since November 2023 and it was hard to imagine that the previous Consultant Pharmacist and the current Consultant Pharmacist did not identify the missing monitoring needed for the use of psychotropic medications. He stated he expected better from the Consulting Pharmacist. 46725 3. Resident #68 was originally admitted to the facility on [DATE] with diagnoses that included generalized anxiety disorder, major depressive disorder, delusional disorders, Alzheimer's disease with late onset, and unspecified psychosis. A review of Resident #68's physician orders included an order dated 6/27/24 for Olanzapine (an antipsychotic medication) 10 milligrams (mg) half a tablet by mouth twice a day and a physician order dated 6/26/24 for Sertraline (an antidepressant medication) 25 milligrams (mg) one tablet by mouth twice a day. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #68 was cognitively impaired and displayed behaviors of physical, verbal abuse, and wandering. Her mood was coded with feeling down, depressed or hopeless 7 out of 11 days during the 14-day look back period. Resident #68 received antipsychotic and antidepressant medication. Review of the Pharmacy Consultant medication review notes for Resident #68 from 6/1/24 to 9/3/24 did not reflect the need for monitoring targeted behaviors and side effects for the use of an antipsychotic medication. A review of Resident #68's social service progress note dated 7/24/24 indicated Resident #68 has had an increase in behaviors which included yelling, agitation, aggression with family members and delusions. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #68's Medication Administration Records (MAR) from 6/1/24 to 9/3/24 indicated she received Olanzapine and Sertraline as ordered. The MAR did not list any targeted behaviors or side effects for staff to monitor. An interview with Nurse Practitioner #1 occurred on 9/4/24 at 2:09 PM and stated she would have expected the Pharmacy Consultant to have caught the missing target behaviors and side effect monitoring for Resident #68's psychotropic medication. A telephone interview was conducted with the Pharmacy Consultant on 9/5/24 at 3:20 PM. She stated she didn't normally review the MARs but reviewed the physician and psychiatric progress notes as well as the nursing notes each month during her medication review. The Pharmacy Consultant stated she understood why target behaviors and side effect monitoring was important in a resident with a history of mood and behaviors. The Pharmacy Consultant was unable to explain why she did not recommend the need to identify target behaviors and side effect monitoring for Resident #68 in her recommendations.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31227 Based on record review, staff, Administrator, resident, Nurse Practitioner (NP) #1 and Consultant Pharmacist interviews, the facility failed to identify the targeted clinical behaviors and side effects to be monitored for the use of psychotropic medications for Resident's #82, #73 and #68. The facility also failed to complete a baseline abnormal involuntary movement scale (AIMS) with the initiation of a newly prescribed antipsychotic for Resident #145. This was for 4 of 5 residents reviewed for unnecessary medications. The findings included: 1. Resident # 82 was admitted on [DATE] with cumulative diagnoses of depression anxiety, dementia with behavioral disturbances, unspecified psychosis and affective mood disorder. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #82 had moderate cognitive impairment, exhibited no behaviors and was coded for the use of an antipsychotic and an antidepressant. Review of Resident #82's comprehensive care included a care area initiated on 10/30/23 and revised on 2/26/24 that read Resident #82 exhibited or was at risk for distressed, fluctuating mood symptoms related to depression, anxiety and affective disorder. She was also care planned initially on 10/30/23 and revised on 2/26/24 for complications related to the use of psychotropic drugs (antidepressant/antipsychotic). Interventions included AIMS testing per protocol, complete behavior monitoring, gradual dose reductions as needed, monitor for changes in mental status and functional level and report to the Physician as indicated, monitor for the continued need of the medication as related to her behaviors and mood and lastly to monitor for side effects and consult the Physician and/or Pharmacist as needed. Review of Resident #82's Physician orders included the following order dated 4/23/24: Seroquel (antipsychotic) Extended Release 24 hour 50 milligrams give one tablet by mouth in the afternoon for dementia with mood/psychotic disturbances. Another order dated 8/1/24 read Sertraline (antidepressant) 50 milligrams give one tablet by mouth at bedtime for dementia with behaviors, depression and anxiety. Review of the medication administration records (MARs) from November 1, 2023 to September 2024 included an order that was not included on the monthly Physician orders that read: Is resident free from side effects of psychotherapeutic medications? (if no, document side effects in progress note every shift-Order Date 11/10/2023. There was no documented evidence of targeted clinical behavior identification and no clarification of what side effects the staff were to monitor with regard to the antipsychotic versus the antidepressant. Review of Resident #82's nursing notes from November 1, 2023, to September 5. 2024 only include 3 nursing notes regarding behaviors, 2 of which were related to new onset of urinary tract infections (UTI's). She was prescribed a prophylactic antibiotic by urology for recurrent UTI's on 2/8/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was completed with Resident #82 on 9/3/24. She was sitting up in her reclining chair dressed for the day. She was very pleasant and engaging in a conversation regarding her jewelry. There were no observed extrapyramidal symptoms such as movement dysfunction, rigidity, jerking or tremors associated with prolonged use of an antipsychotic medications and no drowsiness, dizziness, insomnia or headaches symptoms associated with antidepressants. An interview was completed on 9/4/24 at 1:54 PM with the Assistant Director of Nursing (ADON) who was acting as the Director of Nursing (DON) while she was away. The ADON stated she was aware of the need to identify and monitor target clinical behaviors when a psychotropic medication was added and also needed to monitor specific side effects for psychotropic medications. The ADON stated whoever entered the original order in November 2023, they did not check off specific behaviors for the antipsychotic or the antidepressant from an already computerized list and the same went for the side effect monitoring. When the order was entered, the person should have checked side effects to be monitored with the antipsychotic and the antidepressant. She stated she would start looking at the residents on psychotropic medications today. An interview was completed on 9/4/24 at 2:09 PM with NP #1. She stated she would have expected the facility to have caught the error that had been happening since November 2023 and there was no excuse because when residents in their 90's are prescribed antipsychotics and other psychotropics, they require close monitoring for behaviors to determine if the identified behaviors improved or didn't and to see if the resident remains free for adverse side effects. An interview was completed on 9/5/24 at10:30 AM with Nursing Assistant (NA) #1. She stated she had worked with Resident #82 a long time and she was never known her to exhibit any sort of negative behaviors. NA #1 stated Resident #82 was always cooperative and pleasant with her. An interview was completed on 9/5/24 at 10:40 AM with Nurse #3. She stated at one time sometime after her admission, it was suspected she was sundowning(late-day confusion) but Resident #82's behaviors have been under control for months. An interview was completed on 9/5/24 at 3:50 PM with the Administrator. He stated all residents prescribed an antipsychotic or any other kind of psychotropic medication require a diagnosis and identification of the target clinical behaviors for which the psychotropic was prescribed. The Administrator stated monitoring the side effects of antipsychotics was necessary due to the adverse side effects that can occur with use of antipsychotics over time. The Administrator further stated monitoring for side effects with all other psychotropic medications was imperative as well especially in the elderly population. 2. Resident #145 was admitted on [DATE] with diagnoses of vascular dementia, major depressive disorder and a cerebral vascular accident (CVA). His admission Minimum Data Set (MDS) dated [DATE] indicated Resident #145 had severe cognitive impairment and exhibited no behaviors. He was coded for the use of an antidepressant. Resident #145 was care planned on 8/22/24 and revised on 8/29/24 for exhibiting or had the potential to demonstrate verbal/physical behaviors related to: cognitive loss/dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asheboro Rehabilitation and Healthcare Center	400 Vision Drive Asheboro, NC 27203

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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 - Some	Review of a NP #1 note dated 8/28/24 read staff report Resident #145 was having increased behaviors and agitation. Review of a Physician order dated 8/28/24 read Seroquel (antipsychotic) 25 milligrams give 1 tablet every 6 hours as needed (prn) for agitation, dementia with behaviors and anxiety x 14 days end date 9/11/24. Review of Resident #145's August 2024 medication administration record (MAR) and September 2024 MAR indicated he received the as needed Seroquel on 8/30/24, 9/2/24, 9/3/24 and 9/4/24. Review of Resident #145's medical record did not include a baseline abnormal involuntary movement scale (AIMS) assessment. The AIMS is an assessment done to determine a baseline and periodically assess for involuntary movement that go along with the use of antipsychotic medications. An interview was completed on 9/4/24 at 1:54 PM with the Assistant Director of Nursing (ADON) who was acting as the Director of Nursing (DON) while she was away. The ADON stated she was under the impression that she had 14 days to complete the AIMS assessment since Resident #145 was a new admission. She then stated she would check to make sure and return with an answer. An interview was completed on 9/4/24 at 2:09 PM with NP #1. She stated she would have expected the facility would completed a baseline AIMS for the use of a prn antipsychotic medication because she was familiar with instances where after the 14 days of using the antipsychotic as needed, the provider often removed the as needed part of the order and prescribed it every day. She stated when that happens, since there was no baseline AIMS completed, there is no reference point to determine if the medication was causing adverse side effects over time. On 9/4/24 at 2:43 PM, the ADON provided a copy of an AIMS she had completed on 9/4/24 with her electronic signature but was back dated to 8/28/24. When asked why she back dated the AIMS to 8/28/24, she stated she still signed off on it 9/4/24. An interview was completed on 9/5/24 at 3:50 PM with the Administrator. He stated an AIMS assessment was to be completed at the time a resident was started on an antipsychotic medication in order to establish a baseline for that resident. 40197 3. Resident #73 was originally admitted to the facility on [DATE] with a recent readmitted [DATE]. Her diagnoses included bipolar disorder, depression, anxiety disorder and unspecified psychotic disorder. A review of Resident #73's medical record revealed the following hospitalization for mental health concerns: 2/10/24 through 2/12/24 was seen for suicidal ideations. 3/27/24 through 4/23/24 was seen for bipolar disorder severe with psychotic features. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #73's physician orders included an order dated 4/25/24 for Fluphenazine (an antipsychotic medication) 5 milligrams (mg) one tablet by mouth twice a day. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #73 was cognitively intact and displayed no behavior issues. Her mood was coded with feeling down, depressed or hopeless 7 out of 10 days during the 14-day look back period. Resident #73 received an antipsychotic medication. A psychiatric progress note dated 8/6/24 indicated Resident #73 endorsed having more episodes of depression, irritability and anxiety. A review of Resident #73's active care plan, last reviewed 8/8/24, included the following focus areas: Resident exhibits or has the potential to demonstrate verbal behaviors related to ineffective coping skills, poor anger management, poor impulse control and bipolar with mania. The interventions included to monitor medications for side effects and response contributing to verbal behaviors. Resident is resistive to care related to mood/psychiatric disorder. Will remove shoes and socks and self-ambulates in room and hall, resistive to insulin and personal care. Resident exhibits or is at risk for distressed/fluctuating mood symptoms related to bipolar disorder, anxiety, agitation and depression. The interventions included to observe for signs/symptoms of worsening sadness/depression/anxiety/fear/anger/agitation. Resident is at risk for complications related to use of psychotropic drugs. The interventions included to complete behavior monitoring, monitor for side effects and consult physician and/or pharmacist as needed and monitor for changes in mental status and functional level and report to physician as indicated. A review of Resident #73's nursing progress notes from 2/1/24 to 9/3/24 included behaviors such as crying, suicidal thoughts, agitation, and restlessness. Resident #73's Medication Administration Records (MAR) from 6/1/24 to 9/3/24 indicated she received Fluphenazine as ordered. The MAR did not list any specific behaviors or side effects for staff to monitor. On 9/4/24 at 1:54 PM, an interview occurred with the Assistant Director of Nursing (ADON), who stated there were options in the Electronic Medical Record to enter the monitoring of behaviors and side effects on the MAR for psychotropic medications and felt it was an oversight that this had not been initiated for Resident #73's antipsychotic medication. An interview with Nurse Practitioner #1 occurred on 9/4/24 at 2:09 PM and stated she would have expected the facility to monitor specific behaviors and side effects for Resident #73's antipsychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #1 was interviewed on 9/5/24 at 2:24 PM and was familiar with Resident #73. She stated Resident #73 has a history of suicidal thoughts, but her current behaviors were more anxious behavior and crying. She stated there were no specific behavior or side effect monitoring for the use of the antipsychotic medication, but nursing staff would document a progress note if any were observed and report to the physician/Nurse Practitioner. 46725 4. Resident #68 was originally admitted to the facility on [DATE] with diagnoses that included generalized anxiety disorder, major depressive disorder, delusional disorders, Alzheimer's disease with late onset, and unspecified psychosis. A review of Resident #68's physician orders included an order dated 6/27/24 for Olanzapine (an antipsychotic medication) 10 milligrams (mg) half a tablet by mouth twice a day and a physician order dated 6/26/24 for Sertraline (an antidepressant medication) 25 milligrams (mg) one tablet by mouth twice a day. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #68 was cognitively impaired and displayed behaviors of physical, verbal abuse, and wandering. Her mood was coded with feeling down, depressed or hopeless 7 out of 11 days during the 14-day look back period. Resident #68 received antipsychotic and antidepressant medication. Review of Resident #68's comprehensive care included a care area initiated on 12/31/21 and revised on 1/30/24 that read Resident #68 exhibited or was at risk for distressed, fluctuating mood symptoms related to depression, anxiety and affective disorder. She was also care planned initially on 12/31/21 and revised on 2/21/24 for complications related to the use of psychotropic drugs (antidepressant/antipsychotic). Interventions included abnormal involuntary movement scale (AIMS)testing per protocol, complete behavior monitoring, gradual dose reductions as needed, monitor for changes in mental status and functional level and report to the Physician as indicated, monitor for the continued need of the medication as related to her behaviors and mood and lastly to monitor for side effects and consult the Physician and/or Pharmacist as needed. Review of the Pharmacy Consultant medication review notes for Resident #68 from 6/1/24 to 9/3/24 did not reflect the need for monitoring targeted behaviors and side effects for the use of an antipsychotic medication. A review of Resident #68's social service progress note dated 7/24/24 indicated Resident #68 has had an increase in behaviors which included yelling, agitation, aggression with family members and delusions. Resident #68's Medication Administration Records (MAR) from 6/1/24 to 9/3/24 indicated she received Olanzapine and Sertraline as ordered. The MAR did not list any targeted behaviors or side effects for staff to monitor. An interview with Nurse Practitioner #1 occurred on 9/4/24 at 2:09 PM and stated she would have expected the facility to monitor specific behaviors and side effects for Resident #68's antipsychotic and antidepressant medications.