STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kerr Lake Nursing and Rehabilitation Center	1245 Park Avenue Henderson, NC 27536

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 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** 41772 Based on record review, staff interview and Consultant Pharmacist interview, the Consultant Pharmacist failed to identify and report a medication irregularity on 7 Monthly Medication Reviews when Dyskinesia Identification System Condensed User Scale (DISCUS) assessments (used for medication monitoring of side effects of antipsychotic medication) were not completed for a resident who received Risperdal, Haloperidol and Olanzapine (antipsychotic medications). The Consultant Pharmacist also failed to identify and address an order for as needed (PRN) Haloperidol that extended beyond the 14-day limit for 1 of 6 residents reviewed for unnecessary medications. (Resident #57) The findings included: 1. Resident #57 was admitted on [DATE] with diagnoses that included vascular dementia with agitation, generalized anxiety disorder, and manic episode. a. Review of the medical record revealed a DISCUS assessment was conducted on 1/25/24 when Resident #57 was admitted . A physician's order dated 3/7/24 indicated Risperdal (an antipsychotic medication) 0.5 milligrams (mg) one tablet twice daily for anxiety/dementia with behavioral disturbance. Risperdal was discontinued on 3/24/24. A physician's order dated 3/18/24 indicated Olanzapine (an antipsychotic medication) 5 mg by mouth one time only for agitation for 1 Day. A physician's order dated 3/19/24 indicated Haloperidol (an antipsychotic medication) 0.5 mg one time only for agitation. A physician's order dated 3/19/24 indicated Olanzapine 5 mg at bedtime for agitation related to vascular dementia and manic episode. The Olanzapine 5 mg order remains active. A physician's order dated 3/20/24 indicated Haloperidol 0.5 mg every eight hours as needed for anxiety and dementia with other behavioral disturbances. The Haloperidol order was discontinued on 4/3/24. Review of the Medication Administration Record (MAR) revealed Resident #57 received Haloperidol on 3/28/24 and 3/29/24. (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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician ' s order dated 4/3/24 indicated Haloperidol 0.5 mg every eight hours as needed for anxiety and dementia with other behavioral disturbances. The Haloperidol order was discontinued on 6/3/24. Review of the Medication Administration Record (MAR) revealed Resident #57 received Haloperidol on 4/7/24 and 5/12/24. Review of the Monthly Medication Regimen (MRR) for Resident #57 completed on 4/4/24 revealed no recommendations for completion of a DISCUS assessment. Review of the Monthly Medication Regimen (MRR) for Resident #57 completed on 5/3/24 revealed no recommendations for completion of a DISCUS assessment. A physician's order dated 6/7/24 and revised 6/8/24 indicated Olanzapine 2.5 mg every Tuesday, Thursday, and Saturday for anxiety, agitation. Administer at 11:00 AM prior to dialysis every Tuesday, Thursday, and Saturday. Review of the Monthly Medication Regimen (MRR) for Resident #57 completed on 6/10/24 revealed no recommendations for completion of a DISCUS assessment. Review of the Monthly Medication Regimen (MRR) for Resident #57 completed on 7/8/24 revealed no recommendations for completion of a DISCUS assessment. Review of the Monthly Medication Regimen (MRR) for Resident #57 completed on 8/2/24 revealed no recommendations for completion of a DISCUS assessment. Review of the Monthly Medication Regimen (MRR) for Resident #57 completed on 9/11/24 revealed no recommendations for completion of a DISCUS assessment. Review of the Monthly Medication Regimen (MRR) for Resident #57 completed on 10/4/24 revealed no recommendations for completion of a DISCUS assessment. Review of the most recent Significant Change Minimum Data Set (MDS) dated [DATE] revealed Resident #57 had severe cognitive impairment and was administered antipsychotic medications during the assessment lookback period. Further review of Resident #57's medical record revealed no other discus assessments were completed since admission. A telephone interview was conducted on 11/06/24 at 11:10 AM with the Consultant Pharmacist who revealed the facility was required to complete a DISCUS assessment on all residents that were prescribed an antipsychotic medication upon initiation of the medication and periodically if the medication changes. The Consultant Pharmacist stated the DISCUS assessment was used to monitor residents on antipsychotic medications for abnormal involuntary movements associated with the long-term use of antipsychotic agents. The Consultant Pharmacist stated Resident #57 had been overlooked and confirmed that she would have recommended that Resident #57 had another DISCUS assessment completed. (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 conducted with the Director of Nursing (DON) on 11/06/24 at 03:12 PM. She stated the DISCUS assessment was to be conducted upon admission, every six months and when there was a change in the medication to monitor for abnormal involuntary movement disorders. The DON stated she expected the pharmacist to identify irregularities of antipsychotic medications by ensuring DISCUS assessments were completed for residents on antipsychotic medications. During an interview on 11/06/24 at 03:17 PM, the Administrator stated she expected the Consultant Pharmacist to review residents on antipsychotic medications during the Monthly Medication Regimen (MRR) for medication side effects and make recommendations for the completion of the DISCUS assessment to identify abnormal involuntary movements. b. A physician's order dated 4/3/24 indicated Haloperidol 0.5 mg every eight hours as needed for anxiety and dementia with other behavioral disturbances. The Haloperidol order was discontinued on 6/3/24. Review of the Medication Administration Record (MAR) revealed Resident #57 received PRN Haloperidol on 4/7/24 and 5/12/24. Pharmacy consultant monthly medication regimen reviews dated 4/4/24 and 5/3/24. revealed no recommendations related to the duration of Resident #57's PRN Haloperidol prescribed on 4/3/24 with a 6/7/24 stop date. A phone interview was conducted with the Medical Director on 11/6/24 at 8:36 AM. She stated orders for PRN antipsychotic medication should have a 14 day stop date. The Medical Director stated the order should be reevaluated after 14 days to see if the medication was still needed. The Medical Director further stated if the medication was still needed a new order had to be written. A telephone interview was conducted on 11/06/24 at 11:10 AM with the Consultant Pharmacist. She stated PRN antipsychotic medications are required to be reevaluated every 14 days. The pharmacist stated if the provider wished to continue the antipsychotic medication a new order had to be written. Review of Resident's #57's medical record with the Consultant Pharmacist confirmed there was no reevaluation of Resident #56 and that the 4/3/24 Haloperidol order extended past the 14-day duration. An interview was conducted with the Director of Nursing (DON) on 11/06/24 at 03:12 PM. The DON stated she expected the pharmacist to review PRN antipsychotic medications for stop dates or rationales for continued use.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41772 Based on record review, staff interview, Consultant Pharmacist interview and Medical Director interview, the facility failed to complete a Dyskinesia Identification System Condensed User Scale (DISCUS) assessment (used for monitoring side effects of antipsychotic medication) for a resident who received multiple antipsychotic medications (Resident #57), ensure an as needed (PRN) antipsychotic order was limited to a 14-day duration (Resident #57), and ensure orders for PRN antianxiety medication were time limited in duration (Resident #23) for 2 of 6 residents reviewed for unnecessary medications. The findings included: 1. Resident #57 was admitted on [DATE] with diagnoses that included vascular dementia with agitation, generalized anxiety disorder, and manic episode. 1a. Review of the medical record revealed a DISCUS assessment was conducted on 1/25/24 when Resident #57 was admitted . A physician's order dated 3/7/24 indicated Risperdal (an antipsychotic medication) 0.5 milligrams (mg) one tablet twice daily for anxiety/dementia with behavioral disturbance. A physician's order dated 3/18/24 indicated Zyprexa (an antipsychotic medication) 5mg by mouth one time only for agitation for 1 Day. A physician's order dated 3/19/24 indicated Haloperidol (an antipsychotic medication) 0.5 mg one time only for agitation. A physician's order dated 3/19/24 indicated Zyprexa 5mg at bedtime for agitation related to vascular dementia and manic episode. A physician's order dated 3/20/24 indicated Haloperidol 0.5 mg every eight hours as needed for anxiety and dementia with other behavioral disturbances. A physician's order dated 4/3/24 indicated Haloperidol 0.5 mg every eight hours as needed for anxiety and dementia with other behavioral disturbances. A physician's order dated 6/7/24 and revised 6/8/24 indicated Zyprexa 2.5 MG every Tuesday, Thursday, and Saturday for anxiety, agitation. Administer at 11:00 AM prior to dialysis every Tuesday, Thursday, and Saturday. Review of Resident # 57's electronic medical record from 3/7/24 to 11/5/24 revealed no documentation regarding the completion of a DISCUS assessment. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Significant Change Minimum Data Set (MDS) dated [DATE] revealed Resident #57 had severe cognitive impairment and no behaviors during the lookback period. Resident #57 was further coded as change in behavior improved. Resident #57 was coded as received antipsychotic medications during the assessment lookback period. Review of the care plan last reviewed on 5/16/2024 revealed Resident #57 used psychotropic medications with the potential or characterized by side effects of cardiac, neuromuscular, gastrointestinal systems as evidenced by or/due to diagnosis of antipsychotic use anxiety, depression, psychophysiological insomnia, manic episode, vascular dementia with mood disorder and agitation. The goal was for Resident #57 to receive the lowest therapeutic dose through the next review. The interventions included administer medications per physician's orders, monitor resident's mood/behaviors with documentation per facility policy and notify physician of any significant changes. A telephone interview was conducted on 11/06/24 at 11:10 AM with the Consultant Pharmacist who revealed the facility was required to complete a DISCUS assessment on all residents that were prescribed an antipsychotic medication upon initiation of the medication and periodically if the medication changes. The Consultant Pharmacist stated Resident #57 had been overlooked and confirmed that she would have recommended that Resident #57 had another DISCUS assessment completed. An interview was conducted with the Director of Nursing (DON) on 11/06/24 at 03:12 PM. The DON stated the admission nurse was responsible for initiating the admission DISCUS. She further stated the DISCUS assessment was to be conducted upon admission, every six months and then there was a change in the medication. During an interview on 11/06/24 at 03:17 PM the Administrator stated the DISCUS assessment was missed due to a breakdown in their process and communication. She further stated expected the DISCUS assessment would be completed per the schedule. 1b. A physician's order dated 4/3/24 indicated Haloperidol 0.5 mg every eight hours as needed for anxiety and dementia with other behavioral disturbances. The Haloperidol order was discontinued on 6/3/24. Review of the Medication Administration Record (MAR) revealed Resident #57 received PRN Haloperidol on 4/7/24 and 5/12/24. A phone interview was conducted with the Medical Director on 11/6/24 at 8:36 AM. She stated orders for PRN antipsychotic medication should have a 14 day stop date. The Medical Director stated the order should be reevaluated after 14 days to see if the medication was still needed. The Medical Director further stated if the medication was still needed a new order had to be written. A telephone interview was conducted on 11/06/24 at 11:10 AM with the Consultant Pharmacist. She stated PRN antipsychotic medications are required to be reevaluated every 14 days. The pharmacist stated if the provider wished to continue the antipsychotic medication a new order had to be written. Review of Resident's #57's medical record with the Consultant Pharmacist confirmed there was no reevaluation of Resident #56 and that the 4/3/24 Haloperidol order extended past the 14-day duration. An interview was conducted with the Director of Nursing (DON) on 11/06/24 at 03:12 PM. The DON stated she expected the pharmacist to review PRN antipsychotic medications for stop dates or rationales for continued use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45044 2. Resident #23 was admitted to the facility on [DATE] with diagnoses that included anxiety. A Physician order dated 8/22/24 indicated Xanax 0.25 milligrams (mg) 1 tablet by mouth every 8 hours as needed (PRN) for anxiety was ordered without a stop date. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired. The MDS revealed the resident was coded for taking an antianxiety medication. An interview was conducted on 11/6/24 at 11:00 AM with the Director of Nursing (DON). She indicated she was aware all PRN psychotropic medications required an initial 14 day stop date, and the Physician then reevaluated the resident at the end of the medication regimen for continued use. A telephone interview was completed on 11/6/24 at 11:10 AM with the Pharmacy Consultant. She indicated PRN psychotropic medications required an initial 14 day stop date. The Pharmacy Consultant continued to state the Physician then reevaluated the Resident for continued use of the medication and documented the rationale for extending the medication. A telephone interview was completed on 11/6/24 at 11:56 AM with Physician #2. He revealed all PRN psychotropic medications that were ordered should have included a 14 day stop date. The Physician stated he then revaluated the resident and extended the medication for a time frame he felt was appropriate. Physician #2 stated he was unable to state why the medication order did not include a stop date. An interview was completed on 11/6/24 at 1:45 PM with the Administrator. She stated it was her expectation all PRN psychotropic medications have a stop date included in the order.