STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366471	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Broadview Heights	1201 Akins Road Broadview Heights, OH 44147

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, observation and interview, the facility failed to ensure Resident #19's choices were honored with rising out of bed in the morning. This affected one (Resident #19) out of two residents reviewed for choices concerning care. The facility census was 67. Findings include: Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses including cerebral infarction (stroke) and difficulty walking. Review of the care plan dated 07/09/24 for Resident #19 revealed he had self-care performance deficit with activities of daily living related to impaired mobility and muscle weakness. Interventions stated Resident #19 required one staff member to dress and assist with personal hygiene. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #19 had intact cognition, staff were able to understand him, he required partial to moderate assistance from staff for toileting, showers and dressing. Resident #19 also needed substantial to maximum assist from staff for transferring in and out of bed. Interview on 10/04/24 at 9:56 A.M. with Resident #19 revealed he was still in bed waiting for staff to assist him with care. He stated it took staff a long time to come assist him with getting out of bed for the day. Resident #19 placed his call light on at 10:02 A.M. while the surveyor was in the room for staff to come assist him out of bed for the day. Observation on 10/04/24 from 10:02 A.M. through 10:09 A.M. revealed Resident #19's call light to be on. Registered Nurse (RN) #384 went to Resident #19's room at 10:09 A.M., spoke to the resident, and then returned to the nursing station. On 11/04/24 at 10:37 A.M. Resident #19 was observed to still be in bed. Interview on 11/04/24 at 10:39 A.M. with RN #384 revealed she went to Resident #19's room and answered the call light at 10:09 A.M. She stated he wished to get out of bed for the day and needed assistance. She stated his aide was busy assisting other residents on the unit and would go when she had time. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/04/24 at 10:40 A.M. with Licensed Practical Nurse (LPN) #301 revealed she was the aide taking care of Resident #19. She stated the aide had called off for the day so she was working the floor in her place. She stated she was unaware that Resident #19 had wanted out of bed as he did not have his call light on and she was not updated by another staff member that he had called wanting out of bed. Review of the facility policy titled, Activities of Daily Living, dated March 2023, revealed that the facility would provide necessary care and services based on the resident's assessment and choices. This deficiency represents non-compliance investigated under Complaint Number OH00159219.

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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** 43063 Based on record review, observation and interview, the facility failed to ensure standard nursing practices were followed for safe meidcation administration. This affected two (Residents #8 and #44) of six residents observed for medication administration. The facility census was 67. Findings include: 1. Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including multiple sclerosis. Review of the Medication Administration Record (MAR) for Resident #8 revealed she received Calcium with Vitamin D 600 milligrams, Cranberry 500 milligrams, Lexapro 10 milligrams (anti-depressant) and Lubiprostone 8 micrograms (medication for constipation) in the morning of 11/06/24. Review of the Medication Administration Audit Report dated 11/06/24 revealed Licensed Practical Nurse (LPN) #383 documented that she had administered Resident #8's calcium, cranberry, Lexapro and Lubiprostone at 7:48 A.M. Observation and interview on 11/06/24 at 8:10 A.M. of the medication administration by LPN #383 to Resident #8 revealed she was not using a computer or paper physician orders to administer Resident #8's medication. LPN #383 stated she looked at the computer before she started her medication administration to the residents on her unit. She stated she looked at all her long-term residents, checked to make sure there were no changes and then signed off the medications. LPN #383 stated she signed off the MAR for Resident #8 prior to administering the medications. At 8:10 A.M., with this surveyor, LPN #383 then administered Resident #8's calcium, cranberry, Lexapro and Lubiprostone. Review of the facility policy titled, Medication Administration, revised August 2014, revealed the MAR was always employed during the medication administration. The nursing staff were to compare the medication against the MAR by reviewing the five rights which were the right resident, right drug, right dose, right route and right time. 2. Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses including paraplegia and depression. Review of the Medication Administration Record (MAR) for Resident #44 revealed he received Magnesium Oxide 400 milligrams, a multivitamin, Vitamin D3 25 micrograms and Pregabalin 150 milligrams (medication for pain) in the morning of 11/06/24. Review of the Medication Administration Audit Report dated 11/06/24 revealed Licensed Practical Nurse (LPN) #383 documented that she had administered Resident #44's Magnesium Oxide, multivitamin, Vitamin D3 and Pregabalin at 7:43 A.M. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 11/06/24 at 8:16 A.M. of the medication administration by LPN #383 to Resident #44 revealed she was not using a computer or paper physician orders to administer Resident #44's medication. LPN #383 stated she looked at the computer before she started her medication administration to the residents on her unit. She stated she looked at all her long-term residents, checked to make sure there were no changes and then signed off the medications. LPN #383 stated she signed off the MAR for Resident #44 prior to administering the medications. At 8:16 A.M., with this surveyor, LPN #383 then administered Resident #44's magnesium oxide, multivitamin and Pregabalin. LPN #383 administered the incorrect dose of Resident #44's Vitamin D3, as she administered 10 micrograms instead of 25 micrograms. LPN #383 verified she administered the incorrect dosage. Review of the facility policy titled, Medication Administration, revised August 2014, revealed the MAR was always employed during the medication administration. The nursing staff were to compare the medication against the MAR by reviewing the five rights which were the right resident, right drug, right dose, right route and right time.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, observation and interview, the facility failed to ensure Resident #169 was assisted with toileting as needed. This affected one (Resident #169) out of five residents reviewed for activities of daily living. The facility had a census of 67. Findings include: Review of the medical record for Resident #169 revealed an admitted [DATE] with diagnoses including multiple fractures of the pelvis, muscle weakness and difficulty in walking. Review of the nursing progress note dated 10/31/24 revealed Resident #169 was alert and oriented to person, place and time. Review of the nursing skilled assessment dated [DATE] revealed Resident #169 was incontinent of bladder and needed one person to physically assist with toileting. Review of the care plan dated 11/01/24 for Resident #169 revealed she was incontinent of bowel and bladder. Interventions included to check on her and change her on care rounds and as needed. Interview on 11/05/24 at 8:04 A.M. with Resident #169 revealed staff had not assisted her with toileting since the previous day (11/04/24) around lunch. She stated the midnight shift staff had not come in her room until 5:00 A.M. on 11/05/24 and it was only to turn off her lights. She stated she was incontinent of urine and was unable to get up on her own. Interview on 11/05/24 at 8:10 A.M. with Licensed Practical Nurse (LPN) #371 revealed she was aware of the concern that Resident #169 had with staff not going in her room to assist her with incontinence care and toileting. She stated she would update an aide to go assist the resident with care. LPN #371 stated staff were to go to check and change residents every two hours or sooner if needed. Observation on 11/05/24 at 8:15 A.M. revealed an aide went to Resident #169's room for care. Observation and interview on 11/05/24 at 12:05 P.M. with Resident #169 revealed she had gray sweatpants on that was saturated with urine. She stated no one had come to assist her with incontinence care since the aide had come in after 8:00 A.M. She stated her call light was not working properly and she was unable to call for help. This surveyor updated LPN #371 about Resident #169's need for assist and her call light. The call light was observed by LPN #371 and noted to be non-functional. LPN #371 assisted Resident #169 with incontinence care. LPN #371 then provided Resident #169 call bells and updated maintenance on the concern. Review of the facility policy titled, Activities of Daily Living, dated March 2023, revealed that the facility would provide necessary care and services based on the resident's assessment and choices. The facility would provide care and services for activities of daily living including hygiene and toileting. This deficiency represents non-compliance investigation under Complaint Number OH00159653.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, observation and interview, the facility failed to ensure an anchoring device for Resident #51's suprapubic catheter was implemented to prevent accidental pain or injury from excessive tension to the suprapubic catheter. This affected one (Resident #51) of one resident reviewed for catheters. The facility census was 67. Findings include: Review of the medical record revealed an admitted [DATE] with diagnoses including urinary tract infection (10/10/24) and obstructive and reflux uropathy (when the urine cannot flow normally due to a blockage). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #51 had intact cognition and had an indwelling catheter. Observation on 11/05/24 at 2:17 P.M. of Resident #51's suprapubic catheter care by Certified Nursing Assistant (CNA) #307 revealed his catheter had no anchoring device to hold the catheter in place from pulling. Resident #51 stated it caused pain when he repositioned in the bed as it tugged on the catheter line. CNA #307 verified there should have been an anchoring device in place. Interview on 11/05/24 at 2:32 P.M. with Licensed Practical Nurse (LPN) #340 verified Resident #51 should have an anchoring device for his suprapubic catheter.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, observation and interview, the facility failed to ensure Resident #36's head of the bed was elevated safely per the physician's order, during continuous enteral feedings. This affected one (Resident #36) of three residents reviewed for enteral feedings. The facility census was 67. Findings include: Review of the medical record for Resident #36 revealed an admitted [DATE] with diagnoses including chronic respiratory failure, heart failure, dysphagia (difficulty swallowing) and gastrostomy status (enteral feeding tube). Review of the physician's order for Resident #36 revealed she had an order to keep the head of her bed at least 30 degrees while feeding dated 03/25/24. Observation on 11/04/24 at 1:54 P.M. of Resident #36 revealed her head of the bed was almost completely flat while the continuous enteral feed was running at 50 milliliters. Resident #36's bed did not have a degree measure device on the side of the bed to allow staff to know the exact degree of placement of the head of the bed. Interview on 11/04/24 at 2:03 P.M. with Licensed Practical Nurse (LPN) #371 verified Resident #36's enteral feeding was running at 50 milliliters and the head of her bed was almost completely flat. She stated her head of the bed was below 30 degrees. She stated staff would provide care and not elevate Resident #36's head when completed. LPN #371 stated staff would have to guess where 30 degrees was as there was no device on the side of the bed showing the degree measurements.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45442 Based on record review, interview, and review of the facility policy and procedure, the facility failed to ensure pharmacy recommendations were addressed in a timely manner. This affected one resident (Resident #22) of five residents (Residents #13, #22, #38, #51, and #62) reviewed for drug regimens. The facility census was 67. Findings include: Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included but were not limited to Alzheimer's dementia, hemiplegia and hemiparesis and bipolar disorder. Review of the 08/24/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #22 revealed a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. Resident #22 was noted to receive antipsychotics, antidepressants, anticonvulsants and opioid. Last noted General Dose Reduction (GDR) was attempted on 06/22/23. Last GDR contraindicated was on 02/15/24. Review of physician orders for Resident #22 revealed an order for Lamictal 100 milligrams (mg) at bedtime dated 03/13/24. This order was noted to be discontinued on 07/14/24. However, another physician order dated the same date, 07/14/24, was noted for the same dose, Lamictal 100 mg at bedtime. Review of the Medication Administration Record (MAR) for July of 2024 for Resident #22 revealed an order for Lamictal 100 mg at bedtime with a start date of 03/13/24 and a discontinuation date of 07/14/24. A second active order was started on 07/14/24 for Lamictal 100 mg at bedtime. The medication was given as ordered. Review of Consultant Pharmacist's Medication Review Recommendations dated 07/24/24 for Resident #22 revealed a recommendation for a GDR for Lamictal 100 mg daily. Beside the recommendation it stated Response: Positive. Review of the nursing progress note dated 07/24/24 timed at 8:51 P.M. for Resident #22 revealed pharmacy had reviewed Resident #22's medications and regimen and had noted no irregularities and/or observations on a separate report to the Director of nursing and prescriber. Interview on 11/01/7/24 at 11:05 A.M. with the Director of Nursing (DON) confirmed the Consultant Pharmacist's Medication Review Recommendations dated 07/24/24 for Resident #22 had positive indicated in the outcome/response column but was unable to provide evidence the recommended Gradual Dose Reduction was completed as recommended. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the November 2017 revised facility policy called; Psychotropic Drug Use revealed the consultant pharmacy will report any irregularities specific to psychotropics and unnecessary medication to the attending physician and the facility's medical director as well as the facility's Director of Nursing (DON) as irregularities are identified. These reports will be acted upon in a timely manner. The attending physician will document in the resident's medical record that the identified irregularity has been reviewed and addressed along with what actions, if any, are taken. If there has been no change made by the attending physician to the drug regimen the attending physician will document his/her rational within the resident's medical record.

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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** 38522 Based on record review, interview and review of the facility policy, the facility failed to provide routine monitoring for behaviors and side effects for psychotropic medications. This affected three residents (#22, #38 and #51) of five residents reviewed for unnecessary medications. Facility census was 67. Findings include: 1. Review of Resident #38's medical record revealed an admitted [DATE] and diagnoses including acute and chronic respiratory failure with hypoxia, dependence on respirator [ventilator] status, tracheostomy status, quadriplegia, depression, adjustment disorder with depressed mood, insomnia and anxiety. Review of Resident #38's quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #38 was cognitively intact and received antianxiety and antidepressant medications. Review of Resident #38's physician orders as of 11/06/24 revealed an order dated 03/22/24 for Busprione hydrochloride oral table, 10 milligrams (mg) give two tablets by mouth two times a day related to anxiety disorder; an order dated 05/09/24 for Venlafaxine hydrochloride extended release oral capsule give 75 mg by mouth in the morning related to depression; an order dated 09/23/24 for Venlafaxine hydrochloride extended release oral capsule give 37.5 mg with 75 mg every morning for a total of 112.5 mg daily related to depression; an order dated 10/01/24 for Remeron oral tablet 15 mg give 7.5 mg by mouth at bedtime for depression and appetite stimulant; an order dated 10/01/24 for trazodone hydrochloride oral tablet 100 mg give 125 mg by mouth at bedtime related to insomnia and an order dated 10/24/24 for valium oral tablet 5 mg give one tablet my by mouth at bedtime related to insomnia. No orders were noted directing staff to document behavior or medication side effects. Review of Resident #38's abnormal involuntary movement scale (AIMS) assessments revealed the last assessment was completed on 03/12/24. Review of Resident #38's psychiatry notes dated 12/21/23, 02/15/24, 03/28/24, 05/09/24, 06/06/24, 08/01/24 and 09/26/24 revealed no AIMS assessments were completed during these visits. Review of point-of-care behavior monitoring revealed no behavior or lack of behavior was documented for the past 30 days. (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 Resident #38's care plans revealed a care plan dated 03/14/23 for psychotropic medications related to depression and anxiety. Listed interventions included administer psychotropic medications as ordered by physician, monitor side effects and effectiveness each shift (03/14/23) and monitor/document/report as needed any adverse reactions of psychotropic medications (03/14/23). A second care plan dated 03/14/23 and revised 03/20/23 revealed Resident #38 had depression and anxiety and saw talk therapy and psychiatrist for depression management. Listed interventions included monitor/document/report as needed any signs/symptoms of depression (03/14/23) and administer medications as ordered, monitor/document for side effects and effectiveness (03/14/23). Interview on 11/06/24 at 11:26 A.M. with Licensed Practical Nurse (LPN) #383 revealed this facility did not have to document medication side effects on the Treatment Administration Record (TAR). LPN #383 indicated progress notes would be written for antibiotic side effects but this was not done for psychotropic medications. Interview on 11/06/24 at 3:07 P.M. with the Director of Nursing (DON) verified the facility had not yet addressed monitoring for psychotropic medications and indicated there was not a location in the medical record for nurses to document behaviors and medication monitoring on Resident #38. The DON verified Resident #38's last AIMS was done in March 2024 and was overdue as AIMS assessments were to be completed every six months and were not done on the psychiatry visit notes. The DON confirmed State tested Nursing Assistants (STNAs) were to document on behaviors or lack thereof each shift and confirmed there was no behavior data documented for the last 30 days on Resident #38. 2. Review of Resident #51's medical record revealed an admitted [DATE] and diagnoses including unspecified protein-calorie malnutrition, depression, anemia, alcohol dependence and muscle weakness. Review of Resident #51's 5-day MDS 3.0 assessment dated [DATE] revealed Resident #51 was cognitively intact and received hypnotic and antidepressant medications. Review of Resident #51's physician orders as of 11/06/24 revealed an order dated 10/08/24 for Mirtazapine oral tablet 15 mg by mouth at bedtime for depression/appetite stimulant, an order dated 10/08/24 for Sertraline hydrochloride oral tablet 50 mg in the morning for depression and an order dated 10/08/24 for Zolpidem tartrate 10 mg at bedtime for insomnia. No orders were noted directing staff to document behavior or medication side effects. Review of Resident #51's AIMS assessments revealed the last assessment was completed on 04/16/24. Review of Resident #51's psychiatry notes dated 11/09/23, 02/29/24, 05/09/24, 07/01/24 and 09/26/24 revealed no AIMS assessments were completed during these visits. Review of point-of-care behavior monitoring revealed no behaviors were documented for three of the past 30 days on 10/11/24, 10/14/24 and 10/31/24. Review of Resident #51's plan of care revealed a care plan dated 05/08/23 for antidepressant medication use due to depression and appetite. Listed interventions included administer antidepressant medications as ordered by physician, monitor/document side effects and effectiveness each shift (05/08/23) and monitor/document/report as needed adverse reactions to antidepressant therapy (05/08/23). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/06/24 at 11:26 A.M. with LPN #383 revealed this facility did not have to document medication side effects on the TAR. LPN #383 indicated progress notes would be written for antibiotic side effects but this was not done for psychotropic medications. Interview on 11/06/24 at 3:07 P.M. with the DON verified the facility had not yet addressed monitoring for psychotropic medications and indicated there was not a location in the medical record for nurses to document behaviors and medication monitoring on Resident #51. The DON verified Resident #51's last AIMS was done in April 2024 and was overdue as AIMS assessments were to be completed every six months and were not done on the psychiatry visit notes. The DON confirmed CNA's were to document on behaviors or lack thereof each shift and confirmed there was incomplete behavior data documented for the last 30 days on Resident #51. 45442 3. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included but were not limited to Alzheimer's dementia, hemiplegia and hemiparesis, chronic obstructive pulmonary disorder (COPD), anxiety disorder, schizoaffective disorder, suicidal ideations, and bipolar disorder. Review of the current physician orders for Resident #22 revealed an order dated 07/14/24 for Zyprexa 5 milligram (mg) oral tablet given at bedtime for schizoaffective disorder bipolar type. Review of the quarterly Minimum Data Set (MDS) 3.0 dated 08/24/24 for Resident #22 revealed intact cognition. Resident #22 was indicated to be receiving antipsychotic, antidepressant, and opioid. Review of Resident #22's October 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no evidence of resident specific behavior monitoring or medication side effects monitoring were completed. Review of Resident #22's care plan last reviewed on 10/14/24 revealed Resident #22 uses psychotropic medication related to bipolar disorder, dementia with behaviors, schizophrenia and anxiety. Interventions listed were: monitor and document as needed any adverse reactions of psychotropic medication; unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, shaking, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscled cramps, nausea, vomiting, behavior symptoms not usual to the person. Review of Resident #22's nursing progress notes for the past three months did not reveal any notes related to behavior monitoring. Review of the medical record under the behavior monitoring task and interventions for the past 30 days for Resident #22 revealed no noted behaviors documentation on 10/16/24, 10/19/24, 10/29/24 and 11/03/24. Review of the psychiatrist visit notes dated 08/26/24 for Resident #22 revealed the Abnormal Involuntary Movement Scale (AIMS) was not completed during the visit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366471	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Broadview Heights	1201 Akins Road Broadview Heights, OH 44147

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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	Review of Resident #22's assessments from 08/25/22 through 11/06/24 indicated three Abnormal Involuntary Movement Scale (AIMS) testing were completed on 08/25/22, 01/22/24 and 04/16/24 which was indicated as being the most recent test. Interview on 11/06/24 at 3:50 P.M. with the Director of Nursing (DON) stated behaviors are to be monitored under the task section for the Certified Nursing Assistants (CNA's). DON confirmed the last AIMS testing for Resident #22 was completed on 04/16/24 and should have been completed every six months. DON also confirmed behavior monitoring tasks were not being completed consistently for Resident #22 for review. Review of the November 2017 revised facility policy titled; Psychotropic Drug Use revealed qualified staff will monitor the resident for potential undesirable adverse effects that are associated with the use of psychotropic drugs upon initiation of the psychotropic medication and at a minimum every six months utilizing the Abnormal Involuntary Movement Scales as well as monitor for other adverse effect in accordance with CMD and state specific rules and regulation routinely. Under procedure number two, it states the licensed nurse will identify and document the number of behavioral episodes on the Behavior Tracking Form as they occur as well as document the attempted intervention and outcomes of the targeted behaviors such as continuous screaming, yelling pacing etc. Under number four, the licensed nurse and the interdisciplinary team (IDT) will develop a comprehensive care plan addressing the resident's behaviors, medications and established non-pharmacological interventions. Under number 12, the IDT will discuss the need for the on-going use of psychotropic medication on a quarterly basis and determine if the benefit outweighs the risks.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, observation and interview, the facility failed to ensure medications were properly stored and secured. This affected one (Resident #40) out of one resident reviewed for improperly stored medications. The facility census was 67. Findings include: Review of the medical record for Resident #40 revealed an admitted [DATE] with diagnoses including depression, anxiety and respiratory failure. Review of the physician's orders revealed Resident #40 had an order for Guaifenesin 600 milligrams two times a days for cough. There was no indication that Resident #40 could self-administer her medication or keep the medication at bedside. Review of the Medication Administration Record (MAR) for November 2024 for Resident #40 revealed Licensed Practical Nurse (LPN) #371 had documented that she had administered Resident #40's Guaifenesin the morning of 11/05/24. Observation and interview on 11/05/24 at 8:27 A.M. revealed Resident #40 had an orange liquid medication in a medication cup on her tray table. She stated it was her cough medication the nurse had left because she was sleeping. Interview on 11/05/24 at 8:54 A.M. with LPN #371 verified Resident #40's Guaifenesin was sitting on her tray table and she had not observed Resident #40 take the medication prior to leaving the room. Review of the facility policy titled, Storage of Medications, revised November 2018, revealed medications were to be stored safely, securely and properly. The supply should only be accessible to licensed nursing personnel.