STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435062	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alcester Care and Rehab Center, Inc	101 Church Street Alcester, SD 57001

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 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** 50015 Based on record review, interview, and policy review the provider failed to follow physician orders for one of one sampled resident (237). Findings include: 1. A review of resident 237's electronic medical record (EMR) revealed: *She had diagnoses of: -Generalized anxiety disorder (severe ongoing anxiety that interferes with daily activities). -Paroxysmal anxiety (unpredictable recurrent attacks of severe anxiety). -Bipolar disorder, depressed, severe without psychotic features (mood swings ranging from depressive to manic high episodes). * She returned to the facility on [DATE] following a hospital stay with a physician's order for quetiapine (Seroquel) (a medication to stabilize mood) 25 milligrams (mg) one tablet by mouth three times daily as needed (PRN) for anxiety or agitation for 14 days. That order had ended on 4/25/24. *On 4/26/24 resident 237's physician extended that order for another 14 days. *There was no face-to-face visit completed by physician for the 4/26/24 order. *The order was faxed to [NAME] Pharmacy. *The order was not in resident 237's EMR. *An interdisciplinary progress note on 4/27/24 at 9:51 p.m. Resident given PRN Seroquel 25 mg at 2010 [8:10 p.m.]. Resident does have a PRN order, is not in TAR [treatment administration record]. Resident requests for anxiety. *The resident's 4/29/24 physician order summary did not include that Seroquel order. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*A progress note on 4/29/24 at 1928 [7:28 p.m.] Resident requested PRN Seroquel with HS [hour of sleep] medication. Administered 25 mg PRN dose with HS medication. Observation and interview on 4/30/24 at 8:19 a.m. of the medication cart containing resident 237's medications with licensed practical nurse (LPN) C revealed: *Resident 237's medication card of the PRN Seroquel was still available for administration. *LPN C verified there was no physician's order in the EMR for that medication. Interview on 4/30/24 at 1:57 p.m. with director of nursing (DON) B revealed: *The pharmacy puts all orders into the EMR system. *She verified there was no face-to-face visit by resident 237's physician for the 4/26/24 Seroquel PRN order. *Staff were to use a checklist to process physician orders as follows: -Fax pharmacy. -eMAR/eTAR [electronic medication administration record/electronic treatment administration record]. -Removed medication/tx [treatment]. -Notify POA [Power of attorney]. -Progress note. -Report book. -Charting list. -Other. *No interdisciplinary progress note were in the resident chart except for the PRN doses given after original PRN order had been discontinued. *There was no system in place to monitor PRN psychotropic medications. *She confirmed the checklist had not been completed for resident 237's 4/26/24 Seroquel physician order and staff did not follow the physician's order. Review of provider's 7/7/23 Antipsychotic Medication Policy revealed: *PRN antipsychotic drug administration, in the event that a resident has a prn antipsychotic medication order, the following will apply: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Before an as needed or PRN antipsychotic drug is administered, multiple non-pharmacological interventions are to be attempted and documented. -Non-pharmacological interventions will be documented on the eMAR with the antipsychotic medication's progress notes.