STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525525	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Maison	700 South Fremont Prairie Du Chien, WI 53821

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review the facility did not develop a comprehensive person-centered care plan for 5 of 5 residents (R19, R38, R30, R28, and R16) reviewed for unnecessary medications. R19 does not have a comprehensive person-centered care plan for the use of an antipsychotic medication and anti-seizure medication. R38 does not have a resident specific care plan for the use of an antidepressant and use of Melatonin as a sleep aid. R30's care plan does not include individualized targeted behaviors and non-pharmacological interventions for the use of a psychotropic medication. R30 does not have a care plan for insomnia. R28 does not have care plans that include his psychotropic medications and what they are being used for. R16's care plan does not include individualized targeted behaviors and non-pharmacological interventions for the use of an antidepressant medication. R16 does not have a care plan for insomnia. This is evidenced by: The facility's policy titled Care Plan Policy/Procedure dated 6/10/15, states, in part: .To have a plan that is developed and used by the interdisciplinary team .as determined by the residents' needs .1. Indicate problem or behavior the plan will address .3. Select approaches/interventions that will ensure goal is reached .4 .The staff nurse will also initiate, review and update the residents' care plans at any time when the nurse is on duty and it is indicated .6. Updates and changes need to occur as soon as a change, problem, need or preference, etc. is identified . Example 1: R19 was admitted on [DATE] with diagnoses that include epilepsy and epileptic syndromes with seizures, insomnia, anxiety disorder, major depressive disorder, and unspecified dementia without behavioral disturbance, (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R19 is taking Quetiapine Fumarate (antipsychotic) for generalized anxiety disorder and Levetiracetam (anti-seizure medication) for seizures. R19's care plan does not address individualized targeted behaviors for continued use of an antipsychotic medication (Quetiapine) and non-pharmacological interventions used to alleviate episodes of anxiety. R19's care plan does not address seizures or the use of anti-seizure medication. Example 2: R38 was admitted on [DATE] with diagnoses that include insomnia, anxiety, major depressive disorder, and dementia. R38 is taking Nortriptyline and Sertraline for depression and Melatonin for insomnia. R38's care plan does not address individualized targeted behaviors for continued use of an antidepressant medication and non-pharmacological interventions used to alleviate feelings of depression. R38's care plan does not address having insomnia. 44552 Example 3: R30 was admitted to the facility on [DATE] with diagnoses including stroke, diabetes, kidney disease, end stage renal disease, mild neurocognitive disorder, difficulty in walking, weakness, anxiety disorder, chronic pain, heart disease, and dependence on renal dialysis. R30 receives Escitalopram Oxalate Oral Tablet 10mg by mouth in the afternoon related to anxiety disorder . start date 11/23/23 . R30 receives Melatonin Oral Tablet 3mg give 2 tablet by mouth at bedtime to promote sleep .start date 11/24/23 . R30's care plan does not address individualized targeted behaviors and non-pharmacological interventions used to assist with alleviating feelings of anxiety. R30's care plan states, in part; .resident uses psychotropic medications due to resident's diagnosis of generalized anxiety disorder .administer psychotropic medications as ordered .antidepressant behaviors: monitor/record occurrence of target behavior symptoms increase drowsiness, increased risk of suicidal risks/actions, feeling agitated, anxious, angry, irritable, trouble sleeping . R30's care plan does not address R30's trouble with sleeping/insomnia. 38725 Example 4 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R28's Physician Orders include: Remeron 15 mg (milligrams) take 3 tablets by mouth at bedtime for appetite stimulation. R28's Nutrition care plan does not include the remeron that was started as an appetite stimulant. R28 does not have a care plan for depression. Remeron is an antidepressant medication. This medication was increased from 15 mg to 30 mg and then to 45 mg in hopes of helping with his mood/depression. R28's Certified Nursing Assistant (CNA) Kardex does not contain any information that they should monitor for his psychotropic medications. On 6/20/24 at 10:55 AM, Surveyor interviewed LPN C (Licensed Practical Nurse). Surveyor asked LPN C if R28 is receiving remeron for appetite stimulation only, LPN C stated depression, originally depression and appetite. Surveyor asked LPN C if R28 should have a care plan for the use of remeron for appetite and for depression, LPN C said yes this all should be in his care plan. On 6/20/24 at 12:30 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B would you expect there to be a care plan for psychotropic medications, DON B stated absolutely, then they'd be seen on the kardex (CNA care plan) too. Surveyor asked DON B would you expect remeron to be care planned for both appetite and depression, DON B said yes. 39849 Example 5 R16 was admitted to the facility on [DATE] with diagnoses that include, in part: Parkinson's Disease, Insomnia, and Major Depressive Disorder. R16 is taking the antidepressants Celexa (Citalopram) daily for Major Depressive Disorder. R16 is also taking melatonin for insomnia. R16's care plan does not address individualized targeted behaviors and non-pharmacological interventions used to assist with alleviating feelings of depression. R16's care plan indicates the following: Focus: The resident uses antidepressant medication r/t Depression . Interventions/Tasks: .Monitor/document/report PRN (as needed) adverse reactions to Antidepressant therapy . R16's care plan does not address R16's trouble with sleeping/insomnia. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/24 at 11:43 AM, Surveyor interviewed LPN C (Licensed Practical Nurse) and asked where she would find the individualized targeted behaviors for a resident. LPN C indicated it should be on the care plan. Surveyor asked LPN C what individualized behaviors are being monitored for R16 in regard to mood. LPN C indicated that R16 likes going out to activities and she likes music and sings, so if she wasn't attending those things and was wanting to stay in her room more, she would look into that further. LPN C reviewed R16's care plan and was not able to see any of the above individualized behaviors she had indicated she would monitor for. Surveyor asked LPN C if the antidepressant care plan for R16 was individualized. LPN C indicated it was not. On 6/20/24 at 12:30 PM, Surveyors interviewed DON B (Director of Nursing) and asked if resident care plans should include individualized targeted behaviors and non-pharmacological interventions for psychotropics and sleep aides. DON B indicated it should and that the Kardex should include this as well so that CNA's (Certified Nursing Assistant) know what to report to the nurse. Surveyors asked DON B if sleep issues/insomnia should be included on resident care plans. DON B indicated it should.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on observation, interview, and record review, the facility did not ensure residents received adequate supervision and assistive devices to prevent accidents from occurring for 2 of 4 residents (R) reviewed for falls (R38 and R11). R38 has a known history of falls, including one with a fracture. The facility did not identify the root cause for R38's falls or develop/implement a care plan with interventions to prevent falls. R38 fell on [DATE] and sustained a fracture of her left hip. The facility staff did not follow R11's care plan related to fall interventions after R11 sustained a pelvic fracture. Evidenced by: The facility's policy titled, Fall Prevention Protocol dated 6/22/21, updated 10/25/21, states in part: .All residents who are indicated by a > (greater than) 24 fall assessment score .and history of falls or risk for falls, will be identified and individualized fall precautions will be developed for that resident. Preventative measures shall be taken to decrease the number of falls whenever possible. 1. To consistently identify and evaluate residents who are at risk for falls and treat and/or refer for appropriate interventions .3. To prevent/reduce injuries related to falls . 1. A fall risk assessment will be completed at the following times: a. upon admission b. annually c. quarterly . f. PRN (as needed). 2. If the assessment finds the resident at high risk, implement appropriate interventions/precautions . 3. Risk Management Assessment identifying the nature of the incident will be completed after each fall . A root cause analysis will be completed and any changes in interventions will be noted on the form and the care plan updated immediately . 4. IDT (Interdisciplinary Team) reviews fall incident report each morning (Monday through Friday) and will discuss findings and interventions that were put in place, ensure the care plan was updated and adjust as necessary . It is important to note, although the policy states a score >24 is at risk for falls, the assessment tool the facility uses states a score of >10 is at risk. The facility's policy titled Resident Assessment Instrument and Baseline Care Plan - Policy and Procedure dated 10/22, states in part: .Within the first 48 hours of an admission a baseline care plan will be completed and will include the following information . 2. Instructions needed to provide effective and person-centered care that meets professional standards of quality care. 3. The resident's immediate health and safety needs . Example 1: R38 was admitted to the facility on [DATE] with diagnoses including history of falling, fracture of upper end of right humerus (a break in the upper part of the arm), fracture of neck of right femur (a hip fracture), syncope and collapse (fainting), difficulty in walking, weakness, and dementia. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R38's most recent Minimum Data Set (MDS) dated [DATE], states R38 has a Brief Interview of Mental Status (BIMS) of 15, indicating R38 is cognitively intact. R38's baseline care plan states, in part: .Sit to stand: the ability to come to a standing position from sitting . substantial/maximal assistance .transfer: the ability to transfer to and from a bed to a chair . substantial/maximal assistance .Does the resident have a history of falls? Yes .Did the resident have a fall any time in the last month prior to admission/entry or reentry? Yes. Of note, a fall care plan and interventions to prevent falls was not initiated for R38. R38's fall risk evaluation dated 4/8/24 states, in part: .4. Score of 10 or higher indicated the resident is at high risk of fall. 5. Risk for falls was left blank, no information documented. R38's score on 4/8/24 was 21 indicating a high risk for falls. Under the Risk for falls contains a section for goals and fall interventions. This section was left blank, indicating no fall interventions were initiated. R38's Comprehensive Care Plan states, in part: .The resident has had an actual fall with serious injury r/t (related to) Unsteady gate. Date initiated: 6/3/24. Goal: The resident's left hip fx (fracture) will resolve without complication by review date. Date initiated: 6/3/24. Of note, the fall care plan for R38 was initiated on 6/3/24 and R38 did not have a care plan for falls or fall interventions prior to 6/3/24. R38 had a fall on 5/10/24. R38's fall report dated 5/10/24 at 15:30 (3:30 PM) states, in part: .Resident was ambulating to the bathroom using her walker, unassisted, when she lost her balance and fell to the floor. Resident found lying on the floor between the bathroom and wall. Resident said she hit her head on the wall and floor during her fall. Denies pain at this time. ROM (Range of Motion) to all extremities performed without pain. Small lump noted on back of head. No bleeding noted from lump. Resident said she was going to the bathroom . Lump approx. (approximately) [sic] 2 by 3 cm (centimeters) on back of scalp .Resident did mention that when she tried to raise her head her neck felt a little weird. Resident then turned her head herself from side to side and up and down without pain, just felt a little heavy. Resident taken to Hospital? N Of note, no immediate interventions were put in place to prevent future falls, no root cause analysis was completed, no care plan was initiated, and no interdisciplinary team (IDT) review was completed. R38 had another fall on 5/31/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R38's fall report dated 5/31/24 at 04:15 (4:15 AM) states, in part: .This nurse called to unit from caregiver to come to room immediately. Upon entering room resident was noted to be in a very awkward position lying on the floor on her right side with her left side noted to be rotated. Resident did state that she hit her head and that she broke her leg. Upon assessment it was noted that the left side not in normal position and resident stated extreme pain when even touched [sic]. Resident stated she got up to go to the bathroom. Unsure of when she actually did fall. Rounds were performed per usual routine. Call light was not on and resident was noted to not be verbal [sic] calling out . This nurse immediately called EMS (Emergency Medical Services) for transfer to hospital for possible fractures. EMS arrived around 0430 (4:30 AM), fall found at 0415 (4:15 AM). This nurse did not move resident at all prior to EMS arriving. Updated them when they arrived. Agreed no movement and scoop board needed to transfer to gurney. With resident's pain and possible fractures, EMS administered IV (intravenous) with Fentanyl 25mcg (micrograms) & Zofran 4mg (milligrams) prior to transport. Resident left facility at 0515 (5:15 AM) with EMS .Resident stated she got up to go to the bathroom and fell . R38's hospital records dated 5/31/24 states, in part: .comminuted, impacted femur fracture involving greater and lesser trochanter and extending to subtrochanteric region (fragmentation fracture involving multiple areas of the femur) . Surgical treatment of left hip fracture .later today. R38's discharge summary from hospital dated 6/3/24 states, in part: .fracture of left hip .IM nail stabilization (a surgical procedure that uses a metal rod to stabilize a fractured bone) on 5/31. R38's care plan was initiated after her fall with major injury. On 6/20/24 at 9:31 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) regarding falls. LPN E indicated when a resident falls, staff are responsible to look at the reason they fell . LPN E indicated a new fall intervention should be put in place for each fall immediately and the resident's care plan should be updated. LPN E indicated the nurses are required to update their supervisor of every fall. Surveyor asked LPN E about R38's falls and care plan. LPN E indicated R38 should have had a care plan implemented on admission with interventions to prevent falls and the care plan should have been updated on 5/10/24 when R38 fell . On 6/20/24 at 10:05 AM, Surveyor interviewed DON B (Director of Nursing). DON B indicated R38 should have had a baseline care plan for falls and interventions put in place on admission and after R38's fall on 5/10. DON B indicated the facility did not implement a baseline care plan for R38 and did not review and update R38's comprehensive care plan with new interventions after R38's fall on 5/10. On 6/20/24, DON B initiated a performance improvement plan. DON B gave Surveyor a form dated 6/20/24 titled: Performance Improvement Plan - Falls DX (diagnosis) included in Care plan on admission. The form states in part: .Area of concern - Falls risk not placed in care plan with newly admitted resident with history of falls. The facility did not ensure there was a robust discussion around the root cause for R38's fall on 5/10. The facility did not ensure R38's risk for falls was identified. The facility did not ensure interventions were in place for R38 after she fell on her way to the bathroom on 5/10/24. R38 fell again on 5/31/24 on her way to the bathroom that resulted in a femur fracture requiring surgery. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The example below is cited at a potential for minimal harm/isolated. Example 2: R11 admitted to the facility on [DATE] with diagnoses including weakness, other symptoms and signs involving cognitive functions and awareness, and abnormalities of gait and mobility. R11's most recent Minimum Data Set (MDS) dated [DATE], states R11 has a Brief Interview of Mental Status (BIMS) of 11, indicating R11's cognition is moderately impaired. R11 fell on [DATE]. R11's fall report dated 6/3/24 at 06:15 (6:15 AM) states, in part: Nursing Description: CNA (Certified Nursing Assistant) went to resident room for call light turned on, this writer was in hallway be [sic] medcart and CNA came to doorway and stated R11's on the floor. This writer entered room and noted resident to be on the floor with her head against the wall between her bed and the recliner. Resident Description: I'm not sure, my eyes were swirly and I was dizzy. I think I rolled out of bed .Hoyer lift (mechanical lift used to transfer residents) utilized with assist of 3 and resident put back in bed per her request. Continued to deny pain or discomfort while in bed. Resident requested at 07:15AM to go to the bathroom. CNAs came out after taking her to bathroom resident is complaining of leg pain. This writer assessed resident. She was unable to bear weight on right left [sic] and c/o (Complained Of) pain. Resident was pivoted into wheelchair. it's ok when I'm sitting' Resident sent to ER (emergency room) via ambulance for evaluation. Emergency Department (ED) Provider Notes dated 6/3/24 states, in part: .Acute minimally displaced superior and inferior pubic ramus fractures on the right (pelvic fracture) .They felt if they could take care of this patient back at the nursing home. Plan will be discharge . R11's comprehensive care plan states, in part: .Focus: The resident is Moderate risk for falls. Date initiated 3/23/23. Interventions: Bed in lowest position. Date initiated 6/3/24. R11's CNA Kardex (a care plan CNAs use) printed on 6/20/24, states, in part: .Safety: Bed in lowest position. Of note, the CNA Kardex is viewed by the CNAs in the electronic health record. The CNA Kardex interventions pull from the resident's comprehensive care plan. The interventions on the CNA Kardex are not dated with a start date of the interventions. On 6/19/24 at 1:13 PM, Surveyor observed R11 resting in bed. R11's bed height was approximately 2.5 feet off the ground. This is not the lowest bed position. On 6/19/24 at 1:16 PM, Surveyor interviewed CNA F. CNA F indicated R11 should have floor mats next to her bed but was unsure of any other interventions. CNA F went and reviewed the CNA Kardex and noted R11's fall interventions included bed in lowest position. CNA F lowered R11's bed to lowest position. CNA F indicated she works 12 hour shifts three times a week. CNA F indicated she was unaware of the fall prevention intervention until Surveyor made her aware. CNA F indicated she had not been placing R11's bed in lowest position when she worked. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/19/24 at 1:16 PM, Surveyor interviewed CNA G. CNA G indicated she has worked 10 days this month. CNA G indicated she was unaware R11's fall interventions included bed to be in lowest position. CNA G indicated she had not been placing R11's bed in lowest position when she worked. On 6/20/24 at 9:48 AM, Surveyor interviewed DON B (Director of Nursing). DON B indicated she expects fall interventions to be followed. DON B indicated R11's bed should be in the lowest position. The facility did not ensure staff were following R11's care plan for fall interventions after R11 had a fall on 6/3/24.

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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** 39849 Based on interview and record review, the facility did not ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record for 5 of 5 Residents (R28, R16, R30, R38, and R19) reviewed for unnecessary medications. R16, R30, R19, and R38 were prescribed psychotropic medications without individualized behavior monitoring or non-pharmacological approaches/interventions utilized. R16, R30, and R38 receive medication for insomnia and have no sleep assessment/sleep monitoring documented. R28 does not have any individualized targeted behaviors for his use of psychotropic medications. This is evidenced by: The facility's undated policy titled Psychotropic Medication Use, states in part: Policy Statement - Residents will not receive medications that are not clinically indicated to treat a specific condition. Policy Interpretation and Implementation - 1. A psychotropic medication is any mediation [sic] that affects brain activity associated with mental processes and behavior .3.Psychotropic medication management includes: .d. adequate monitoring for efficacy and adverse consequences; .8. Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes .10. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible . Example 1 R16 was admitted to the facility on [DATE] with diagnoses that include, in part: Parkinson's Disease, Insomnia (sleep disorder that affects the ability to fall or stay asleep), and Major Depressive Disorder. R16 is taking the antidepressants Celexa (Citalopram) daily for Major Depressive Disorder. R16 is also taking melatonin for insomnia. R16's Medication Administration Record (MAR) does not list resident specific behaviors to monitor for. R16's MAR indicates, in part: Antidepressant Medication - Increased agitation, nausea, diarrhea, dizziness, headaches, insomnia, loss of appetite, indigestion or stomach aches, lethargy, excessive hunger . (continued on next page)

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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	Monitor/record occurrence of target behavior symptoms increase drowsiness, increased risk of suicidal risks/actions, feeling agitated, anxious, angry, irritable, trouble sleeping, nausea, dry mouth, fatigue, blurred vision, rash, itching, dizziness, trouble breathing, and loss of appetite, weight gain, or loss . There is no documentation that the facility is monitoring R16 for individualized targeted behaviors related to her antidepressant and no indication of how R16 presents when she is depressed. R16 does not have any type of sleep assessment/sleep monitoring completed for utilization of Melatonin to indicated whether the medication is effective for R16. On 6/20/24 at 11:37 AM, Surveyor interviewed CNA D (Certified Nursing Assistant) and asked what individualized behaviors are being monitored for R16 in regard to mood. CNA D indicated she was not monitoring any behaviors and if there were behaviors to be monitored, they would be on the Kardex. CNA D reviewed R16's Kardex with surveyor and confirmed there were no individualized behaviors noted. Surveyor asked CNA D if she knew to monitor R16 for signs and symptoms of depression and CNA D indicated she did not. On 6/20/24 at 11:43 AM, Surveyor interviewed LPN C (Licensed Practical Nurse) and asked where she would find the individualized targeted behaviors for a resident. LPN C indicated it would be on the care plan. LPN C reviewed R16's care plan with surveyor and indicated it was not individualized. Surveyor asked what the process is to monitor individualized behaviors for residents. LPN C indicated when a new medication is started we document in the progress notes the first couple of weeks of any new medicine or a change, decrease/increase in a medication. LPN C indicated that after that time if things are going well the documentation is stopped and generalized monitoring that is found on the care plan and MAR is completed. If anything changes after that time a progress note should be put in. Surveyor asked LPN C how behaviors are monitored quantitatively so that the number of behaviors can be trended to know if there is a change. LPN C indicated they would have to go back through the progress notes. It is important to note that without targeted behaviors or sleep assessments the facility is unable to show evidence of the efficacy of the medications. 44552 Example 2: R30 was admitted to the facility on [DATE] with diagnoses including stroke, anxiety disorder, chronic pain, heart disease, and dependence on renal dialysis. R30 receives Escitalopram Oxalate Oral Tablet 10mg by mouth in the afternoon related to anxiety disorder . start date 11/23/23 . R30 receives Melatonin Oral Tablet 3mg give 2 tablet by mouth at bedtime to promote sleep .start date 11/24/23 . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525525	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Maison	700 South Fremont Prairie Du Chien, WI 53821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R30's Medication Administration Record (MAR) does not list resident specific behaviors to monitor for. R30's MAR indicates, in part; .Antidepressant Medication- increased agitation, nausea, diarrhea, dizziness, headaches, insomnia, loss of appetite, indigestion or stomach aches, lethargy, excessive hunger . Monitor/record occurrence of target behavior symptoms increase drowsiness, increased risk of suicidal risks/actions, feelings agitated, anxious, angry, irritable, trouble sleeping, nausea, dry mouth, fatigue, blurred vision, rash itching, dizziness, trouble breathing, and loss of appetite, weight gain, or loss . There is no documentation that the facility is monitoring R30 for individualized targeted behaviors related to anxiety and no indication of how R30 presents when R30 is anxious. R30 does not have any type of sleep assessment/sleep monitoring completed for utilization of Melatonin to indicate whether the medication is effective for R30. On 6/20/24 at 9:00 AM, LPN E (Licensed Practical Nurse) indicated when R30 is anxious R30 needs to talk and get the feelings out. LPN E indicated R30 likes to sit outside and talk with staff. LPN E indicated she has worked with R30 and knows what triggers anxiety for him. LPN E indicated when R30 experiences anxiety it should be documented in progress notes, and she would expect that this information be in R30's care plan. 49436 Example 3: R19 was admitted on [DATE] with diagnoses that include epilepsy and epileptic syndromes with seizures, insomnia, anxiety disorder, major depressive disorder, and unspecified dementia without behavioral disturbance. R19 is taking Quetiapine Fumarate (antipsychotic) for generalized anxiety disorder. R19's medical record does not contain an appropriate diagnosis or indication of use for an antipsychotic. R19's medical record does not contain documentation of monitoring for individualized targeted behaviors that would indicate the use of an antipsychotic medication. On 06/20/24 at 11:03 AM, Surveyor asked LPN C (Licensed Practical Nurse) if generalized anxiety disorder is an appropirate diagnosis for use of an antipsychotic. LPN C stated I don't know. On 06/20/24 at 12:47 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated generalized anxiety disorder is not an appropriate diagnosis for use of an antipsychotic and should not have been used as the indication for use. Example 4: R38 was admitted on [DATE] with diagnoses that include insomnia, anxiety, major depressive disorder, and dementia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R38 is taking Nortriptyline (antidepressant medication) and Sertraline (antidepressant medication) for depression and Melatonin (sleep aid) for insomnia. R38's medical record does not contain documentation of monitoring for individualized targeted behaviors that would indicate the use an antidepressant medication. R38's medical record does not contain non-pharmacological interventions offered to alleviate feelings of depression. R38 does not have a sleep assessment or sleep monitoring to indicate continued use of Melatonin. On 6/20/24 at 12:30 PM, Surveyors interviewed DON B (Director of Nursing) and asked if the facility has individualized behavior tracking that is quantitative in nature and non-pharmacological interventions for residents on psychotropic medications . DON B indicated they do not and should. Surveyors asked DON B if residents on a sleep medication should have documentation of a sleep assessment/sleep monitoring and if they have this for R16, R38, and R30. DON B indicated she would expect this to be completed and they do not have documentation of this for these residents. 38725 Example 5 R28's Physician Orders include: Remeron 15 mg (milligrams) take 3 tablets by mouth at bedtime for appetite stimulation. R28's Nutrition care plan does not include the medication, remeron that was started as an appetite stimulant. R28 does not have a care plan for depression. Remeron is an antidepressant medication. This medication was increased from 15 mg (milligrams) to 30 mg and then to 45 mg in hopes of helping with his mood/depression. CNA kardex does not contain any information that they should monitor for his psychotropic medications. Reviewed R28's Medication Administration Record (MAR) from April-June: R28's MAR does not contain any individualized targeted behaviors that staff should monitor for R28's use of psychotropic medications. R28's MAR does contain side effects that R28 may experience from these medications. On 6/20/24 at 10:44 AM, Surveyor interviewed CNA H (Certified Nursing Assistant). Surveyor asked CNA H where do you document behaviors, CNA H said I don't write a note, I tell my nurse and she makes a note. Surveyor asked CNA H if there was anything in their computer documentation to document behaviors, CNA H replied Nothing for CNA's to document on behaviors. Surveyor asked CNA H what behaviors do you monitor for R28, CNA H stated he doesn't really have too many, there are no behaviors I am reporting to my nurse. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/24 at 10:55 AM, Surveyor interviewed LPN C (Licensed Practical Nurse). Surveyor asked LPN C if R28 is receiving remeron for appetite stimulation only, LPN C said depression, originally depression and appetite. Surveyor asked LPN C was the remeron started at 15 mg, LPN C said I don't know what he was started at. Surveyor asked LPN C do you know why/when the remeron was increased, LPN C replied I would have to go back and go through. I am sure it was for his appetite. Surveyor asked LPN C where do you document behaviors, LPN C explained they are documented under behaviors in the progress notes. Surveyor asked LPN C what behaviors do you monitor R28 for, LPN C stated his behaviors are about eating, other than that he doesn't have behaviors. But he is withdrawn, straight faced, no emotions, doesn't want to be bothered, and wants to lay in bed. On 6/20/24 at 12:30 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B would you expect targeted behaviors to be identified, DON B said yes. Surveyor asked DON B if she would expect behaviors to be tracked, DON B replied yes. Surveyor asked DON B who should be tracking and documenting the behaviors, DON B stated CNA's alert the nurse for the nurse to chart. Surveyor asked DON B would you expect there to be a care plan for psychotropic medications, DON B stated absolutely, then they'd be seen on the kardex too. Surveyor asked DON B would you expect remeron to be care planned for both appetite and depression, DON B said yes. Surveyor asked DON B if R28's remeron started at 15mg, DON B explained that yes he was started on it for his appetite and then it was increased to try to assist with his depression.