STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555164	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Rehabilitation & Nursing Center	900 North Church Street Lodi, CA 95240

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40583 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was treated with dignity and respect when Resident 1's request to use the bathroom was denied. This failure had the potential to negatively impact Resident 1's psychosocial well-being. Findings: A review of Resident 1's clinical document titled, ADMISSION RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included muscle weakness and multiple fractures of ribs on the left side of the ribcage. A review of Resident 1's clinical document titled, Care Plan Report, (contains goals and interventions for Resident 1), dated 3/6/25, indicated, . Toilet upon rising and before or after meals at bedtime and PRN [as needed] as tolerated . During an interview on 5/6/25, at 8:38 a.m., Certified Nursing Assistant (CNA) 3 stated following Resident 1 ' s fall, on 3/16/25, Resident 1 stated she needed to go to the bathroom. CNA 3 explained she had informed Resident 1 that she was wearing a brief (incontinence brief - disposable undergarment designed to absorb urine) and that she could go to the bathroom in the brief. During an interview on 5/6/25, at 2:40 p.m., CNA 4 stated she would never tell a resident to use their brief to go to the bathroom if they verbalized, they wanted to get up and go to the restroom and were able to do so with assistance. CNA 4 further stated it was a dignity concern. During an interview with the Director of Nursing (DON), on 5/6/25, at 1:20 p.m., the DON stated Resident 1 was on a toileting program. The DON explained it was not appropriate to tell Resident 1 to go to the bathroom in her brief when Resident 1 had requested to use the bathroom. The DON stated it was important to preserve Resident 1 ' s dignity and to prevent psychosocial harm. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Dignity - Promoting/Maintaining Dignity, implemented 10/22, indicated, . It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality . Staff members involved in providing care or interacting with residents must promote and maintain resident dignity and respect's Resident Rights . Respond to requests for assistance in a timely manner . Speak respectfully to residents .

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 40583 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1)'s Responsible Party (RP - person responsible for making healthcare and medical decisions) was informed and consented to the use of psychotropic (drugs that affect a person's mind, emotions, and behavior) medications for Resident 1 when, the facility had Resident 1 sign the informed consent for psychotropic medications instead of Resident 1's RP. This failure resulted in Resident 1 receiving the psychotropic medication quetiapine (used to manage symptoms of various mental health condition) for four days. This failure also resulted in the use of the medication escitalopram (used to treat depression) for the entirety of Resident 1's stay at the facility, without having an informed consent in place, potentially negatively affecting Resident 1's psychosocial health and physical well-being. Findings: A review of Resident 1's clinical document titled, ADMISSION RECORD (a document that contained Resident 1's demographic information), indicated Resident 1 was admitted to the facility with diagnoses which included depression. A review of Resident 1's clinical document titled, FACILITY VERIFICATION / INFORMED CONSENT FOR PSYCHOTHERAPEUTIC [psychotropic] DRUGS, dated 3/7/25, indicated, . Quetiapine . Escitalopram . Please do not sign until you have had the opportunity to speak with your physician about the potential risks and benefits of using each medication . The Informed Consent was signed by Resident 1 (who did not have the mental capacity to give consent). A review of Resident 1's clinical document titled, Medication Administration Record (MAR - contained physician's orders and dates and times of medication administration), dated 3/1/25 through 3/31/25, indicated the following psychotropic medication orders: . Escitalopram . 1 tablet by mouth at bedtime for Depression . Order Date . 03/06/2025 . and, QUEtiapine . 1 tablet by mouth for bi-polar [a mental health condition characterized by extreme mood swings, ranging from periods of elevated mood to periods of low mood] Order Date . 03/06/2025 . D/C [discontinue] 03/11/2025 . A review of Resident 1's clinical document titled, Order Details, dated 3/7/2025, indicated, . MD [physician] determines that Resident does NOT have the Mental Capacity [an individual's ability to understand, retain, and use information to make decisions, communicate those decisions, and appreciate the consequences of their actions] to make Healthcare decisions . During a concurrent interview and record review, of Resident 1's clinical record, with the Director of Nursing (DON), on 5/1/25, at 3:51 p.m., the DON verified Resident 1 signed the Informed Consent for the quetiapine and escitalopram. The DON explained Resident 1 did not have the capacity to sign the Informed Consent and Resident 1 would not have understood the risks and benefits of the medications. The DON further explained Resident 1's RP should have signed the Informed Consent. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 1's RP, on 5/2/25, at 9:50 a.m., Resident 1's RP stated the facility never discussed the quetiapine medicaion or escitalopram medicaion with Resident 1's RP, and the risks and benefits of the medications were not discussed. Resident 1's RP explained the RP was never asked to sign an informed consent regarding the use of quetiapine or escitalopram. A review of the facility policy titled, Psychotropic Medication Management, dated 11/2017, indicated, . Psychotropic Medications will only be used when necessary to promote or maintain a Resident's highest practicable mental, physical, and psychosocial well-being . PURPOSE To Avoid unnecessary medications and facilitate the proper use, dose, and duration of psychotropic agents in accordance with Resident assessed need(s) and condition(s) . When psychoactive medications are prescribed, the clinical record should reflect the diagnosis and specific condition or targeted behavior being treated . Informed Consent for psychoactive medications must be verified prior to use .

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40583 Based on interview and record review, the facility failed to notify Resident 1's Responsible Party (RP - responsible for making medical and healthcare decisions) when Resident 1 fell on [DATE]. This failure had the potential for Resident 1's necessary and/or preferred medical decisions to be delayed, which could have negatively affected Resident 1's health and well-being. Findings: A review of Resident 1's clinical document titled, ADMISSION RECORD (a document that contained Resident 1's demographic information), indicated Resident 1 was admitted to the facility with a diagnoses which included multiple rib fractures on Resident 1's left side of the ribcage. A review of Resident 1's clinical document titled, SBAR [SBAR - Situation, Background, Assessment, and Recommendation - A structured communication tool to relay critical information] Fall Report of Incident . , dated 3/16/25, indicated, . Responsible Party Notified . Self RP . During an interview with licensed nurse (LN) 2, on 5/2/25, at 2:20 p.m., LN 2 confirmed he documented Resident 1 was her own RP, and did notify Resident 1's RP. During a concurrent interview and record review of Resident 1's clinical record, with the Director of Nursing (DON), on 5/1/25, at 3:51 p.m., the DON stated Resident 1's clinical record titled, SBAR . dated 3/16/25, was inaccurate when it listed Resident 1 as her own RP. The DON explained that the Resident 1's RP was required to be notified in case the RP wanted to send Resident 1 to the emergency room . The DON further explained, RP notification included that the facility provided the RP with a complete and accurate accounting of Resident 1's condition. A review of the facility policy titled, Fall Prevention and Response, revised 8/2023, indicated, . Each Resident will be assessed for fall risk factors and will receive care and services in accordance with individualized level of risk to minimize the likelihood of falls . Notify Physician and Responsible Party .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40583 Based on observation, interview, and record review, the facility failed to maintain a safe and supervised environment to prevent accidents and hazards for three of three sampled residents (Resident 1, Resident 2, and Resident 3) when: 1a. Resident 1 was moved, prior to being assessed, following Resident 1's fall on 3/16/25; b. Resident 1's physician was not notified of Resident 1's blurred vision, on 3/17/25, following a fall on 3/16/25, resulting in a 5-day delay in treatment; 2. Resident 2's clinical documentation was incomplete for a fall on 3/23/25; 3a. Resident 3's clinical documentation was incomplete for a fall on 3/31/25; and, b. Resident 3's care plan interventions to prevent falls were not followed on 5/1/25. These failures resulted in delayed treatment for Resident 1, the potential for Resident 1 to experience further injuries following Resident 1's fall, and had the potential for Resident 1, Resident 2, and Resident 3 to experience falls, negatively affecting their health and well-being. Findings: 1a. During an interview with licensed nurse (LN) 2, on 5/2/25, at 2:20 p.m., LN 2 stated he had observed Resident 1's fall. LN 2 explained Resident 1 was walking when she slipped and then fell on the roommate's floor mat. LN 2 further explained Resident 1 bumped her head on the side rail. LN 2 stated a certified nursing assistant (CNA) assisted him to get Resident 1 in her bed and then LN 2 assessed Resident 1. LN 2 explained he should not have moved Resident 1 before she was assessed because if Resident 1 was injured, the move could have made the injury worse. LN 2 further explained it was kind of the shock in the moment and that is why he moved Resident 1 prior to her being assessed. During an interview with CNA 3, on 5/6/25, at 8:38 a.m., CNA 3 stated LN 2 called her to assist him with getting Resident 1 back to bed. CNA 3 explained they lifted Resident 1 up and got her back to bed. CNA 3 further explained after getting Resident 1 back to bed, LN 2 assessed Resident 1 for any injuries. During an interview with the Director of Nursing (DON), on 5/6/25, at 1:08 p.m., the DON stated the process for post fall assessments were to assess for any injuries, conduct neurochecks (alert and oriented status, headache), and vital signs (blood pressure, heart rate and respiratory rate per minute, pain assessment, temperature, and oxygen saturation percentage). The DON explained licensed nurses were supposed to check for injuries before they moved Resident 1. The DON further explained the importance of the assessment was to ensure there was not an injury before Resident 1 was moved. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled, Fall Prevention and Response, dated 8/2023, indicated, . When any resident experiences a fall, the Licensed Nurse should . Evaluate for signs of physical injury or trauma prior to moving the Resident . b. A review of Resident 1's clinical record titled, ADMISSION RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included multiple rib fractures on Resident 1's left side of her ribcage. A review of Resident 1s clinical record titled, SBAR [SBAR - Situation, Background, Assessment, and Recommendation - a communication tool used in healthcare], dated 3/16/25, at 10:29 AM, indicated, . Resident [1] was attempting to walk to the bathroom when she was seen slipping and falling onto roommate's fall mat. Resident [1] was witnessed hitting her head on roommates bed rail . A review of Resident 1's clinical record titled, Progress Notes, dated 3/17/25 at 3:10 p.m., indicated, . [Resident 1] c/o [complained of] headache . around 10:00 AM [Resident 3] assessed by physiotherapist and c/o head pain and double vision to him . A review of Resident 1's clinical record titled, Progress Notes, dated 3/21/25, at 1:07 p.m., indicated, . [Resident 1] has been refusing OT [occupational therapy] d/t [due to] headache and double vision . A review of Resident 1's clinical record titled, Progress Notes, dated 3/21/25, at 2:07 p.m,, indicated, . Writer was informed [Resident 1] was refusing OT due to headache and blurred vision . writer notified MD . sent to ED [emergency department] . During an interview with the physician (MD) 1, on 5/6/25, at 3:10 p.m., MD 1 stated he had not been informed that Resident 1 had experienced double vision on 3/17/25 and stated the facility staff should have called and informed him. MD 1 further explained it was important to ensure Resident 1 did not have a head injury. MD 1 further explained if he had been informed Resident 1 was having double vision, the day after her fall on 3/16/25, he would have had Resident 1 transferred to the hospital emergency room . During a concurrent interview and record review of Resident 1's clinical record titled, Progress Notes, dated 3/17/25, with the Assistant Director of Nursing (ADON), on 5/15/25 at 3:56 p.m., the ADON stated MD 1 should have been notified of Resident 1's double vision. The ADON explained MD 1 should have been notified to ensure Resident 1 received appropriate treatment following a fall. A review of Resident 1's clinical document from an outside acute care hospital, titled, CT [catscan - a medical imaging technique that uses X-rays to create detailed cross-sectional images of the body] Cervical Spine [upper part of the spinal column, also known as the neck] WO [without] Contrast [a substance, like a dye, that is injected into the body or taken orally to help make certain structures or organs more visible on the images], dated 3/21/25, indicated, . T1 [thoracic vertebra - spinal column bone right before the neck spinal bones start] . compression fracture [bone in spine collapses or flattens] . acute [a condition that is sudden in onset] . A review of the facility policy titled, Fall Prevention and Response, dated 8/2023, indicated, . When any Resident experiences a fall, the Licensed Nurse should . Monitor Resident's condition for at least 72 hours for any post-fall complications . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled, Change of Condition, dated 2016, indicated, . Purpose . appropriately assess, document and communicate changes of condition . to the primary care provider in accordance with the resident needs . Document assessment findings and communications as soon as practical . Notify the physician of assessment findings . 2. A review of Resident 2's clinical record titled, ADMISSION RECORD, indicated Resident 2 was admitted to the facility with diagnoses which included muscle weakness. A review of Resident 2's clinical record titled, SBAR (Situation Background Assessment Recommendation - a communication tool used in healthcare), dated 3/23/25, indicated the assessment for night shift, on 3/25/25, was not completed. During a concurrent interview and record review on 5/1/25, at 3:05 p.m., Resident 2's clinical record titled SBAR, dated 3/23/25, was reviewed with the Director of Nursing (DON). The DON confirmed Resident 2's post fall assessment for night shift, on 3/25/25, was not completed. The DON explained the purpose of the post fall assessments were to ensure there were no hidden injuries and to implement post fall interventions. 3a. A review of Resident 3's clinical record titled, ADMISSION RECORD, the record indicated Resident 3 was admitted to the facility with a diagnoses that included hemiplegia and hemiparesis (a medical condition that causes paralysis or weakness on one side of the body). A review of Resident 3's clinical document titled, Neurocheck [monitoring for any signs of deterioration or developing problems]-Q [every] 15 X4 [every 15 minutes for the first hour], Q30 X4 [every 30 minutes for the next two hours], Q60 X2 [every 60 minutes for the next two hours], dated 3/31/23, indicated, of the 10 neurochecks that were supposed to have been completed, 8 neurochecks used vital signs taken, on 3/31/25, at 7:38 AM, prior to Resident 3's fall at 8:15 AM. b. During a concurrent observation and interview with Resident 3, on 5/1/25, at 2:04 p.m., Resident 3 was in his wheelchair, outside of his room, dressed and wearing regular socks. Resident 3 stated he has had fallen three times in the facility. During a concurrent observation and interview with certified nursing assistant (CNA) 1, outside of Resident 3 room with Resident 3 present, on 5/1/25, at 2:06 p.m., CNA 1 confirmed Resident 1 was wearing regular socks. CNA 1 explained Resident 3 should have been wearing nonskid socks. CNA 1 further explained, by Resident 3 not wearing the appropriate nonskid socks, Resident 3 could have had another fall with injury. During a concurrent observation and interview with licensed nurse (LN) 1, outside of Resident 3 room with Resident 3 present in his wheelchair, on 5/1/25, at 2:08 p.m., LN 1 stated when Resident 3 was up in his wheelchair he was supposed to be wearing nonskid footwear. LN 1 explained Resident 3 was supposed to wear nonskid footwear to prevent Resident 3 from falling. LN 1 stated Resident 3 was at risk of injury if he had fallen. A review of Resident 3's clinical document titled, Care Plan Report, (contains Focus, Goals and Interventions for care) dated 3/5/25, indicated, . Focus . At risk for falls and injuries r/t [related to] Medications . Goal . Decrease risk of fall and/or minimize injuries from falls x 90 days . Provide/Reinforce use of non-skid foot wear . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 3's clinical record, on 5/1/25, at 3:18 p.m., with the Director of Nursing (DON), the DON confirmed post fall documentation and assessments were incomplete after Resident 1's fall, A review of the facility policy titled, Fall Prevention and Response, revised 8/2023, indicated, . Each Resident will be assessed for fall risk factors and will receive care and services in accordance with individualized level of risk to minimize the likelihood of falls . When any Resident experiences a fall, the Licensed Nurse should . Evaluate for signs of physical injury or trauma prior to moving the Resident . Assist Resident to a safe and comfortable position . Obtain vital signs and conduct a physical assessment . Implement neurological checks for known, reasonably suspected, or verbalized head injury . Notify Physician and Responsible Party . Review Resident's care plan and update (as indicated) to address any immediate safety needs .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 40583 Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1)'s, management and administration of pain relieving medication, (including a narcotic [a drug that could have induced sleep, stupor, or a state of insensitivity to pain]), was done according to professional standards of practice and the narcotic pain medication did not have pain level parameters in place (pain level parameter are assessed using the numeric pain assessment tool: 0=no pain and 10=the worst pain) associated with the narcotic medication order. These failures resulted in Resident 1 not receiving the appropriate type of pain medication for the assessed pain level. Findings: A review of Resident 1's clinical document titled, ADMISSION RECORD, indicated Resident 1 was admitted to the facility with multiple rib fractures on the left side of his ribcage. A review of Resident 1's clinical document titled, Care Plan Report, (contained focus, goals and interventions that addressed Resident 1's pain) dated 3/7/25, indicated, Focus . The resident has acute pain r/t [related to] rib fracture . Goal . verbalize adequate relief of pain . Interventions . Administer analgesia [pain medication] as per orders . A review of Resident 1's clinical document titled, Medication Administration Record, (MAR - contained physician orders) dated 3/1/25 through 3/31/25, indicated the following pain medications were administered for Resident 1, as follows, Acetaminophen (pain medication) . 2 tablets . every 6 hours as needed for mild pain (1-3 on the numeric pain assessment tool) . was administered as follows: 3/9/25 at 5:01 a.m. for a pain level of 4; 3/19/25 at 1:54 p.m. for a pain level of 5; 3/23/25 at 8:25 a.m. for a pain level of 4; and, 3/31/25 at 6:52 p.m. for a pain level of 4. HYDROcodone-Acetaminophen (narcotic) . 1 tablet by mouth every 6 hours as needed for pain . was administered as follows: 3/10/25 at 7:25 a.m. for a pain level of 3; 3/11/25 at 9:29 a.m. for a pain level of 3; 3/12/25 at 9:42 a.m. for a pain level of 3; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/25/25 at 8:45 a.m. for a pain level of 3; 3/27/25 at 4:44 p.m. for a pain level of 3; 3/28/25 at 7:55 p.m. for a pain level of 3; and, 3/29/25 at 8:18 p.m. for a pain level of 3. During a concurrent interview and record review of Resident 1's clinical record, with the Director of Nursing (DON), on 5/6/25, at 1:38 p.m., the DON confirmed the above medications and pain levels for Resident 1. The DON explained it was important to have administered the least amount of medication possible (for the assessed pain level) and assessed if the medication was effective. The DON further explained that when pain medications were given outside of ordered parameters, she would expect to see a progress note that indicated the rationale. The DON verified there were no progress notes that indicated the rationale for the administration of the pain medication (Acetaminophen) outside of the pain level parameters ordered by the physician. The DON further explained the hydrocodone could have caused neurological symptoms (dizziness, confusion, disorientation), and it could have increased Resident 1's risk for falls. The DON explained it was important to have adequate pain control, and Resident 1 should have been educated on sufficient pain control interventions for pain levels above 3. During an interview with physician (MD) 1, on 5/6/25, at 3:10 p.m., MD 1 stated he typically placed parameters (pain level 1-10 using the numeric pain assessment tool) in the order set for pain medication. MD 1 stated the facility should have contacted him for parameters for the hydrocodone order. MD 1 further stated he would have used hydrocodone for moderate pain (4-6 on the numeric pain assessment tool). MD 1 further explained Resident 1 had significant dementia (a group of thinking and social symptoms that could interfere with daily functioning) and MD intended to use the hydrocodone sparingly. A review of the facility policy titled, . PAIN MANAGEMENT PROCESS, dated 6/2009, indicated, . It is the responsibility of the licensed nurse to consistently assess, manage, and monitor pain for all residents . The objective of the pain management process is to identify resident needs and determine potential referrals/interventions to affect positive functional change through pain reduction, modification of perception of pain, and enhancement of the quality of life . Documenting pain assessment effectiveness of both routine and prn [as needed] pain medication in the nurses progress notes and/or MAR every shift using scale of 0 - 10 .

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 40583 Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1), was free from unnecessary medications when Resident 1 received the psychotropic (drugs that affect a person's mind, emotions, and behavior) medication quetiapine (used to treat episodes of mania [frenzied, abnormally excited or irritated mood]) or (bipolar disorder - could cause episodes of depression, episodes of mania, and other abnormal moods) without having an accurate diagnosis and indications for use of the medication quetiapine. These failures resulted in Resident 1 receiving the medication quetiapine for four days, potentially negatively affecting Resident 1's health and well-being. Finding: A review of Resident 1's clinical record titled, ADMISSION RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included depression. A review of Resident 1's clinical document titled, Medication Administration Record, (MAR - a document that contained physician's orders and dates and times of medication administration) dated 3/1/25 through 3/31/25, the MAR indicated the following psychotropic medication order, QUEtiapine . 1 tablet by mouth for bi-polar . Order Date . 03/06/2025 . D/C [discontinue] 03/11/2025 . The medication quetiapine was administered from 3/7/25 through 3/10/25. Resident 1 did not have a diagnosis of bipolar as indicated in the order. During a concurrent interview and record review of Resident 1's clinical record, with the Director of Nursing (DON), on 5/1/25, at 3:51 p.m., the DON confirmed Resident 1's physician order did not have an accurate diagnosis for the administration of quetiapine. The DON explained the importance of an accurate diagnosis for medication administration was to ensure the facility was administering an appropriate medication for Resident 1's diagnosis. During an interview with Resident 1's physician (MD) 1, on 5/7/25, at 1:30 p.m., MD 1 stated a review of Resident 1's medications should have been completed. MD 1 explained that the facility should have been more diligent with the rationale as to why Resident 1 was prescribed a psychotropic medication. MD 1 further explained the nurses should have called MD 1 for clarification of the medication quetiapine, so he could have intervened sooner. MD 1 further explained that a bipolar diagnosis was not a preferred indication for the medication quetiapine. A review of the facility ' s policy titled, Psychotropic Medication Management, dated 11/2017, indicated, . Psychotropic Medications will only be used when necessary to promote or maintain a Resident's highest practicable mental, physical, and psychosocial well-being . PURPOSE To Avoid unnecessary medications and facilitate the proper use, dose, and duration of psychotropic agents in accordance with Resident assessed need(s) and condition(s) . When psychoactive medications are prescribed, the clinical record should reflect the diagnosis and specific condition or targeted behavior being treated . Informed Consent for psychoactive medications must be verified prior to use .