STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675958	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Care Center	1008 Citizens Trail Texarkana, TX 75501

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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** 45643 Based on interview and record review, the facility failed to promote resident self-determination through support of resident choice for 1 of 11 residents (Resident #10) reviewed for resident rights. The facility failed to ensure Resident #10 was provided a shower per his preference instead of bed baths. This failure could place dependent residents at risk for feelings of depression, lack self-determination and decreased quality of life. Findings included: Record review of the face sheet dated 04/19/23 indicated Resident #10 was an [AGE] year old male admitted on [DATE] with diagnoses including Vascular Dementia (a chronic condition that affects memory, thinking, and behavior), Hypertension (a common condition that occurs when the pressure in your blood vessels is consistently too high), Muscle Weakness (a lack of muscle strength that can make it difficult for muscles to contract or move as easily as usual). Record review of the Quarterly MDS dated [DATE] indicated Resident #10 was understood and understood others. The MDS indicated a BIMS score of 8 which indicated moderate cognitive impairment. The MDS indicated Resident #10 required partial/moderate assistance with bathing. The MDS indicated Resident #10 required partial/moderate assistance on staff for chair/bed-to-chair transfers. Record review of a care plan last revised on 07/5/24 indicated Resident #10 required assistance with all his ADL's and wheelchair transfers. During an interview on 08/19/24 at 9:53 a.m., Resident #10said he wanted to complain about not getting a shower. He said he had not had a shower in over 6 weeks. He said he didn't remember the last time he had a shower. He said that he had bed baths, but he wanted to take a shower. He said every time he had been offered a shower, he said yes but staff rarely offered him a shower. He said he preferred showers over bed baths. During an interview on 08/20/24 at 02:02 p.m., he said that he had not received a shower since the last time the surveyor spoke to him. He said that he had not been in the shower room for many weeks. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of shower schedule dated from 7/22/24 to 8/20/24 reflected Resident #10 only received bed baths and no showers during that time period. During an interview on 08/20/24 at 2:21 p.m., with the DON she said that it was the responsibility of charge nurses to ensure residents are having their showers as scheduled. She said that the issue with Resident #10 was brought to her attention. She said that according to documentation Resident #10 had only received bed baths. She said that she in-serviced staff today on following posted shower schedules. She said that residents who did not have their choices respected or followed were at risk for low self-esteem and it could make them unhappy. During an interview on 08/21/24 at 12:20 p.m., with the ADM he said that it was the responsibility of nurses to ensure that residents shower schedule was being followed. He said that residents can be placed at risk for being dissatisfied with services the facility rendered. Review of a Resident Rights facility policy dated November 2021 indicated, Residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States. They have the right to be free of interference, coercion, discrimination, and reprisal in exercising these rights as citizens of the United States Live in safe, decent and clean conditions.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment 1 of 11 residents reviewed for environment. (Resident #35) The facility failed to provide Resident #35 with a pillowcase. These failures could place residents at risk of an unsafe or uncomfortable environment and a decrease in quality of life and self-worth. Findings included: Record review of the face sheet dated 06/18/23 indicated Resident #35 was a [AGE] year-old male admitted on [DATE] with diagnoses including Hyperlipidemia (a condition where there are abnormally high levels of lipids or lipoproteins in the blood), Chronic Fatigue (a serious and often long-lasting illness that keeps people from doing their usual activities), Hypomagnesemia (a condition where the body has a lower-than-normal level of magnesium in the blood). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #35 was understood and understood others. The MDS indicated a BIMS score of 05 indicating Resident #35 was severely cognitively impaired. The MDS indicated Resident #35 required assistance from staff for activities of daily living. During an observation and interview on 8/19/24 at 9:47 a.m., Resident #35 was observed with a T-shirt underneath his head. He stated that he was lying on his T-shirt because he didn't want to lay on his pillow without its case. He said he didn't remember when it had been taken off, but he didn't want to lay on his pillow because the pillow was old and frayed. Resident #35's pillow was observed at his side near the middle of the bed lacking a pillowcase. The pillow appeared heavily used, frayed in areas, with parts of the pillow top layer peeling off. He said his pillow had been like that all night. He said he wanted the pillowcase put back on his pillow. During an observation and interview on 8/19/24 at 3:30 p.m., revealed Resident #35 was observed lying his head on the mattress with the pillow still lacking a pillowcase. He said that no one came and offered him a pillowcase. The Surveyor asked a staff in the hallway if they would bring him a pillowcase. Resident #35 said he was grateful to have a pillowcase which was provided to Resident #35. During an interview on 08/21/24 at 2:58 p.m., the DON said it was the responsibility of CNAs to ensure that residents bed linen was properly placed each day. She said that residents could be placed at risk of being dissatisfied with their environment if they lacked clean bed linens. During an interview on 08/21/24 at 4:24 p.m., the ADM said that it was the responsibility of CNAs to ensure that bed linens were on the bed after being cleaned and delivered by housekeeping. He said that residents could become dissatisfied with the services the facility rendered if they lacked clean bed linens. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Requested a policy on 8/21/24 at 4:24 p.m. regarding a homelike environment from the DON. A policy regarding proper sanitation of bed linens was received.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on interview and record review, the facility failed to develop and implement a Baseline Care Plan that included the instructions for resident care needed to provide effective and person-centered care for 1 of 5 residents reviewed for new admissions. (Resident #29) The facility failed to develop and implement a Baseline Care Plan for Resident #29 within 48 hours of admission. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of Resident #29's face sheet dated 8/19/24 indicated she was [AGE] years old and admitted to the facility initially on 5/04/24 and readmitted on [DATE] with diagnoses including hypoxic ischemic encephalopathy (lack of oxygen causing damage to brain), dementia (forgetfulness) with mood disturbance, major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), dysphagia (difficulty swallowing), weakness, cognitive communication deficit, heart disease, chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), respiratory failure, hypertension (high blood pressure), urinary tract infection, and sepsis (life-threatening complication of an infection). Record review of Resident #29's admission MDS assessment dated [DATE] indicated she was understood and understood others. Resident #29's BIMS score was 00 which indicated severely impaired cognition. Resident #29 had disorganized thinking. Resident #29 used a wheelchair for mobility. Resident #29 required maximal to moderate assistance for most ADL's. Resident #29 had an indwelling urinary catheter and was frequently incontinent of bowel. Resident #29 had a feeding tube and had a mechanically altered diet. Resident #29 was at risk for developing pressure ulcers. Resident #29 was on antianxiety and antidepressant medications. Resident #29 was receiving speech therapy, occupational therapy, and physical therapy. Record review of Resident #29's Baseline Care Plan revealed there was not a Baseline Care Plan completed. During an interview on 8/19/24 at 1:47 PM, Resident #29's RP said she was very satisfied with the care Resident #29 was receiving. Resident #29's RP said Resident #29 came from the hospital with a feeding tube (tube inserted into the stomach to administer nutrition) and a urinary catheter (tube placed in the bladder to drain urine). Resident #29's RP said Resident #29 no longer had the feeding tube or the urinary catheter. Resident #29's RP said Resident #29 admitted to the facility in May of 2024. On 8/20/24 at 3:25 PM, a Baseline Care Plan for Resident #29 was requested from the DON. The DON provided a care conference with the family done on 5/6/24. The Baseline Care Plan that was due within 48 hours of Resident #29's admission was requested. The DON said she was going back to look for it. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/23 at 9:30 AM, the Regional Nurse Consultant said there was not a Baseline Care Plan for Resident #29. During an interview on 8/21/24 at 10:55 AM, LVN C said she had worked at the facility for one and a half years and normally worked the 6 AM-6 PM shift. LVN C said the admitting nurse was responsible for completing the Baseline Care Plan. LVN C said the purpose of Baseline Care Plan was so staff knew what the resident was there for and what kind of care the resident needed, so everyone was on the same page to ensure the resident was getting the care that they needed. LVN C said if the Baseline Care Plan was not completed, staff would not know how to treat the resident effectively. LVN C said the Baseline Care Plan showed what medications the resident was, what the resident's discharge plans were, if they were a fall risk, what amount of assistance the resident needed, and any special needs or care the resident may need so staff can provide effective care. LVN C said if a resident had a feeding tube and/or a urinary catheter and the Baseline Care Plan was not completed, staff may not know how to care for them. During an interview on 8/21/24 at 11:19 AM, the ADON said the admission nurse was responsible for completing the Baseline Care Plan. The ADON said the purpose of Baseline Care Plan was to start developing the care of the resident and how the facility was going to take care of the resident, and to initiate the discharge plan or if the resident planned to reside long-term. The ADON said if there was no Baseline Care Plan, it would be difficult to communicate to the staff and family on how the facility was going to meet the resident's care needs. The ADON said nurse management, consisting of the ADON, DON, Treatment Nurse, MDS Nurse or anyone on the IDT team) was responsible for ensuring the Baseline Care Plan was completed. During an interview on 8/21/24 at 1:11 PM, the DON said the nurses were responsible for completing the Baseline Care Plan. The DON said the purpose of the Baseline Care Plan was to ensure that all parties knew how to care for the resident when the resident first arrived to the facility initially before the comprehensive care plan was built. The DON said the ADON or herself followed up behind the nurses to ensure the Baseline Care Plan was completed. The DON said the risk to the resident if there was not a Baseline Care Plan would be maybe the information might not get to the CNAs on what the resident required for care to meet their needs. The DON said nurses could visibly see a feeding tube or a foley catheter so they would know how to care for those, even if there was not a Baseline care Plan. Requested a policy for Baseline Care Plans on 8/21/24 at 1:25 PM from the DON. During an interview on 8/21/24 at 1:29 PM, the ADM said he would expect the Baseline Care Plan to be completed within 48 hours of admission. The ADM said the Baseline Care Plan was for the staff to know what care the resident needed. The ADM said the ADON and DON were responsible for ensuring the Baseline Care Plans were completed, along with the charge nurse. The ADM said the staff would not know the resident as well as they should know them if there was no Baseline Care Plan. On 8/21/24 at 1:46 PM, the DON said they did not have a policy on Baseline care plans.

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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** 44128 Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain personal hygiene for residents who are unable to carry out activities of daily living for 1 of 16 residents reviewed for ADL's. (Resident #22) The facility failed to remove facial hair from female Resident #22. This failure could place residents who required assistance from staff for ADL's at risk of not receiving care and services to meet their needs which could result in poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity and health. Findings included: Record review of a face sheet dated 08/20/24 revealed Resident #22 was an [AGE] year-old female and was admitted on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), major depressive disorder (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and generalize anxiety disorder (Severe, ongoing anxiety that interferes with daily activities). Record review of the most recent MDS dated [DATE] indicated Resident #22 was sometimes understood and sometimes understood others. The MDS indicated a BIMS score of 99 which indicated the resident was unable to complete the interview. The MDS indicated Resident #22 was dependent on staff for showers/baths and personal hygiene. Record review of a care plan dated 06/12/24 indicated Resident #22 had a diagnosis of depression. The care plan indicated the resident required assistance with ADL's. There was a long-term goal for the resident to maintain a sense of dignity by being clean, dry, odor free, and well groomed. There were interventions to assist Resident #22 with ADL's as needed and to assist/give showers, shave, provide oral, hair, and nail care as scheduled and as needed. There was no indication the resident refused care or was resistive to care. Record review of nurse's notes from 08/01/24 to 08/21/24 did not indicate Resident #22 had refused care or refused to be shaved. Record review of an undated Shower List indicated Resident #22 received baths on Tuesdays, Thursdays, and Fridays. Record review of a Point of Care History of ADL documentation dated 08/01/24 - 08/21/24 indicated Resident #22 had received her scheduled baths. The Point of Care History indicated CNA A had given Resident #22 partial bed baths on 08/19/24 and 08/20/24. During an observation on 08/19/24 at 12:14 p.m., revealed Resident #22 was in the dining room eating lunch. She had many gray chin hairs approximately 0.5 centimeters in length covering her chin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 08/20/24 at 7:55 a.m., revealed Resident #22 was sitting in bed eating breakfast. She had many gray chin hairs approximately 0.5 centimeters in length covering her chin and extending down to her neck. An attempt was made to interview the resident. She had garbled and unclear speech. What she was saying could not be understood. During an observation on 08/20/24 at 1:40 p.m., revealed Resident #22 was sleeping in bed. She had many gray chin hairs approximately 0.5 centimeters in length covering her chin and extending down to her neck. During an observation on 08/21/24 at 8:16 p.m., revealed Resident #22 was sleeping in bed. She had many gray chin hairs approximately 0.5 centimeters in length covering her chin and extending down to her neck. During an interview on 08/21/24 at 10:20 a.m., CNA A said she was the aide for Resident #22. She said she removed facial hair from female residents anytime she saw any. She said facial hair on female residents should at least be removed on bath days. She said residents were bathed three times a week. She said they had to be gentle with Resident #22. She said the last few days she had worked a different hall and had not provided care to Resident #22. She said she did not know why the resident's facial hair had not been removed. She said the facility had a lot of new aides. She said the new aides should at least attempt to remove facial hair from female residents. During an interview on 08/21/24 at 10:38 a.m., LVN B said the CNAs were responsible for removing facial hair from female residents. She said she usually helped the CNAs. She said facial hair should be removed on bath days if needed. She said some residents were bathed on Mondays, Wednesdays, and Fridays. Others were bathed on Tuesdays, Thursdays, and Saturdays. She said she was not sure what days Resident #22 was bathed. She said each resident was bathed three times a week. She said Resident #22 used to have a hospice aide that came to bathe her and remove her facial hair. She said Resident #22 did say no at times. She said any refusals should be charted in the progress notes. She said not removing facial hair from female residents could affect their confidence. During an interview on 08/21/24 at 12:32 p.m., the DON said the CNAs and nurses were responsible for removing facial hair from female residents. She said it was ultimately the nurses' responsibility to make sure it was done. She said facial hair should be removed from female residents when it could be seen. She said any refusals should be documented in the nurse's notes and care planned. She said she would have expected Resident #22's facial hair to have been removed or there have been some type of documentation indicated she refused. She said females with facial hair might feel embarrassed. During an interview on 08/21/24 at 12:48 p.m., the Administrator said unless a female wanted facial hair it needed to be shaved. He said if the female wanted the facial hair it should be care planned. He said CNAs were responsible for removing facial hair from female residents with oversight from the charge nurses and nurse management. He said the appearance of facial hair on females did not look good. Record review of a Shaving the Resident facility policy dated 12/2017 indicated, .It is the policy of this home to ensure that residents are groomed to include shaving to promote a sense of well-being and dignity . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Activities of Daily Living facility policy dated 12/2017 indicated, .It is the policy of this home to assure resident have their activities of daily living met .encourage resident to apply shave cream or electric preshave .

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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** 46062 Based on interviews and record review, the facility failed to ensure each residents' drug regimen was free from unnecessary psychotropic drugs (without adequate behavior monitoring) for 1 of 7 residents (Resident #39) whose medications were reviewed in that: 1. The facility failed to ensure Resident #39 had side effect monitoring (monitoring for unintended responses to medication) for his prescribed Quetiapine (an antipsychotic medication used to treat several types of mental health conditions) during the months of July and August 2024. 2. The facility failed to ensure Resident #39 had behavior monitoring for his prescribed Quetiapine during the months of July and August 2024. These failures could place residents at risk of not receiving the intended therapeutic benefits of their psychotropic medications. Findings included: Record review of Resident #39's face sheet dated 8/19/24 indicated he was [AGE] years old and admitted to the facility initially on 11/29/22 and readmitted on [DATE] with diagnoses including dementia, severe, with behavioral disturbance (severe forgetfulness with behavioral disturbances such as agitation, delusions (belief in things that were not real), hallucinations (seeing, hearing, or feeling things that were not there)), major depressive disorder (serious mood disorder that could affect how people feel, think, and function in their daily lives), and cognitive communication disorder. Record review of Resident #39's quarterly MDS assessment dated [DATE] indicated he was understood and usually understood others. Resident #39 had a BIMS score of 3 which indicated he had severe cognitive impairment. The MDS indicated Resident #39 had disorganized thinking. The MDS indicated Resident #39 had diagnoses including non-Alzheimer's dementia, depression, dementia, severe, with other behavioral disturbances. The MDS indicated Resident #39 was receiving antipsychotic medications. Record review of Resident #39's care plan last updated 8/19/24 revealed he had behavioral symptoms with episodes of inappropriate behaviors as evidenced by threatening other residents; he had impaired cognitive function; he had a diagnosis of depression; he resided in the secure unit related elopement/wandering; and he required psychotropic drugs (taken to effect the chemical makeup of the brain and nervous system, used to treat mental disorders, and included the anti-psychotic class of medications) for the treatment of depression with interventions to educate the resident/family/caregivers about the risks, benefits and side effects and/or toxic symptoms. Record review of Resident #39's Physician Order Report dated 7/21/24-8/21/24 revealed an order for Quetiapine 25 mg 2 tablets (50 mg) twice daily and 100 mg 2 tablets at bedtime with an order date of 7/25/24. Further review revealed there was no order for side effect monitoring or behavioral monitoring noted for antipsychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #39's MAR dated 7/01/24-7/31/24 indicated Resident #39 was ordered and received Quetiapine 25 mg 2 tablets (50 mg) twice daily and 100 mg 2 tablets at bedtime with start dates of 7/25/24. There was no documentation of behavior or side effect monitoring noted for antipsychotic medications. Record review of Resident #39's MAR dated 8/01/24-8/21/24 indicated Resident #39 was ordered and received Quetiapine 25 mg 2 tablets (50 mg) twice daily and 100 mg 2 tablets at bedtime with start dates of 7/25/24. There was no documentation of behavior or side effect monitoring noted for antipsychotic medications . During an interview on 8/19/24 at 3:09 PM, Resident #39's RP said Resident #39 had to go to the behavioral hospital last month. Resident #39's RP said they had started Resident #39 on a new medication for his behaviors, but she could not remember the name of it. Resident #39's RP said the facility called her and asked if they could give him the new medication and she agreed. Resident #39's RP said she did not remember if they discussed the side effects of the medication. Resident #39's RP said she came to visit Resident #39 last week. During an interview on 8/19/24 at 3:51 PM, Resident #39 said he was doing good and making progress with his therapy. Resident #39 said he did not know what medication he was taking. During an interview on 8/21/24 at 10:55 AM, LVN C said she had worked at the facility for one and a half years and normally worked the 6 AM-6 PM shift in the memory care unit. LVN C said the ADON, or the DON put the side effect and behavioral monitoring into the Matrix software and the nurses put the actual medication into the Matrix software. LVN C said the purpose of having the side effect and behavioral monitoring was so the nurses could monitor side effects and behaviors to determine if the resident continued to need the medication or was having any adverse effects from the medication. LVN C said the risk to the resident if side effect and behavioral monitoring was not on the resident's chart was the resident could experience side effects of the medication or continue to have behaviors and it would not be documented. LVN C said if side effects or behaviors were not being monitored or documented, then they would not know there was an issue and know they would need to contact physician for something abnormal. LVN C said side effect and behavioral monitoring was on the MAR to prompt the nurses to document any behaviors and side effects and it listed side effects and behaviors to watch for and required documentation each shift. During an interview on 8/21/24 at 11:19 AM, the ADON said she had worked at the facility for about a year. The ADON said the nurses were responsible for adding the behavioral and side effect monitoring when entering the medications into the resident's chart. The ADON said the purpose of the behavioral and side effect monitoring was to make sure the resident was not having any side effects and to monitor if the medication was being effective in treating a specific behavior. The ADON said if there was no behavioral or side effect monitoring being documented related to an antipsychotic medication, then you would not be effectively caring for the resident. The ADON said nurses should be monitoring and documenting behaviors and side effects every shift. The ADON said the nurse management team was responsible for ensuring behavioral and side effect monitoring was added to the residents MAR, so the MAR would prompt the nurses to document any behaviors or side effects and any interventions attempted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675958	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Care Center	1008 Citizens Trail Texarkana, TX 75501

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 - Few	During an interview on 8/21/24 at 1:11 PM, the DON said the nurses were responsible for adding the behavioral and side effect monitoring to the resident's chart when the new antipsychotic medication was started. The DON said the purpose of behavioral and side effect monitoring was to make sure the medication was working for the resident and not having behaviors and to ensure the resident was not having side effects to the medications. The DON said there should be an order for behavioral and side effect monitoring in the Matrix software and they should be documented on the MAR. The DON said if behavioral and side effect monitoring was not being documented in the resident's chart, it could delay treatment and other staff may not know the resident was having behaviors or side effects. The DON said if the behavioral and side effect monitoring was not documented, the physician may not see the continued behaviors or any side effects to determine if any treatment changes were needed. The DON said the ADON or herself were responsible for ensuring the monitoring for behaviors and side effects were added to the MAR . The DON said the residents should have documentation every shift for behavioral and side effect monitoring documented on the MAR. During an interview on 8/21/24 at 1:29 PM, the ADM said he would expect a resident on an antipsychotic medication to have behavioral monitoring and side effect monitoring. The ADM said you want to see the progress of the medication and effectiveness to see if any changes needed to be made. The ADM said he would not have sufficient documentation for that resident if there was no behavioral monitoring or side effect monitoring for an antipsychotic medication. The ADM said the behavioral and side effect monitoring should be documented in the progress notes. Record review of the facility's policy titled, Behavioral Management-Psychoactive Medication-Antipsychotic Drug Therapy, dated 12/2017, indicated . it was the policy of the home to use antipsychotic medications per CMS guidelines and to perform dose reductions and monitoring as required by regulation, to promote the highest level of resident care and safety . documenting the specific behaviors which the resident exhibits . for residents receiving an antipsychotic medication for behavioral symptoms related to an organic mental syndrome, all symptoms or behaviors which relate to the specific condition for the drug's use would be listed on the appropriate clinical software monitoring flow sheet . at the end of each shift, the nurse would document the number of times each behavior occurred . each month, the nursing staff would sum the occurrences of each behavior and record a total for each one . determining the need for a dose reduction . when the resident's behavior [NAME] was stable, that is, there was no instances of behaviors documented during a two month period consecutively, the consultant pharmacist would send a recommendation to the resident's physician . monitoring for adverse effects . on the behavior monitoring form or on the MAR, the nurse would indicate the presence of an adverse effect by checking off any appropriate adverse effect listed, or describing any others noted .