STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676119	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande City Nursing and Rehabilitation Center	2530 Central Palm Dr Rio Grande City, TX 78582

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care received such care consistent with professional standards of practice and the comprehensive person-centered care plan for 1 of 1 resident (Resident #83) reviewed for respiratory care. The facility failed to ensure Resident #83 received oxygen at the prescribed rate. He received oxygen at a rate less than prescribed. This failure could place residents receiving oxygen at risk for respiratory distress. The findings included: Record review of Resident #83's Quarterly MDS assessment dated [DATE] revealed resident with a BIMS score of 06 which suggests a severe cognitive impairment. Resident required Substantial/maximal assistance for self-care except eating and oral hygiene which required supervision or touching assistance. Resident with diagnosis of Congestive Heart Failure and Pulmonary Fibrosis and received oxygen therapy under special treatments/respiratory treatments. Record review of Resident #83's Face Sheet dated 8/7/24 revealed the following diagnosis: Acute Pulmonary Edema (a condition caused by too much fluid in the lungs, making it difficult to breathe), Pulmonary Fibrosis (a condition in which the lungs become scarred over time which makes it difficult to breathe), Chronic Obstructive Pulmonary Disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs, Heart failure (occurs when the heart muscle does not pump blood as well as it should, which caused blood to back and fluid to build up in lungs causing shortness of breath), Hypertension (high blood pressure) and Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). Record review of the Care Plan for Resident #83 revealed resident has Oxygen at 4LPM via Nasal Canula every shift for Pulmonary Fibrosis to maintain O2 above 90% Date Initiated: 03/26/2024 Revision on: 07/18/2024. Interventions include: o Medication per MD orders. Date Initiated: 03/26/2024. o Oxygen at 4LPM via Nasal Canula Date Initiated: 05/27/2024. o Oxygen Saturation - Check every 6 hours for hypoxia (low levels of oxygen in your body tissues which causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate and bluish skin). Date Initiated: 03/26/2024. Revision on: 07/18/2024. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has altered respiratory status/difficulty breathing r/t Pulmonary Edema/Fibrosis. Date Initiated: 04/04/2024 Revision on: 04/04/2024. Interventions include: o OXYGEN SETTINGS: O2 via nasal cannula as ordered Date Initiated: 04/04/2024 Revision on: 04/04/2024. Record review of the Doctor's Order Summary revealed Resident # 83 was prescribed Oxygen at 4LPM via Nasal Canula every shift for Pulmonary Fibrosis to maintain O2 above 90%. Order and Start Date: 04/03/2024 . Oxygen Saturation - Check (frequency) every 6 hours for hypoxia. Order and Start Date: 04/03/2024. Record review of Skilled Administration Record for Resident #83 revealed an order for Oxygen at 4LPM via Nasal Canula every shift for Pulmonary Fibrosis to maintain O2 above 90%. Start Date: 4/03/24 and Oxygen Saturation Check (frequency) every 6 hours for hypoxia -Start Date: 04/03/2024. On 08/5/24 at 12:55 PM observed Resident #83 sitting up in wheelchair. Groomed and dressed appropriately. Room was clean and without clutter. Resident with no complaints. She said that all staff treat her well. Resident received O2 via nasal cannula and this surveyor observed O2 set at 3.0 LPM. Resident denied any shortness of breath or difficulty breathing. Observation and interview 08/5/24 at 12:55 AM LVN A she said that since Resident #83 arrived at facility, she had been on 4L of O2 via NC. She said that the Resident does not adjust the O2 herself. She said the nurse is supposed to check that the rate of the oxygen is accurate every shift. She said they don't move the oxygen unless there is an order. She said that her shift began at 6:00 am and when she arrived, she rounded with the night nurse. She said she didn't check the flow rate at that time. LVN assessed O2 and said it was set between 3L and 4L, then adjusted the rate to 4L. She said this was the first time Resident #83's oxygen was below 4L. She checked the resident's O2 saturation = 99. Resident denied shortness of breath or difficulty breathing. She said that she feels like she could dance. LVN said that if a resident receives less oxygen than prescribed by doctor, their oxygen saturation can drop. On 08/5/24 at 10:54 AM interviewed LVN B and she said that all nurses are responsible for ensuring the rates for O2 are accurate. She said that she checked O2 levels for her residents to make sure they are accurate every round we make and that includes during initial rounds. She said that if a resident received less oxygen than prescribed by the MD, their O2 saturation could go low. She said they can become short of breath and become cyanotic (a bluish or purple color in the skin, lips, and nail beds that's caused by low oxygen levels in the blood). She said that they would notify MD. On 8/7/24 at 1:30 PM interviewed ADON/RN and she said that the oxygen rate should be checked every shift by the floor nurse, usually when they enter and doing their initial rounds. She said that the O2 saturations are checked every 6 hrs. She said that if a resident received less oxygen than prescribed by the doctor, the resident could have a drop to their O2 saturations. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 1:55 PM interviewed the DON and she said that licensed nurses are responsible to ensure O2 rates are accurate every shift. She said that the nurses should check the oxygen rate when coming on shift and checking to see if the order is accurate. She said that the responsibility falls on the floor nurse of the hallway. She said she also completes rounds and spot check oxygen rates. She said that if a resident received less oxygen than the doctor prescribed, the resident could have shortness of breath. She said that Resident #83 also had orders to check her oxygenation saturation every 6 hours. She said that Resident #83 has a family member who comes and spends most of the day with the resident, so either the resident or the family will vocalize any of the Resident's needs. The DON said that the staff have already been in-serviced. On 8/7/24 the DON provided me with a copy of pages 179-180 out of the Lippincott Nursing Procedure. As per RCN/RN, they do not have an Oxygen Administration policy, they use [NAME] as their guidance. Record review of [NAME] 11th Edition, pp 179 -180, Administering Oxygen Therapy revealed: Administering Oxygen Therapy: Oxygen is used to treat or prevent symptoms and manifestations of hypoxia. Methods of Oxygen Administration: 1. Nasal cannula - nasal prongs that deliver low or high flow of the oxygen. a. Requires nose breathing. b. Cannot deliver oxygen concentrations much higher than 40%. Nursing Assessment and Interventions: 1. Assess need for oxygen by observing for symptoms of hypoxia . 3. Administer oxygen in the appropriate concentration and device . 5. Increase or decrease the inspired oxygen concentration, as appropriate.

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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** 26141 41761 Based on interview and record review the facility failed to ensure 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 3 (Resident #14, Resident #58, and Resident #65) of 7 residents whose records were reviewed for pharmacy services. 1.The facility failed to ensure Resident #14 was not prescribed Risperidone (an antipsychotic) without appropriate diagnosis for its use. 2.The facility failed to ensure Resident #58 was not prescribed Seroquel (an antipsychotic) without appropriate diagnosis for its use. 3.The facility failed to ensure Resident #65 was not prescribed Seroquel (an antipsychotic) without appropriate diagnosis for its use. This deficient practice could place residents without a diagnosis for taking psychotropic medications at risk for receiving unnecessary medications. The findings were: 1. Record review of Resident #14's admission record, dated 08/06/2024, revealed he was a [AGE] year old female, admitted to the facility on [DATE], with diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, psychotic disturbance, mood disturbance, and ant, hypertension (high blood pressure), atherosclerotic heart disease (CAD - coronary artery disease which is characterized by a buildup of plaque, or fatty deposits, in the walls of the coronary arteries, which supply blood to the heart that narrows the arteries and reduces or blocks blood flow), chronic kidney disease, Stage 3B (a late stage of the disease that indicates moderate to severe kidney function loss), and osteoporosis (brittle bones). Record review of Resident #14's quarterly MDS assessment dated [DATE], revealed Resident #14 had a BIMS of 10 which indicated her cognition was moderately impaired. Resident #14 had minimal difficulty hearing and staff could understand her and she was able to understand. Resident #14 was always continent of bladder and occasionally incontinent of bowels. Record review of Resident #14's comprehensive person-centered care plan revised date of 06/06/2024 revealed Focus .the resident uses antipsychotic medication Risperidone r/t mood disorder (dementia with behavioral disturbance) aeb paranoia. Date initiated: 04/16/24 Revision on: 04/16/24. Interventions/Tasks Monitor/document/report PRN any adverse reactions of antipsychotic medications . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Physician Order dated 04/15/2024, risperiDONE Oral Tablet 0.25 MG (Risperidone) Give 1 tablet by mouth at bedtime for Mood disorder (dementia with behavioral disturbances) Start 04/15/2024 1107 (11:07 a.m.) Record review of Consultant Pharmacist / Physician Communication dated 04/17/2024 revealed, This resident (Resident #14) has an order for an antipsychotic, Risperidone 0.25 mg QHS, with an inappropriate diagnosis. Please attempt a gradual dose reduction to Risperidone 0.25 mg QOD HS for 2 weeks then discontinue and/or clarifying the diagnosis and making the necessary corrections. Record review of April 2024 MAR revealed Resident #14 was to receive risperiDONE Oral Tablet 0.25 MG (Risperidone) Give 1 tablet by mouth at bedtime for Mood disorder (dementia with behavioral disturbances) Start 04/15/2024 2000 (08:00 p.m.) -D/C Date - 05/16/2024 1654 (04:54 p.m.) Record review of Physician Order dated 05/16/2024, risperiDONE Oral Tablet 0.25 MG (Risperidone) Give 1 tablet by mouth at bedtime for Mood disorder (dementia with behavioral disturbances) Start 05/16/2024 1654 (04:54 p.m.) Record review of Consultant Pharmacist / Physician Communication dated 05/28/2024 revealed, This resident (Resident #14) has an order for an antipsychotic, Risperidone 0.25 mg QHS, with an inappropriate diagnosis. Please attempt a gradual dose reduction to Risperidone 0.25 mg QOD HS for 2 weeks then discontinue and/or clarifying the diagnosis and making the necessary corrections. Record review of May 2024 MAR revealed Resident #14 was to receive risperiDONE Oral Tablet 0.25 MG (Risperidone) Give 1 tablet by mouth at bedtime for Mood disorder (dementia with behavioral disturbances) Start 05/16/2024 2000 (08:00 p.m.) -D/C Date - 06/04/2024 1654 (04:54 p.m.) Record review of Physician Order dated 06/04/2024, risperiDONE Oral Tablet 0.25 MG (Risperidone) Give 1 tablet by mouth at bedtime for Mood disorder (dementia with behavioral disturbances) Start 06/04/2024 1654 (04:54 p.m.) Record review of June 2024 MAR revealed Resident #14 was to receive risperiDONE Oral Tablet 0.25 MG (Risperidone) Give 1 tablet by mouth at bedtime for Mood disorder (dementia with behavioral disturbances) Start 06/04/2024 2000 (08:00 p.m.) -D/C Date - 08/01/2024 1216 (12:16 p.m.) Record review of Progress Notes dated 08/01/24 at 12:13 p.m. Progress Note written by ADON/LVN: Note Text: Telemed consult with PA. Medications reviewed and behaviors discussed. Resident (#14) with no abnormal behavioral noted at this time. Recommendations to dc risperiDONE Oral Tablet 0.25 MG (Risperidone) at bedtime. RP agreed to recommendations. Orders carried out, SN to report any changes if any. 2. Review of Resident #58's Face Sheet dated 8/7/24, revealed he was a [AGE] year-old male originally admitted to the facility 11/6/22 with a most recent admitted [DATE]. He had diagnoses which included Alzheimer's disease; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; Parkinson's disease; unspecified mood disorder; depression, psychotic disorder with hallucinations due to known physiological condition; and depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #58's Comprehensive MDS Assessment, dated 4/14/24, revealed Resident had a BIMS of 05 which indicated a severe cognitive impairment. Resident Self-Care required substantial/maximal assistance for all ADLs. Revealed Resident had diagnosis of Alzheimer's Disease, Non-Alzheimer's Dementia, Parkinson's Disease, Unspecified dementia, unspecified severity without behavioral/psychotic/mood/anxiety. Resident received an antipsychotic. Review of Resident #58's most recent Care Plan, revealed: The resident has impaired cognitive function abilities and has impaired thought processes as he is forgetful/confused and needs to be given cues daily r/t Alzheimer's/Dementia Date Initiated: 11/07/2022 Revision on: 08/06/2024. Interventions include the following: Seroquel Black Box Warning: Increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Quetiapine is not approved for the treatment of patients with dementia-related psychosis. Suicidal thoughts and behavior. Antidepressants increased the risk of suicidal thoughts and behavior in children, adolescents, and young adults in short-term studies. These studies did not show an increase in the risk of suicidal thoughts and behavior with antidepressant use in patients older than [AGE] years; there was a reduction in risk with antidepressant use in patients [AGE] years and older. In patients of all ages who are started on antidepressant therapy, monitor closely for clinical worsening and for emergence of suicidal thoughts and behaviors. Advise families and caregivers of the need for close observation and communication with the prescriber. Quetiapine is not approved for use in pediatric patients younger than [AGE] years. Date Initiated: 12/22/2022 Revision on: 10/08/2023. Review of Resident #58's Order Entry, order date 5/13/24, revealed: Seroquel Oral Tablet 200 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for Dementia with Psychotic Features. Review of Resident #58's Order Summary Report, dated 8/8/24, revealed: Seroquel Oral Tablet 200 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for Mood disorder (depression behavioral disturbances). Active Phone Order/Start Date: 8/6/24. Review of Resident #58's MAR for May 2024 revealed: Seroquel Oral Tablet 200 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for Dementia with Psychotic Features Start Date: 05/13/2024 D/C Date: 08/06/2024. Medication administered 5/13/2024 to 5/31/2024. Review of Resident #58's MAR for June 2024 revealed: Seroquel Oral Tablet 200 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for Dementia with Psychotic Features Start Date: 05/13/2024 D/C Date: 08/06/2024. Medication administered 6/1/2024 to 6/30/2024. Review of Resident #58's MAR for July 2024 revealed: Seroquel Oral Tablet 200 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for Dementia with Psychotic Features Start Date: 05/13/2024 2000 D/C Date: 08/06/2024 1816. Medication administered 7/1/2024 to 7/31/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #58's MAR dated 8/7/24 revealed August 2024 medication order: Seroquel Oral Tablet 200 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for Dementia with Psychotic Features. Start Date: 05/13/2024 D/C Date: 08/06/2024. Medication administered 8/1/2024 to 8/5/2024. Seroquel Oral Tablet 200 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for Mood disorder (depression behavioral disturbances) Start Date: 08/06/2024. Record review of the Consultant Pharmacist/Physician Communication on 4/25/2024 revealed that the Pharmacy Consultant informed the prescriber that Resident #58 had an order for an antipsychotic, Seroquel 200 mg QHS with an inappropriate diagnosis. Consultant pharmacist recommended a gradual dose reduction with the goal of discontinuing the medication and /or clarifying the diagnosis and making the necessary corrections. The prescriber checked the box disagreed and wrote Dx modified 5/13 dated 5/15/24. On 8/7/24 at 3:35 pm interviewed LVN C. She said that she felt that if the Seroquel is helping him to not hurt himself or others, it is ok to give him the medication. She said that the resident still has the behaviors even if taking medication. She said that she is aware of the Black Box Warning. She said that they don't give these medications to put residents to sleep, they just want them to not hurt themselves or others. She said that when she received medication orders from the MD, she typed into PCC, and it links to the Pharmacy. She said that they receive a form that medication is a Black Box Warning. She said when they do the order on PCC and try to submit, it gives them a screen that the medication has a Black Box Warning. She said that when it flags them, they must enter a note that they are aware of the Black Box Warning and follow the MD orders that were prescribed. On 8/7/24 at 4:24 pm interviewed LVN A. She said, Honestly with Resident #58, he went to see his MD and they made changes to his medication. The family was not happy about it. The family noticed he was very aggressive when they made the changes. She said that the psychiatrist made the order for Seroquel with Dementia and Psychotic Dx on the order. She said they just go by the order. She said usually if she is rounding, she will receive the order verbally with in-house prescriber and then complete a progress note. If the order comes from outside of the facility, they follow what orders they send. She said that she types everything into PCC. She said that Black Box warnings will come up with Seroquel. She said that when those come up, they notify doctor and see if he/she still wants to continue with the order. She said that she has never completed a progress not regarding the communication for Black Box Warnings. She said that she just carries out what the prescribers want. 3. Record review of Resident #65's Admission Face Sheet, dated 08/08/24, revealed he was a [AGE] year-old male admitted to the facility 09/14/23, with the following diagnoses: unspecified dementia with other behavioral disturbance (a condition characterized by progressive or persistent loss of intellectual functioning resulting from organic disease of the brain); major depressive disorder (a mood disorder that causes persistent feeling of sadness and loss of interest); Wernicke's encephalopathy (a condition that is similar to dementia and is caused by drinking too much alcohol); anxiety disorder (any group of mental conditions characterized by excessive fear or apprehension about real or perceived threats, leading to altered behavior); unspecified mood (Affective) disorder (condition with emotional behavior inappropriate for one's age or circumstances characterized by unusual excitability, guilt, anxiety, or hostility). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #65's Significant Change MDS assessment, dated 05/21/24, indicated Resident #65 was rarely understood by others, would sometimes understand others, had severe cognitive impairment, did not have any behaviors and antipsychotic medication was received on a routine basis. Record Review of Resident #65's care plan dated 12/05/23 and revised on 05/24/24 revealed Resident #65 uses antipsychotic medication (Seroquel) that included the interventions of Black Box Warning of increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Quetiapine (Seroquel) is not approved for the treatment of patients with dementia-related psychosis. Suicidal thoughts and behavior. Record review of Resident #65's Physician's Orders, dated July 2024, revealed an order for Seroquel (antipsychotic medication) 200 mg give one tablet via Peg-tube two times a day mood disorder (Dementia with behavioral disturbance), the order start date was for 05/28/24 and the discontinue date was 08/01/24. Record review of Resident #65's Medication Administration Record, for August 2024 revealed Resident #65 received the antipsychotic medication Seroquel 200 mg on 08/01/24 for mood disturbance (dementia with behavioral disturbance). Record review of the Consultant Pharmacist/Physician Communication Report dated 12/28/23 revealed the Pharmacy Consultant made a recommendation to the facility that This resident (Resident #65) had an order for an antipsychotic, Seroquel 150 md BID, with an inappropriate diagnosis. Please attempt a gradual dose reduction to Seroquel 100 mg BID with the goal of discontinuing the medication and/or clarifying the diagnosis and making the necessary corrections. The prescriber checked the box disagreed and wrote continue with medication. In an interview on 08/07/24 at 3:33 PM LVN C said Resident #65 had behaviors of aggression during care. Resident #65 was bed bound. LVN C said Resident #65 went to the hospital and was very aggressive and was trying to get out of bed, so the hospital put Resident #65 back on the antipsychotic medication. LVN C said they try not to use the antipsychotic but when they have behaviors of aggression , they will prescribe an antipsychotic. LVN C said when they try to do the peg care Resident #65 will punch her. LVN said residents with dementia should not be prescribed antipsychotic medications but sometimes they are necessary for their safety and safety of others. LVN said would put the order into PCC when the physician prescribed an antipsychotic. The PCC is linked to the Pharmacy and the pharmacy would get the order. PCC will alert the nurse that there is a black box warning, and the nurse needs to acknowledge the warning. The LVN said if there is a problem with the diagnosis the pharmacy will ask them to clarify. The nurse can then call the doctor to clarify the diagnosis. In an interview on 8/8/24 at 2:09 pm ADON/LVN said that she deals with all the antipsychotic medications. She said that she received recommendations via emails, prints them out and then she separated the forms by doctor. She said that they usually try to call psych for any psych medication recommendations. She said that the psych PA for the facility comes once a month. She said that she showed or called the PA to get her recommendations. She said that Resident #58 had his own PCP or another psych he sees. The ADON/LVN said that from what she has read, antipsychotics are not recommended for diagnosis of Dementia, but we go by what the doctor's usually recommend. She said that she didn't know why the MD disagreed with the pharmacist recommendations for GDR and recommended Dx modified but was not. She said that she would have to go back and look at why. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview 8/8/24 at 3:08 pm DON said that she and her ADONs receive medication orders. She said that she goes over them with her ADONs and that they go over when they discuss with the doctors. She said that it should be a team approach. She said that she read the diagnosis and they would see if they needed clarification or a psych evaluation to ensure Dx is appropriate. She said that Dementia is not an appropriate diagnosis for an antipsychotic medication. She said that it should be a different diagnosis. She said that if a resident is given an antipsychotic for a Dx of dementia, they could have adverse effects depending on the side effects of the individual medication. She said that is why they monitor and report all psych medications. Record review of facility's Psychotropic Policy, date implemented 08/15/22, revealed: Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). 49301