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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 10/12/21.	F 000		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		

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

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.

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maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:

The facility had a census of 43 residents. The sample included 13 residents with six reviewed for unnecessary medications. Based on observation, interview, and record review the facility's consultant pharmacist failed to notify the Director of Nursing, medical director, or the residents' physicians regarding six of six sampled residents' PRN (as needed) psychotropic medications (chemical substance that changes nervous system function and results in alterations in perception, mood, consciousness, cognition, or behavior) lacked a required stop date, Resident (R) 10, R18, R26, R29, R32, R33.

Findings included:

- R26's "Significant Change Minimum Data Set" (MDS), dated 08/11/21, documented severely impaired decision making, and received antipsychotic (used to treat psychotic disorders), and antidepressive (used to alleviate depression) medications 7 days of the lookback period.

The "Care Area Assessment" (CAA), dated 08/11/21, documented R26 received Ativan (antianxiety medication) as needed for severe anxiety. These medications are associated with Black Box Warnings (BBW) (these warnings communicate potential rare but dangerous side effects).

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The "Medication Care Plan," dated 08/25/21, directed staff to provide medications to alleviate agitation as physician ordered, monitor and document side effects and effectiveness. R26 used to respond well to familiar staff; however, she doesn't seem to recognize people anymore. This often leads to an increase in frustration and anxiety, ask yes or no questions in order to determine the resident's needs. The care plan included the BBW for Ativan, may result in sedation, respiratory depression, or death.

The "Physician Order," dated 02/02/21, directed staff to administer to R26 Ativan, 0.5 milligrams (mg), three times daily as needed for severe anxiety. The order did not include a required stop date.

The "Consultant Pharmacist Reviews" dated 02/24/21, 03/27/21, 04/21/21, 05/24/21, 06/21/21, 07/29/21, 08/28/21, and 09/23/21 did not address the use of the PRN Ativan without a stop date. On 02/24/21 and 06/24/21 the consultant pharmacist requested a risk versus benefit statement for the continued use of Ativan but did not request a stop date.

On 09/29/21 at 04:51 PM, observation revealed R26 seated in a recliner in her room. R26 appeared calm and more alert than earlier in the day.

On 10/04/21 at 07:50 AM, Certified Medication Aide (CMA) S stated the resident showed anxiety or agitation when staff rolled her over during cares. CMA S stated PRN Ativan was rarely used.

On 10/04/21 at 04:28 PM, Administrative Nurse D verified the resident's Ativan order lacked a stop

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date and the facility's consultant pharmacist had not notified the physician, the medical director, or her of the lack of stop date for the use of the PRN Ativan.

On 10/06/21 at 10:20 AM, Consultant Pharmacist (CP) GG verified the PRN antianxiety medications required an initial stop date of 14 days, and then could be ordered for longer if needed.

The facility's "Monthly Medication Review" policy, dated October 2021, documented the consultant pharmacist provides a review and analysis of prescribed medication therapy and medication use review, including nursing documentation of medication ordering and administration. Findings and recommendations are reported to the administrator, Director of Nursing, the responsible physician, and the Medical Director.

The facility's consultant pharmacist failed to notify the Director of Nursing, the medical director, or the physician of the lack of required stop date for R26's PRN Ativan.

- R32's "Significant Change Minimum Data Set" (MDS), dated 08/19/21, documented Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS documented R32 received antianxiety medication (drug used to relieve anxiety) four days of the lookback period.

R32's "Care Plan," dated 07/22/21, documented the resident received Black Box Warning (BBW- these warnings communicate potential rare but dangerous side effects) medications.

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The "Physician Order," dated 09/09/21, directed staff to administer PRN Ativan, 0.5 milligrams (mg) every four hours, as needed. The order lacked a stop date.

The "Pharmacist Review," dated 09/23/21 lacked recommendation to include a stop date for the PRN Ativan.

On 09/30/21 at 09:53 AM, observation revealed R32 seated in bed when Certified Medication Aide (CMA) S administered medications to him without problems.

On 10/04/21 at 04:28 PM, Administrative Nurse D verified the resident's Ativan order lacked a stop date and the pharmacist had not notified the physician, the medical director, or her of the lack of stop date for the use of the PRN Ativan.

On 10/06/21 at 10:20 AM, Consultant Pharmacist (CP) GG verified the PRN antianxiety medications required an initial stop date of 14 days, and then could be ordered for longer if needed.

The facility's "Monthly Medication Review" policy, dated October 2021, documented the consultant pharmacist provides a review and analysis of prescribed medication therapy and medication use review, including nursing documentation of medication ordering and administration. Findings and recommendations are reported to the administrator, Director of Nursing, the responsible physician, and the Medical Director.

The facility's consultant pharmacist failed to notify the Director of Nursing, the medical director, or the physician of the lack of required stop date for

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R32's PRN Ativan.

- Resident (R) 10's "Physician Order Sheet" (POS), dated 09/08/21, documented diagnoses of major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) with psychotic features, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), psychotic disorder (mental disorder characterized by a gross impairment in reality testing) with delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disturbance.

The "Quarterly Minimum Data Set" (MDS), dated 07/19/21, recorded the resident had moderately impaired cognition, physical behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others which occurred one to three days of the look back period. The MDS further documented R10 received an antipsychotic (class of medications used to treat psychosis and other mental emotional conditions), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), and hypnotic (a sleep inducing drug) seven days during the look back period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 01/29/21, had not been completed.

The "Care Plan" dated 08/10/21, recorded the

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resident chose to isolate herself in her room, had diagnoses of anxiety, depression with psychosis, periods of paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking), and fabricate situations or ideas when anxious. The care plan further recorded the resident received Xanax (medication to treat anxiety) as needed for anxiety which is a Black Box Warning (BBW - these warnings communicate potential rare but dangerous side effects) medication, which directed to limit dosages and durations to the minimum required, and follow patients for signs and symptoms of respiratory depression and sedation.

The "Physician Order Sheet" (POS), dated 09/08/21, directed staff to administer Xanax 0.25 milligrams (mg) by mouth every eight hours PRN for anxiety. The start date for the order was 02/01/21 and did not include a required stop date.

The "Pharmacist Record Review", dated 04/21/21, documented a request for a risk versus benefit statement for the use of Xanax from the physician. The request lacked guidance for 14-day discontinuation.

The "Pharmacy Record Reviews," dated 05/24/21, 06/21/21, 07/14/21, and 08/11/21, did not address the use of the PRN Xanax without a stop date.

The "Pharmacist Record Review," dated 09/08/21, documented a request to the physician for a gradual dose reduction of Xanax 0.25 mg every eight hours PRN. The pharmacist's note lacked guidance for a 14 day discontinuation for PRN antianxiety medication. The physician

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responded, do not attempt to taper the dose of the medication due to chronic anxiety.

The "Progress Note" dated 09/08/21 at 08:01 PM, documented the physician saw the resident earlier in the day, and the resident had no complaints or concerns. The note further documented vital signs and medication reviewed and no changes were ordered.

On 10/04/21 at 09:07 AM, observation revealed the resident was anxious to lie in bed and staff transferred the resident to her bed.

On 10/04/21 at 02:50 PM, Administrative Nurse D stated as needed psychotropic medications should have a stop date of 14 days. She had expected the pharmacy consultant to have recognized the orders did not have a stop date and the pharmacist had not notified the physician, the medical director, or her of the lack of stop date for the use of the PRN Xanax.

On 10/06/21 at 10:25 AM, Pharmacy Consultant (PC) GG stated the prn psychotropic medication should have a stop date. She stated a stop date of 14 days should be in place, and then a review/evaluate the need for continued use of the medication by the ordering practitioner.

The facility's "Monthly Medication Review" policy, dated October 2021, documented the consultant pharmacist provides a review and analysis of prescribed medication therapy and medication use review, including nursing documentation of medication ordering and administration. Findings and recommendations are reported to the administrator, Director of Nursing, the responsible physician, and the Medical Director.

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The facility's consultant pharmacist failed to notify the Director of Nursing, the medical director, or the physician of the lack of required stop date for R10's PRN Xanax, placing the resident at risk for receiving unnecessary psychotropic medication.

- Resident (R) 18's "Significant Change Minimum Data Set" (MDS), dated 07/29/21, documented the resident had moderately impaired cognition, and disorganized thinking which fluctuated. The MDS further documented R18 received an antianxiety and antidepressant seven days of the look back period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 08/12/21, documented R18 was treated daily with an antidepressant and an antianxiety daily with PRN Ativan 0.25 milligram (mg) every 12 hours for the treatment of anxiety.

R18's "Care Plan," dated 08/19/21, lacked documentation regarding the use of PRN Ativan.

The "Physician Order," dated 09/07/21, directed staff to administer PRN Ativan 0.5 mg, give half a tablet for a 0.25 mg dose every 12 hours. The start date for the PRN Ativan was 02/01/21 and did not include a required stop date.

The "Progress Note," dated 05/07/21 at 03:33 PM documented the physician had seen the resident for a routine visit. The physician was notified of gradual dose reduction recommendation for Ativan and no changes ordered.

On 09/30/21 at 07:51 AM, observation revealed the resident wheeled herself out of her room and

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requested help for her knee and shoulder pain.

On 10/04/21 at 04:28 PM, Administrative Nurse D verified the resident's Ativan order lacked a stop date and the pharmacist had not notified the physician, the medical director, or her of the lack of stop date for the use of the PRN Ativan.

On 10/06/21 at 10:25 AM, Pharmacy Consultant (PC) GG stated the prn psychotropic medication should have a stop date. She stated a stop date of 14 days should be in place, and then a review/evaluate the need for continued use of the medication by the ordering practitioner.

The facility's "Monthly Medication Review" policy, dated October 2021, documented the consultant pharmacist provides a review and analysis of prescribed medication therapy and medication use review, including nursing documentation of medication ordering and administration. Findings and recommendations are reported to the administrator, Director of Nursing, the responsible physician, and the Medical Director.

The facility's consultant pharmacist failed to notify the Director of Nursing, the medical director, or the physician of the lack of required stop date for R18's PRN Ativan, placing the resident at risk for receiving unnecessary psychotropic medication.

- R29's "Quarterly Minimum Data Set" (MDS), dated 08/17/21, documented the resident had severe cognitive impairment, inattention, disorganized thinking, and other behavioral symptoms not directed toward others which occurred one to three days of the look back period. The MDS further documented the resident received antianxiety, antidepressant,

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anticoagulant, and diuretic seven days of the look back period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 05/26/21, documented R29 had vascular dementia and had daily antidepressant medication for the treatment of depression.

The "Medication Care Plan" dated 09/07/21, lacked documentation addressing the use of Xanax.

The "Physician Order Sheet," dated 09/07/21, directed staff to administer Xanax (a drug used to relieve anxiety) 0.25 milligrams (mg) every eight hours PRN for anxiety. The start date for the order was 06/17/21 and did not include a required stop date.

On 10/04/21 at 09:39 AM, observation revealed R29 taking her medication from the Certified Medication Aid without difficulty.

On 10/04/21 at 04:28 PM, Administrative Nurse D verified the resident's Ativan order lacked a stop date and the pharmacist had not notified the physician, the medical director, or her of the lack of stop date for the use of the PRN Ativan.

On 10/06/21 at 10:25 AM, Pharmacy Consultant (PC) GG stated the prn psychotropic medication should have a stop date. She stated a stop date of 14 days should be in place, and then a review/evaluate the need for continued use of the medication by the ordering practitioner.

The facility's "Monthly Medication Review" policy, dated October 2021, documented the consultant

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pharmacist provides a review and analysis of prescribed medication therapy and medication use review, including nursing documentation of medication ordering and administration. Findings and recommendations are reported to the administrator, Director of Nursing, the responsible physician, and the Medical Director.

The facility's consultant pharmacist failed to notify the Director of Nursing, the medical director, or the physician of the lack of required stop date for R29's PRN Xanax, placing the resident at risk for receiving unnecessary psychotropic medication.

-R33's "Quarterly Minimum Data Set," (MDS) dated 08/04/21, documented R33 with intact cognition, had inattention and disorganized thinking which fluctuated. The MDS further documented the resident received antianxiety and antidepressant medication seven days of the look back period.

The "Psychotropic Drug Use Care Area Assessment," (CAA) dated 04/02/21, documented the resident took Ativan (medication for the treatment of anxiety) 0.5 milligrams (mg) four times a day for anxiety.

The "Medication Care Plan," dated 09/14/21, documented the resident may feel down and depressed, took Ativan which had a Black Box Warning (BBW- these warnings communicate potential rare but dangerous side effects) PRN for anxiety.

The "Physician Order Sheet," dated 08/11/21, directed staff to administer Ativan 0.5 milligrams (mg) four times a day for anxiety disorder. The order further directed staff to administer Ativan 1

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mg PRN four times for anxiety. The PRN Ativan start date for the order was 05/07/21 and did not include a required stop date.

The "Pharmacist Record Review," dated 05/31/21, 07/29/21, 08/28/21, and 09/23/21, lacked documentation regarding a stop date for the use of PRN Ativan.

The "Pharmacist Record Review," dated 06/24/21, documented a request for a risk versus benefit statement for the use of Ativan.

On 10/04/21 at 01:29 PM, observation revealed R33 at her doorway with her walker inquiring about the afternoon activities and was eager to attend.

On 10/04/21 at 04:28 PM, Administrative Nurse D verified the resident's Ativan order lacked a stop date and the pharmacist had not notified the physician, the medical director, or her of the lack of stop date for the use of the PRN Ativan.

On 10/06/21 at 10:25 AM, Pharmacy Consultant (PC) GG stated the prn psychotropic medication should have a stop date. She stated a stop date of 14 days should be in place, and then a review/evaluate the need for continued use of the medication by the ordering practitioner.

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F 756	Continued From page 13 physician, and the Medical Director. The facility's consultant pharmacist failed to notify the Director of Nursing, the medical director, or the physician of the lack of required stop date for R33's PRN Ativan, placing the resident at risk for receiving unnecessary psychotropic medication.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) 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; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		

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unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 43 residents. The sample included 13 residents with six reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure six of six sampled residents' PRN (as needed) psychotropic medications (chemical substance that changes nervous system function and results in alterations in perception, mood, consciousness, cognition, or behavior) had a required stop date, Resident (R) 10, R18, R26, R29, R32, R33.

Findings included:

- R26's "Significant Change Minimum Data Set" (MDS), dated 08/11/21, documented severely impaired decision making, and received antipsychotic (used to treat psychotic disorders), and antidepressive (used to alleviate depression)

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medications seven days of the lookback period.

The "Care Area Assessment" (CAA), dated 08/11/21, documented R26 received Ativan (antianxiety medication) as needed for severe anxiety. These medications are associated with Black Box Warnings (BBW - these warnings communicate potential rare but dangerous side effects).

The "Medication Care Plan, dated 08/25/21, directed staff to provide medications to alleviate agitation as physician ordered, monitor and document side effects and effectiveness. R26 used to respond well to familiar staff; however, she doesn't seem to recognize people anymore. This often leads to an increase in frustration and anxiety, ask yes or no questions in order to determine the resident's needs. The care plan included the BBW for Ativan, may result in sedation, respiratory depression, or death.

The "Physician Order," dated 02/02/21, directed staff to administer to R26 Ativan, 0.5 milligrams (mg), three times daily as needed for severe anxiety. The order did not include a required stop date.

The "Consultant Pharmacist Reviews" dated 02/24/21, 03/27/21, 04/21/21, 05/24/21, 06/21/21, 07/29/21, 08/28/21, and 09/23/21 did not address the use of the PRN Ativan without a stop date. On 02/24/21 and 06/24/21 the consultant pharmacist requested a risk versus benefit statement for the continued use of Ativan but did not request a stop date.

On 09/29/21 at 04:51 PM, observation revealed R26 seated in a recliner in her room. R26

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appeared calm and more alert than earlier in the day.

On 10/04/21 at 07:50 AM, Certified Medication Aide (CMA) S stated the resident showed anxiety or agitation when staff rolled her over during cares. CMA S stated PRN Ativan was rarely used.

On 10/04/21 at 04:28 PM, Administrative Nurse D verified the PRN Ativan should have a stop date.

The facility's "Medication Administration" policy, dated August 2021, documented a healthcare provider's order includes dosage, route, frequency, duration when necessary, and other required considerations.

The facility failed to obtain a required stop date for the use of the PRN Ativan for R26, placing the resident at risk for receiving unnecessary psychotropic medications.

- R32's "Significant Change Minimum Data Set" (MDS), dated 08/19/21, documented Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS documented R32 received antianxiety medication (drug used to relieve anxiety) four days of the lookback period.

R32's "Care Plan," dated 07/22/21, documented the resident received Black Box Warning (BBW- these warnings communicate potential rare but dangerous side effects) medications.

The "Physician Order," dated 09/09/21, directed staff to administer PRN Ativan, 0.5 milligrams (mg) every four hours, as needed. The order lacked a stop date.

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The "Pharmacist Review," dated 09/23/21 lacked recommendation to include a stop date for the PRN Ativan.

On 09/30/21 at 09:53 AM, observation revealed R32 seated in bed when Certified Medication Aide (CMA) S administered medications to him without problems.

On 10/04/21 at 04:28 PM, Administrative Nurse D verified the resident's Ativan order lacked a stop date.

The facility's "Medication Administration" policy, dated August 2021, documented a healthcare provider's order includes dosage, route, frequency, duration when necessary, and other required considerations.

The facility failed to obtain a required stop date for the use of the PRN Ativan for R32, placing the resident at risk for receiving unnecessary psychotropic medications.

- Resident (R) 10's "Physician Order Sheet" (POS), dated 09/08/21, documented diagnoses of major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) with psychotic features, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), psychotic disorder (mental disorder characterized by a gross impairment in reality testing) with delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and dementia

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(progressive mental disorder characterized by failing memory, confusion) with behavior disturbance.

The "Quarterly Minimum Data Set" (MDS), dated 07/19/21, recorded the resident had moderately impaired cognition, physical behavioral symptoms directed toward others and other behavioral symptoms not directed toward others which occurred one to three days of the look back period. R10 required extensive assistance of two staff with activities of daily living. The MDS further documented R10 received an antipsychotic (class of medications used to treat psychosis and other mental emotional conditions), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), and hypnotic (a sleep inducing drug) seven days during the look back period. The antipsychotic had been received on a routine basis.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 01/29/21, had not been completed.

The "Care Plan" dated 08/10/21, recorded the resident chose to isolate herself in her room, had diagnoses of anxiety, depression with psychosis, periods of paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking), and fabricate situations or ideas when anxious. The care plan further recorded the resident received Xanax (medication to treat anxiety) as needed for anxiety which is a Black Box Warning (BBW - these warnings communicate potential rare but dangerous side effects) medication, which directed to limit dosages and durations to the minimum required, and follow patients for signs

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and symptoms of respiratory depression and sedation.

The "Physician Order Sheet" (POS), dated 09/08/21, directed staff to administer Xanax 0.25 milligrams (mg) by mouth every eight hours PRN for anxiety. The start date for the order was 02/01/21 and did not include a required stop date.

The "Pharmacist Record Reviews," dated 03/07/21, 05/24/21, 06/21/21, 07/14/21, and 08/11/21, lacked documentation regarding the use of PRN Xanax.

The "Pharmacist Record Review," dated 04/21/21, documented a physician request for a risk versus benefit statement for the use of Xanax. The request lacked guidance for a 14-day discontinuation.

The "Pharmacist Record Review," dated 09/08/21, documented a request to the physician for a gradual dose reduction of Xanax 0.25 mg every eight hours prn. The pharmacist's note lacked guidance for a 14-day discontinuation for as needed antianxiety medication. The physician responded, do not attempt to taper the dose of the medication due to chronic anxiety.

The "Progress Note," dated 09/08/21 at 08:01 PM, documented the physician saw the resident earlier in the day, and the resident had no complaints or concerns. The note further documented vital signs and medication reviewed and no changes were ordered.

On 10/04/21 at 02:50 PM, Administrative Nurse D stated as needed psychotropic medications should have a stop date of 14 days. She had

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expected the pharmacy consultant to have recognized the orders did not have a stop date.

The facility's "Medication Administration" policy, dated August 2021, documented a healthcare provider's order that includes dosage, route, frequency, duration when necessary, and other required considerations is required for administration of medication.

The facility failed to obtain a required stop date for the use of the PRN Xanax for R10, placing the resident at risk for receiving unnecessary psychotropic medication.

- R33's "Physician Order Sheet," (POS), dated 08/11/21, documented diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), insomnia (inability to sleep), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), vascular dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance.

The "Quarterly Minimum Data Set," (MDS) dated 08/04/21, documented R33 had intact cognition, had inattention and disorganized thinking which fluctuated, required extensive assistance of one staff for activities of daily living. The MDS further documented the resident received antianxiety and antidepressant seven days of the look back period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 04/02/21, documented the resident took Ativan (medication

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for the treatment of anxiety) 0.5 milligrams (mg) four times a day for anxiety.

The "Medication Care Plan," dated 09/14/21, documented the resident may feel down and depressed. She takes Ativan which is a Black Box Warning (BBW - these warnings communicate potential rare but dangerous side effects) medication as needed for anxiety.

The "Physician Order Sheet" (POS), dated 08/11/21, directed staff to administer Ativan 0.5 mg four times a day for anxiety disorder. The order further directed staff to administer Ativan 1 mg PRN four times for anxiety. The start date for the order was 05/07/21 and did not include a required stop date.

The "Pharmacist Record Reviews," dated 05/31/21, 07/29/21, 08/28/21 and 09/23/21, lacked documentation regarding the use of PRN Ativan.

The "Pharmacist Record Review," dated 06/24/21, documented a request for a risk versus benefit statement for the use of Ativan.

On 10/04/21 at 02:50 PM, Administrative Nurse D stated as needed psychotropic medications should have a stop date of 14 days. She had expected the pharmacy consultant to have recognized the orders did not have a stop date.

The facility's "Medication Administration" policy, dated August 2021, documented a healthcare provider's order that includes dosage, route, frequency, duration when necessary, and other required considerations is required for administration of medication.

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The facility failed to obtain a required stop date for the use of the PRN Ativan for R33 placing the resident at risk for receiving unnecessary psychotropic medication.

- Resident (R) 18's "Significant Change Minimum Data Set" (MDS), dated 07/29/21, documented the resident had moderately impaired cognition, and disorganized thinking which fluctuated. The MDS further documented R18 received an antianxiety and antidepressant seven days of the look back period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 08/12/21, documented R18 was treated daily with an antidepressant and an antianxiety daily with PRN Ativan 0.25 milligram (mg) every 12 hours for the treatment of anxiety.

R18's "Care Plan," dated 08/19/21, lacked documentation regarding the use of PRN Ativan.

The "Physician Order," dated 09/07/21, directed staff to administer PRN Ativan 0.5 mg, give half a tablet for a 0.25 mg dose, every 12 hours. The start date for the PRN Ativan was 02/01/21 and did not include a required stop date.

The "Progress Note," dated 05/07/21 at 03:33 PM documented the physician had seen the resident for a routine visit. The physician was notified of gradual dose reduction recommendation for Ativan and no changes ordered.

On 09/30/21 at 07:51 AM, observation revealed the resident wheeled herself out of her room and requested help for her knee and shoulder pain.

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On 10/04/21 at 04:28 PM, Administrative Nurse D verified the resident's Ativan order lacked a stop date.

The facility's "Medication Administration" policy, dated August 2021, documented a healthcare provider's order that includes dosage, route, frequency, duration when necessary, and other required considerations is required for administration of medication.

The facility failed to obtain a required stop date for the use of the PRN Ativan for R18 placing the resident at risk for receiving unnecessary psychotropic medication.

- R29's "Quarterly Minimum Data Set" (MDS), dated 08/17/21, documented the resident had severe cognitive impairment, inattention, disorganized thinking, and other behavioral symptoms not directed toward others which occurred one to three days of the look back period. The MDS further documented the resident received antianxiety, antidepressant, anticoagulant, and diuretic seven days of the look back period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 05/26/21, documented R29 had vascular dementia and had daily antidepressant medication for the treatment of depression.

The "Medication Care Plan" dated 09/07/21, lacked documentation addressing the use of Xanax.

The "Physician Order Sheet," dated 09/07/21,

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F 758	Continued From page 24 directed staff to administer Xanax (a drug used to relieve anxiety) 0.25 milligrams (mg) every eight hours PRN for anxiety. The start date for the order was 06/17/21 and did not include a required stop date. On 10/04/21 at 09:39 AM, observation revealed R29 taking her medication from the Certified Medication Aid without difficulty. On 10/04/21 at 04:28 PM, Administrative Nurse D verified the resident's Xanax order lacked a stop date . The facility's "Medication Administration" policy, dated August 2021, documented a healthcare provider's order that includes dosage, route, frequency, duration when necessary, and other required considerations is required for administration of medication. The facility failed to obtain a required stop date for the use of the PRN Xanax for R29 placing the resident at risk for receiving unnecessary psychotropic medication.	F 758		
F 801 SS=C	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)	F 801		

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This includes:
§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016,

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meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 43 residents. Based on observation, record review, and interview, the facility failed to employ a full time certified dietary manager for 43 residents who resided in the facility and received meals from the facility kitchen.

Findings included:

- On 10/05/21 at 10:45 AM, observation revealed Dietary Staff (DS) BB oversaw the preparation of the pureed diets.

On 09/29/21 at 07:20 AM, DS BB verified she had completed the Dietary Manager Course and had not passed the test.

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	175525	A. BUILDING _____ B. WING _____	10/05/2021

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PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801	Continued From page 27 On 10/05/21 at 11:00 AM, Administrative Staff A verified the facility did not have a certified dietary manager currently and stated the facility was aware of the need to have a certified dietary manager, per regulations, but had no policy to that effect. The facility provided a Certificate of Dietary Manager Course completion, fall 2015, but lacked the test certificate for DS BB. Upon request, the facility failed to provide a policy for certified dietary manager. The facility failed to employ a full time certified dietary manager for the 43 residents who resided in the facility and received meals from the facility kitchen, placing the residents at risk for receiving inadequate nutrition.	F 801		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions.	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	10/05/2021

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F 865	Continued From page 28	F 865		

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 43 residents. The sample included 13 residents. Based on interview and record review, the facility failed to develop a Quality Assurance and Performance Improvement (QAPI) plan (a written plan containing the process that would guide the nursing homes efforts in assuring care and services were maintained at acceptable levels of performance and continually improved).

Findings included:

- Review of the QAPI plan as provided by Administrative Nurse E revealed a blank plan.

On 10/05/21 at 04:02 PM, Administrative Nurse E reported she had begun a "Performance Improvement Plan" (PIP) when the facility switched their electronic record program to another source in February 2021. She reported this is ongoing as the facility's staff learn to utilize the current system to capture the full advantage of this form of record utilization. Administrative Nurse E reported she was not aware of the structured PIP from the other departments of the facility. She lacked documentation of departments structured areas of issues and plan to monitor and evaluate the plan for improvement. She did state the Quality Assessment and Assurance (QAA) meetings discuss a number of topics from falls, pandemic assessment and control, infections, resident skin and weight issues, but lacked system to analysis outcomes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 865	Continued From page 29 The facility's "Quality Assurance and Performance Improvement (QAPI/QAA)" policy, dated July 2017, documented the QAPI focuses on systems and processes. The organization sets goals for performance and measures progress toward those goals. Aspects of service and care are measured against established performance goals. Key monitors are measured and trended on a quarterly basis. The policy further documented the scope of the QAPI program encompasses all segments of the facility including resident/family feedback, staff satisfaction, individualized resident care plans, information technology, facility and maintenance plans and QAPI. The facility failed to develop a Quality Assurance and Performance Improvement (QAPI) plan. This failure had the ability to affect all residents in the facility.	F 865		