STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COMPASS HEALTHCARE AND REHAB HAWFIELDS, INC	**2502 S NC 119 MEBANE, NC 27302**

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and medical record reviews, the facility failed to revise a resident's care plan to reflect the use of an antipsychotic medication for the treatment of [REDACTED].#2) reviewed for unnecessary medications. The findings included: Resident #2 was admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. The resident was followed by psychiatry and seen for a visit on 5/20/20. At that time, she was reported to be having delusions / hallucinations on occasions. Her current medications were noted to include 125 milligrams (mg) [MEDICATION NAME] (an antidepressant medication) given once daily for mood. The psychiatry treatment plan included continuation of Resident #2's current medication regimen and to monitor the resident. Resident #2 was seen again by psychiatry on 6/15/20 due to staff reports of an increase in the delusions and hallucinations that caused distress and interruptions in the resident's sleep. Physician orders [REDACTED]. The resident's quarterly Minimum Data Set ((MDS) dated [DATE] reported she had moderately impaired cognitive skills for daily decision making. Section E of the MDS assessment revealed Resident #2 experienced hallucinations and delusions. Section N of the MDS indicated Resident #2 received both an antidepressant and an antipsychotic medication on 7 days out of 7 days during the look back period. Resident #2 continued to be followed by psychiatry and dosage adjustments of quetiapine were made to treat her hallucinations. Review of the resident's physician orders [REDACTED]. A review of Resident #2's current care plan revealed it included a problem (onset dated 12/13/19) which read: The resident uses [MEDICAL CONDITION] medications ([MEDICATION NAME]) related to depression. A [MEDICAL CONDITION] medication is any drug that affects brain activities associated with mental processes and behavior. An antidepressant is a [MEDICAL CONDITION] medication. The stated goal was for the resident to remain free of [MEDICAL CONDITION] drug related complications, including movement disorder, discomfort, [MEDICAL CONDITION], gait disturbance, constipation / impaction or cognitive / behavioral impairment. The target date for this goal was 3/13/20. Upon further review, the resident's plan of care included a handwritten notation in the upper right-hand corner which read, 7/9/20 Reviewed, along with the MDS Coordinator's signature. A second handwritten notation, Need to add hallucinating was written on the first page of the care plan. However, the care plan did not address the hallucinations Resident #2 was experiencing nor did it indicate an antipsychotic medication was used for the treatment of [REDACTED]. During the interview, the care plan for Resident #2 was reviewed and discussed. Upon inquiry, the MDS Coordinator confirmed the care plan reviewed was the most current one completed. She reported the handwritten notation in the upper right hand corner of the care plan indicated a care plan conference was held via telephone on 7/9/20 with the resident's Responsible Party (RP). Upon inquiry as to why the resident's hallucinations and use of the antipsychotic medication (quetiapine) were not addressed in the care plan, the MDS Coordinator stated, Evidently I missed putting it on. When asked if she would have expected the resident's hallucinations and antipsychotic medication to have been included in Resident #2's care plan, the MDS Coordinator responded by saying, Yes, I should have .I definitely need to have it on there. An interview was conducted on 9/22/20 at 3:27 PM with the facility's Director of Nursing (DON). During the interview, concern regarding failure to update and revise Resident #2's care plan to reflect the use of an antipsychotic medication to treat hallucinations / [MEDICAL CONDITION] was discussed. When asked, the DON stated if the reason the resident was placed on an antipsychotic medication was for specific behaviors that were assessed, then they should recognize them in the care plan. He also stated that upon his review of the resident's medical record, the psychiatry report did indicate the antipsychotic medication was initiated due to hallucinations.

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.