STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055531	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEACHSIDE POST ACUTE	22520 MAPLE AVENUE TORRANCE, CA 90505

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 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility's pharmacist consultant failed to recognize medication irregularities for three of three sampled residents (Residents A, B and C). (Cross Reference F758) This deficient practice placed the residents at risk for unnecessary medication administration. Findings: a. A review of Resident A's Admission Records indicated Resident A was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of a physician's orders [REDACTED]. A review of a physician's orders [REDACTED]. A review of a physician's orders [REDACTED]. According to Resident A's Drug Regimen Reviews (DRR), dated 11/2019 through 4/2020, no medication irregularities were recognized and no recommendations were made for the use of [MEDICATION NAME]. b. A review of Resident B's Admission Records indicated Resident B was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. A review of a physician's orders [REDACTED]. According to Resident B's DRR, dated 3/2020 no irregularities were found. Continued review of Resident B's DRR indicated no DRR was available for review for 4/2020 and 5/2020. c. A review of Resident C's Admission Records indicated Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of a physician's orders [REDACTED]. A review of a physician's orders [REDACTED]. According to Resident C's DRR, dated 5/2020, no medication irregularities were noted and no recommendations were made for the use of the medication. On June 1, 2020, during a telephone interview, the Director of Nursing (DON) stated after reviewing Resident A, B and C's clinical records and her DRR review folder the documents provided were the only ones that she had so there must not have been any further recommendations. A review of the facility's policy and procedure titled, Consultant Pharmacist Services Provider Requirements, dated 10/2017, indicated activities that the consultant pharmacist or off-site pharmacist performs includes, but is not limited to: Reviewing the medication regimen (medication regimen review) of each resident at least monthly, or more frequently under certain conditions, incorporating federally mandated standards of care in addition to other applicable professional standards. The review will be documented in the resident medical record. A resident's drug regimen must be free of unnecessary drugs, an unnecessary drug is any drug when used in excessive dose (including a duplicate drug), excessive duration, without adequate monitoring, without adequate indication for its use, in the presence of adverse consequences which indicate the dose should be reduced or discontinued or any combination of the above.
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** Based on interview and record review the facility's nursing staff failed to ensure for three of three sampled residents (Residents A, B and C) who were prescribed and administered anti-psychotic medication; Quetiapine ([MEDICATION NAME]) and [MEDICATION NAME] ([MEDICATION NAME]) (a class of medicines used to treat [MEDICAL CONDITION] (an abnormal condition of the mind)) and Lorazapam (([MEDICATION NAME]) used for anxiety) that the medications were prescribed and administered for appropriate indications, the correct dosage was prescribed, detailed descriptive evidence of resident behaviors were documented, non-pharmacological interventions were attempted and evaluated prior to the administration/continuance of the medications, physician, psychiatric and/or psychological evaluations were appropriately used to diagnose the resident, gradual dose reductions (GDR) were attempted, informed consents were obtained by the physician/prescriber and signed by a person deemed competent to make decisions, and for residents who were admitted to the facility on anti psychotic medications, a comprehensive evaluation of the medication(s) was conducted to determine if continued use was warranted. These deficient practices resulted in unnecessary medication administration continued use of these medications placed the residents at risk for adverse reactions/side effects associated with the medication's use, chemical restraints and death. Findings: a. A review of Resident A's Admission Records indicated Resident A was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident A' Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 8/18/19, indicated Resident A's cognitive skills for daily decision-making were moderately impaired. Resident A required extensive one-person physical assist to complete his activities of daily living ((ADL) normal task such as eating, bathing, dressing, grooming and toileting) and had a functional limitation in range of motion ((ROM) the distance and direction a joint can move to its full potential) to one upper and one lower extremity. Resident A had verbal behavioral symptoms that were not directed toward others and he was incontinent (involuntary voiding of urine and stool) in bowel and bladder functions. Resident A's active [DIAGNOSES REDACTED]. Indication for Use: [MEDICATION NAME] a1. A review of a Physician's Order, dated 11/4/19, indicated Quetiapine 12.5 milligrams (mg) three times a day for [MEDICAL CONDITION] manifested by (m/b) sudden outburst of anger. A review of a Physician's Order, dated 1/17/2020, indicated Quetiapine 12.5 mg three times a day for [MEDICAL CONDITION] m/b sudden outburst of anger and [MEDICAL CONDITION] (mental disorder in which people interpret reality abnormally). A review of a Physician's Order, dated 2/10/2020, indicated 25 mg [MEDICATION NAME] three times a day for [MEDICAL CONDITION] m/b inconsolable (not able to be comforted or alleviated) yelling. On 5/11/2020, at 1:32 p.m., during a telephone interview, Licensed Vocational Nurse 1 (LVN 1) stated Resident A was alert and oriented times 2 (name, place) and was combative with nurses during care, swinging his arm at them and refusing care. LVN 1 stated Resident A has thrown things at them and yells no and help when they go to see what he needs he does not say anything. On 5/11/2020, at 1:51 p.m., during a telephone interview, Certified Nursing Assistant 1 (CNA 1) stated Resident A yells a lot even when he is alone. They check to see what he needs and he does not need anything, when they leave he yells again. CNA 1 stated Resident A can make his needs none and when he does not want to be bothered he swings at them with his good arm but when they leave him alone for a while he will eventually let them provide care to him. On 5/26/2020, at 11:53 a.m., during a telephone interview, the Director of Nursing (DON) stated [MEDICATION NAME] was used for behavior modification, [MEDICAL CONDITION] (mental illness that causes dramatic shifts in a person's mood, energy, and ability to think clearly) mood stabilizer and [MEDICAL CONDITION]. The DON stated she does not know how the [DIAGNOSES REDACTED]. Detailed Description of Behaviors: [MEDICATION NAME] A review of Resident A's Behavior Summary indicated the following: 11/4/19 through 11/30/19 - 7 episodes of sudden outburst of anger 12/1/19 through 12/31/19 - 30 episodes of sudden outburst of anger 1/1/2020 through 1/31/2020 - 72 episodes of inconsolable yelling According to Progress Notes, dated 11/1/19 through 1/17/2020 no detailed

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

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F 0758

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 1)
description of Resident A's 37 episodes of sudden outburst of anger or 72 episodes of inconsolable yelling were documented. On 5/27/2020, at 1:25 p.m., during an interview, the DON stated nurses should tally the resident's behaviors and then document in the progress notes to describe behaviors Resident A is displaying Non-Pharmacological Interventions: [MEDICATION NAME] A review of a Neurobehavioral and Cognitive Evaluation, by a psychologist (a person who specializes in the study of mind and behavior), dated 12/10/19, indicated non pharmacological approaches should also be considered to manage Resident A's neuropsychiatric symptoms, when/if they arise, suggestions included: Agitation - relaxing music during meals; physical contact, such as holding hands; treat pain; reduce noise level; identify and minimize/eliminate triggers in environment Depression - reminiscence; pleasant activities scheduling; increased socialization Anxiety - predictable routines; continuity of care and environment; anticipate and prevent fear-producing stimuli; utilize a calm, gentle approach; explain all care; simplify stimuli. Resistiveness - avoid precipitating factors, which can include attempts to maintain privacy, intrusion into personal space, desire to keep caregivers away, and intense frustration. A review of Resident A's clinical records, dated 11/2019 through 2/2020, indicated no written evidence that non-pharmacological interventions were attempted prior to the administration of [MEDICATION NAME]. On 5/26/2020, at 11:53 a.m., during an interview, the DON stated following a psychological/psychiatric evaluation the report/recommendations are given to their social services designee (SSD) for follow up. The DON stated she was not aware of recommendations left by the psychologist and acknowledged after reviewing Resident A's clinical records that none had been documented. Physician, Psychiatric, Psychological Evaluation: [MEDICATION NAME] A review of Resident A's clinical records indicated a Neurobehavioral and Cognitive evaluation, by a psychologist, dated 12/10/2020 (more than a month after [MEDICATION NAME] was prescribed and administered). Continued review of Resident A's clinical records indicated a psychiatric evaluation on 1/3/2020 (two months after [MEDICATION NAME] was prescribed and administered), by a nurse practitioner for the facility's psychiatrist, indicated Resident A had a history of [REDACTED]. Note: Resident A had no documentation to indicate a history of him being [MEDICAL CONDITION] nor was there an evaluation conducted to determine if he was [MEDICAL CONDITION]. On 5/27/2020, at 1
p.m., during an interview, and after reviewing Resident A's clinical records the DON stated the psychiatrist signed the order adding [MEDICAL CONDITION] to Resident A's [DIAGNOSES REDACTED]. Gradual Dose Reduction (GDR): [MEDICATION NAME] A
review of a Physician's Order, dated 11/4/19, indicated Quetiapine 12.5 mg three times a day for [MEDICAL CONDITION] m/b sudden outburst of anger. A review of a Physician's Order, dated 1/17/2020, indicated Quetiapine 12.5 mg three times a day for [MEDICAL CONDITION] m/b sudden outburst of anger and [MEDICAL CONDITION]. A review of a Physician's Order, dated 2/10/2020, indicated 25 mg [MEDICATION NAME] three times a day for [MEDICAL CONDITION] m/b inconsolable yelling. A review
of Resident A's clinical records indicated no written evidence that a GDR was attempted nor documentation why a GDR was contraindicated. Informed Consent: [MEDICATION NAME] A review of a Physician's Order, dated 11/4/19, indicated Quetiapine [MEDICATION NAME] 12.5 mg three times a day for [MEDICAL CONDITION] m/b sudden outburst of anger. A review of a Physician's Order, dated 1/17/2020, indicated Quetiapine 12.5 mg three times a day for [MEDICAL CONDITION] m/b sudden outburst of anger and [MEDICAL CONDITION]. A review of a Physician's Order, dated 2/10/2020, indicated 25 mg [MEDICATION NAME] three times a
day for [MEDICAL CONDITION] m/b inconsolable yelling According to a [MEDICAL CONDITION] Medication Administration Informed
Consent the following was noted: 11/6/19 - [MEDICATION NAME] 12.5 mg three times a day 1/31/2020 - [MEDICATION NAME] 25 mg
three times a day Continued review the [MEDICAL CONDITION] Medication Administration Informed Consent indicated Resident A's initials, giving consent, as well as the signature of Resident A's attending physician, approving the medication, were present. There was no documented indication for use of the medication. A review Neurobehavioral and Cognitive Evaluation, dated 12/10/19, indicated Resident A evidences diminished capacity to make independent healthcare decisions at this time given his major neurocognitive condition. The recommendations reiterated Resident A does not have the capacity to make independent healthcare decisions. On 5/11/2020, at 2:20 p.m., during a telephone interview, Resident A's family member (FM 1) stated he never received a call from Resident A's physician or any physician regarding the medication. FM 1 stated he only received a call from a nurse at the facility a couple of months prior (not sure of the exact month) stating they were giving Resident A [MEDICATION NAME]. On 5/26/2020, at 1:05 p.m., during a telephone interview, Resident A's attending physician (Physician 1) stated it was reported to him that Resident A was displaying behaviors the psychiatrist came and prescribed [MEDICATION NAME]. Physician 1 stated he only spoke to Resident A's responsible party (RP) when the RP voiced concerns regarding Resident A being over sedated. Physician 1 stated he was not aware [MEDICATION NAME] had been increased. On 5/26/2020, at 1:26 p.m., during a telephone interview, the DON stated when the nurse received an order for [REDACTED]. The DON stated the nurse will call the physician and put the phone to the resident's ear or call the RP and have the physician talk to them. The DON stated the nurses should document in the resident's clinical record how they obtained the informed consent. On 5/27/2020, at 3:18 p.m., during a telephone interview, Registered Nurse Supervisor 1 (RN 1) stated when she received an order from the psychiatrist she called the resident's attending physician to get his ok for the order. RN 1 stated she then called the resident's RP and if the attending physician has not explained the medication to them she would explain what the medication was used for, the side effects, risk and benefits. RN 1 stated in her experience there had only been one physician who called the residents' RP to explain the medication, but the physician was no longer with the facility. RN 1 stated the other physicians did not call the RP so the nurses did. On 5/27/2020, at 3:30 p.m., during a telephone interview, Licensed Vocational Nurse 3 (LVN 3) stated the practice of the nurses at the facility was to obtain an order for [REDACTED]. Evaluation to Determine if Use Is Necessary: [MEDICATION NAME] A review of Resident A's Interdisciplinary Team (IDT) Progress Notes, dated 12/16/19 (five weeks after [MEDICATION NAME] was prescribed and administered) and 2/6/2020 (three months after [MEDICATION NAME] was prescribed and administered) indicated all of Resident A's medications and indications were reviewed with no concerns regarding the medications at this moment. Continued review of Resident A's clinical records indicated no other documented evaluations of [MEDICATION NAME]. On 5/27/2020, at 1:25 p.m., during an interview the DON stated on admission they would usually speak to the resident's family and make them aware the resident was on a particular medication. They will then have their psychiatrist/psychologist see the resident and review the medication for reduction, continuance or discontinuance. The DON stated they do a review quarterly and in Resident A's case there should have been an initial evaluation in 11/2019 and another one in 2/2020, however, she could not find any evaluation of the medication. According to the Geriatric Dosage Handbook, Including Clinical Recommendations and Monitoring Guidelines, Todd P. Semla, PharmD, BCPS, FCCP, Judith L. Beizer, PharmD, CGP, FASCP, Martin D. Higbee, PharmD, 12th Edition, 2007, pg 1330 Quetiapine U.S. Brand Names: [MEDICATION NAME] Use: treatment of [REDACTED].S. Boxed Warning):
Patients with dementia-related behavioral disorders treated with atypical antipsychotics are at an increased risk of death compared to placebo. Quetiapine is not approved for this indication. Monitoring parameters: Vital signs; fasting lipid profile and fasting blood glucose/HgbA1c (prior to treatment, at 3 months, then annually); BMI, personal/family history of obesity, waist circumference; blood pressure; mental status, abnormal involuntary movement scale (AIMS); Weight should be assessed prior to treatment, at 4 weeks, 8 weeks, 12 weeks, and then at quarterly intervals. Special Geriatric Considerations: Any changes in disease status in any organ system can result in behavior changes. Many older adult patients receive antipsychotic medications for inappropriate nonpsychotic behavior. Before initiating antipsychotic medication, the clinician should investigate any possible reversible cause; any stress or stress from any disease can cause acute confusion or worsening of baseline nonpsychotic behavior. Most commonly acute changes in behavior are due to increases in drug dose or addition of new drug to regimen; fluid electrolyte loss, infections; and changes in environment. In the treatment of [REDACTED]. Correct Dosage: [MEDICATION NAME] a2. A review of a Physician's Order, dated 11/4/19, indicated [MEDICATION
NAME] 2 mg every six hours as needed for anxiety m/b restlessness A review of a Physician's Order, dated 2/10/2020, indicated [MEDICATION NAME] 2 mg every six hours as needed for anxiety m/b verbal aggression Detailed Description of Behaviors: [MEDICATION NAME] A review of Medication Administration Records indicated the following: 11/2019 - zero episodes of verbalization of feeling anxious or nervous 11/2019 - one administration of 2 mg of [MEDICATION NAME] 12/2019- one
episode of verbalization of feeling anxious or nervous 12/2019 - three administrations of 2 mg of [MEDICATION NAME] 1/2020 - 51 episodes of restlessness 1/2020 - five administrations of 2 mg of [MEDICATION NAME] 2/2020 - 28 episode of restlessness 2/2020 - one administration of 2 mg of [MEDICATION NAME] According to Progress Notes, dated 11/2019, 12/2019, 1/2020 and 2/2020 there was no documented evidence of descriptive details of Resident A's verbalization of feeling anxious, nervous or restlessness. On 5/27/2020, at 1:25 p.m., during an interview, the DON stated nurses should tally the number of behavioral episodes as well as document in the progress notes to describe resident behavior. Informed Consent: [MEDICATION NAME] A review of Resident A's clinical record indicated no consent for [MEDICATION NAME] was available for review. b. A review of Resident B's Admission Records indicated Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. An MDS Assessment, dated 4/17/2020, indicated Resident B's cognitive skills for daily decision-making were

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F 0758

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 2)

severely impaired. Resident B required extensive one person physical assist to complete his ADLs. Resident B had no documented behaviors. On 5/27/2020, at 4 p.m., Resident B was observed lying in bed, he was alert and oriented and responded to questions with a yes or no. Resident B stated he was fine and there were no problems. Indication for Use: [MEDICATION NAME] A review of a Physician's Order, dated 3/1/2020, indicated [MEDICATION NAME] 25 mg two times a day for [MEDICAL CONDITION] m/b verbalization of sadness or hopelessness. On 5/27/2020, at 3 p.m., during an interview and after reviewing Resident B's clinical record, the DON stated she could find any documentation indicating the resident was [MEDICAL CONDITION] or [MEDICAL CONDITION]. On 5/27/2020, at 2:33 p.m., during a telephone interview, LVN 2 stated Resident B was alert and oriented times one (to name), was very calm, has no behaviors or outburst and can make his needs known. On 5/27/2020, at 3:30 p.m., during an interview, LVN 3 stated she was not aware of any behaviors that Resident B had when he was located in the other nursing station. LVN 3 stated since Resident B had been on her station (about one month) she had not witnessed any behaviors from him. LVN 3 stated Resident 3 was quiet but can make his needs known and was never agitated. On 6/2/2020, at 2 p.m., during a telephone interview, Resident B's attending physician (Physician 2) stated he did not have the resident's clinical record in front of him but generally [MEDICATION NAME] was not indicated for sadness or hopelessness. On 6/2/2020, at 2:32 p.m., during a telephone interview, the facility's psychiatrist (Psychiatrist 1) stated [MEDICATION NAME] was not generally indicated for sadness or hopelessness. According to Resident B's MARs, dated 3/2020, 4/2020, and 5/2020, no episodes of sadness or hopelessness were documented. Physician, Psychiatric, Psychological Evaluation: [MEDICATION NAME] A review of Resident B's clinical record indicated there was no evaluation by a physician, psychologist or psychologist to determine the continued need to administer [MEDICATION NAME] to Resident B. Informed Consent: [MEDICATION NAME] A review of a Physician's Order, dated 3/1/2020, indicated [MEDICATION NAME] 25 mg two times a day for [MEDICAL CONDITION] m/b striking out. A review of a Physician's Order, dated 4/12/2020, indicated [MEDICATION NAME] 25 mg two times a day for [MEDICAL CONDITION] m/b verbalization of sadness or hopelessness. A review of a Physician's Order, dated 5/12/2020, indicated [MEDICATION NAME] 25 mg two times a day for [MEDICAL CONDITION] m/b verbalization of sadness or hopelessness. A review of a [MEDICAL CONDITION] Medication Administration Informed Consent indicated a blank consent with the primary decision makers signature. On 5/26/2020, at 3 p.m., during a telephone interview and after reviewing Resident B's clinical record, the DON stated the informed consent was not complete and she could not find any other consent. Comprehensive Evaluation of Medication: [MEDICATION NAME] A review of Resident B's Interdiscicpinary Notes (IDT), dated 3/3/2020, indicated in regards to his medication that Medications are received as ordered Continued review of Resident C's clinical records indicate further mention/evaluation [MEDICATION NAME]. c1. A review of Resident C's Admission Records indicated Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 5/27/2020, at 2:33 p.m., during a telephone interview, LVN 2 stated Resident C was alert and oriented times one (to name). LVN 2 stated Resident C did not sleep well and tried to get up from her bed unassisted but has not displayed any agitation, anxiety or striking out. On 5/27/2020, at 3:40 p.m., Resident C was observed in her room, sitting in her wheelchair next to her bed coloring, with a sitter at the bedside. Through an interpreter Resident C stated her name and that she was doing fine. Resident C was pleasant, non-combative and showed no agitation or anxious behavior Indication for Use: [MEDICATION NAME] A review of a Physician's Order, dated 5/19/2020, indicated [MEDICATION NAME] 5 mg two times a day for agitation/anxiety. According to Resident C's MAR, dated 5/15/2020 through 5/28/2020, there were seven episodes of agitation/anxiety. On 6/2/2020, at 2:32 p.m., during a telephone interview, the facilities psychiatrist stated [MEDICATION NAME] typically was not indicated for agitation or anxiety. Evaluation to Determine Continued Use of Medication: [MEDICATION NAME] According to Resident C's MAR, dated 5/15/2020 through 5/28/2020, there was seven episodes of agitation/anxiety. According to Progress Notes, dated 5/15/2020 through 5/28/2020, there was no descriptive detailed documentation of Resident C's behaviors of agitation or anxiety. Non-Pharmacological Interventions: [MEDICATION NAME] A review of Resident C's clinical record indicated no documentation of non-pharmacological interventions used prior to the administration of [MEDICATION NAME]. Physician, Psychiatric, Psychological Evaluation: [MEDICATION NAME] A review of Resident C's clinical record indicated no physician, psychiatric or psychological evaluation. There was no physician's order for a psychiatric evaluation. Informed Consent: [MEDICATION NAME] A review of an undated [MEDICAL CONDITION] Medication Administration Informed Consent, indicated [MEDICATION NAME] 5 mg but did not indicate how many times per day it was to be given nor did it indicate why it was to be administered. Evaluation to Determine Continued Use of Medication: [MEDICATION NAME] A review of Resident C's clinical record indicated no written documentation evaluating the use of [MEDICATION NAME]. According to the Geriatric Dosage Handbook, Including Clinical Recommendations and Monitoring Guidelines, Todd P. Semla, PharmD, BCPS, FCCP, Judith L. Beizer, PharmD, CGP, FASCP, Martin D. Higbee, PharmD, 12th Edition, 2007, pg 1129-1132 Brand Names: [MEDICATION NAME] Pharmacological Category: Antipsychotic Agent, Atypical Use: treatment of [REDACTED]. Warnings/Precautions: (U.S. Boxed Warning): Patients with dementia-related behavioral disorders treated with atypical antipsychotics are at an increased risk of death. An increased incidence of [MEDICAL CONDITION] adverse events (including fatalities) has been reported in elderly patients with dementia-related [MEDICAL CONDITION]. [MEDICATION NAME] is not approved for this indication. Dosage: Consider lower starting dose of 2.5-5 mg/day for elderly or debilitated patients; may increase as clinically indicated and tolerated with close monitoring or orthostatic blood pressure. Special Geriatric Considerations: Elderly patients have an increased risk of adverse response to side effects or adverse reaction to antipsychotics. A higher incidence of falls had=s been reported in elderly patients, particularly in debilitated patients. [MEDICATION NAME] half-life that was 1.5 times that of younger adults, therefore lower initial doses are recommended. [MEDICATION NAME] is not indicated in dementia-related [MEDICAL CONDITION]. Correct Dosage: [MEDICATION NAME] c2. A review of a Physician's Order, dated 5/15/2020, indicated 2 mg/ml, give 0.5 ml sublingually every four hours as needed for anxiety/SOB. A review of a Physician's Order, dated 5/20/2020, indicated 2 mg/ml, inject 2 mg intramuscularly every six hours as needed for agitation/anxiety. A review of a Physician's Order, dated 5/28/2020, indicated 2 mg/ml, inject 1 ml intramuscularly every six hours as needed for trying to get out of bed. According to a MAR, dated 5/15/2020 through 5/28/2020, Resident C had seven episodes of anxiety m/b irritation. A review of Resident C's clinical record indicated no documented description of Resident C's behavior. A review of Resident C's clinical records indicated there was no consent for [MEDICATION NAME] available for review. According to the Geriatric Dosage Handbook, Including Clinical Recommendations and Monitoring Guidelines, Todd P. Semla, PharmD, BCPS, FCCP, Judith L. Beizer, PharmD, CGP, FASCP, Martin D. Higbee, PharmD, 12th Edition, 2007, pg 908-910 [MEDICATION NAME] U.S. Brand Names: [MEDICATION NAME] Use: Management of anxiety disorders or short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms Warnings/Precautions: Use caution in patients with renal, hepatic impairment or dementia. Dosage: Geriatrics: Anxiety and sedation: Oral, I.V.: 0.5-4 mg/day refer to adult dosing for other indications. Dose selection should generally be on the low end of the dosage range (i.e., initial dose not to exceed 2 mg) A facility policy and procedure, titled [MEDICAL CONDITION] Medication Use dated 10/2017 indicated the facility should not use [MEDICAL CONDITION] medications to address behaviors without first determining if there is a medical, physical, functional, psychological, social or environmental cause of the resident's behavior. The facility staff should take a holistic approach to behavior management that involves a thorough assessment of underlying causes of behaviors and individualized person-centered non-drug and pharmaceutical interventions. Residents who exhibit new or worsening behavioral or psychological symptoms of dementia will be evaluated by a health care professional and the care team to identify contributing factors: Treatable medical conditions, physical problems, emotional stressors, psychiatric or psychological factors, social issues or environmental factors. [MEDICAL CONDITION] medications may be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use. [MEDICAL CONDITION] medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavior symptoms. For [MEDICAL CONDITION] PRN medications, excluding antipsychotics, 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 rational in the resident's medical record and indicate the duration for the PRN order. All medication used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. When a physician/prescriber orders a [MEDICAL CONDITION] medication for a resident, the facility should ensure that a physician/prescriber has conducted a comprehensive assessment of the resident and has documented in the clinical record that the psychopharmacological medication is necessary. Within the first year in which a resident is admitted on a [MEDICAL CONDITION] medication or after the prescribing practitioner has initiated a [MEDICAL CONDITION] medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless contraindicated. Facility staff should inform the resident and/or resident representative of the initiation, reason for use and the risks associated with the use

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) of [MEDICAL CONDITION] medications, per facility policy or applicable state regulations. since [DIAGNOSES REDACTED]. function, and/or substantial difficulty receiving needed care.