STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0758 **Level of harm -** Actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Physician and staff interview, the facility failed to have an adequate indication for the use of the as needed (PRN) [MEDICAL CONDITION] medication, failed to try non-pharmacological intervention prior to administering a PRN [MEDICAL CONDITION] medication and failed to identify the use of the [MEDICAL CONDITION] medications as a possible cause of the falls, sleepiness and decreased po (per Orem) intake for 1 of 3 sampled residents reviewed for unnecessary medication (Resident #1). Resident #1 was administered [MEDICATION NAME] (a drug used to reverse opioid overdose) due to increased lethargy and was sent to the hospital due to unresponsiveness. Resident #1 expired on [DATE] and the cause of death was [MEDICAL CONDITIONS]. Findings included: Resident #1 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #1 had severe cognitive impairment with behaviors of rejection of care, verbal and physical behavioral symptoms and wandering. The assessment further indicated that Resident #1 needed supervision with transfers and ambulation. The assessment also revealed that Resident #1 had 1 fall prior to admission and had no falls since admission to the facility. The assessment also indicated that Resident #1 had received an antipsychotic medication for 1 day, antianxiety medication for 2 days and antidepressant medication for 3 days during the assessment period. Resident #1's care plan dated [DATE] was reviewed. The resident was care planned for the use of the [MEDICAL CONDITION] medications (antianxiety and antidepressant medications) and for physical behavioral symptoms of wandering into other resident's rooms, removing stop signs and fidgeting other resident's belongings and for verbal behavior of yelling at staff. The goals included resident will not exhibit signs of drug related sedation, drowsiness/over-sedation, disturbed balance/gait/positioning ability, [MEDICAL CONDITION] or [MEDICATION NAME] symptoms. The approaches included attempt non-pharmacological interventions, monitor drug use effectiveness and adverse consequences, monitor mood and response to medication, assess/record effectiveness of drug treatment, monitor and report signs of sedation, [MEDICAL CONDITION] or [MEDICATION NAME] symptoms and provide care, activities and daily schedule that resembles the resident's prior lifestyle. Review of the admission doctor's orders dated [DATE] revealed that Resident #1 did not have orders for [MEDICAL CONDITION] medications. On [DATE] at 6:29 PM, a nurse's note (written by Nurse #3) indicated that Resident #1 was admitted to the facility. He was confused and was combative towards the staff during care. On [DATE] at 2:04 PM, the nurse's note (written by Nurse #2) revealed that Resident #1 was observed rummaging through items on medication cart and wandering into other residents' rooms. The resident was resistant to redirection at times. On [DATE] at 3:28 AM, a nurse's note revealed resident up in wheelchair (w/c) propelling self-short distances before getting up and pushing w/c or leaving w/c and walking throughout facility. Resident frequently becomes very agitated when attempting to be redirected. Resident grabs staff's arms and squeezes/shakes them and refuses what staff requested of him. At times resident is easier to redirect without becoming aggressive. Snacks offered and resident took the tissues and crackers, sat on the floor, tore tissues into pieces, took crackers apart and laid them in an orderly fashion on the floor to use the tools to fix the bushings that had gone bad on his friend's car (another resident's w/c). Resistant to having blood sugar taken. Attempted times 5 before successful. Another male resident encouraged resident to take his bedtime medications with success. Resident wearing pull up and taking self to bathroom. Resident observed sitting on shower chair urinating then turning around and wiping the seat off with his hands, then began assessing shower seat for mechanical problems. Resident was in bed multiple times for short periods of time. Resident going into other resident's rooms and quickly became agitated and aggressive when being directed out of rooms. Resident requires much observation due to poor safety awareness and impulsive behavior. Resident attempted to exit facility several times without success. Resident refusing grippy socks or shoes preferring to be barefoot. Educated resident about the dangers of falling. Resident stated a verbal understanding but pushed this nurse in the chest and stated, get out of here! I put my wife in here! (opening closet door in room). Attempts made to start a conversation to reorient resident as to wife's whereabouts and try to get him to rest in bed. Resident continued to look for wife in linen cart and under bed. Several staff members attempting to keep resident calm. Medicated times 2 per prn orders of 25 milligram (mg) [MEDICATION NAME] (a pain reliever), somewhat effective results noted. Resident was pushing w/c in hallway, shaking arms in the air and speaking loudly and crying, unable to distinguish words. Resident appeared to be adjusting to new environment when in his room with bathroom light on. Best outcomes appear to be slowly approaching resident with snack/drink already in hand prior to initiating any conversation and try to distract/redirect with questions about vehicle repair. Will continue to monitor progress in adjustment to new environment. On [DATE] at 8:00 AM, a nurse's note (written by Nurse #2) revealed resident observed in room [ROOM NUMBER] going through items in drawers. This nurse attempted to redirect resident and inform him that he was not in his room. Resident states, this is my room. This nurse pointed out pictures on the wall to show resident that room belongs to someone else. Resident became agitated and yelled this is my stuff d-----. This nurse sat with resident in room until he was able to be redirected to his own room. This nurse noted that resident had removed the stop sign from doorway of 101 and placed it into the trash can. Resident was back in his room at this time. Will continue to monitor and redirect as needed. On [DATE] at 12:45 PM, a nurse's note (written by Nurse #2) indicated that this nurse has observed resident on 6 occasions, lower self to the floor and sit. Resident has laid on floor in the middle of 200 hall during one instance. Other instances, resident observed leaning under wheelchair and recliner in room. When asked why he sat on floor, resident states I gotta fix it. This nurse observed resident messing with wheelchair legs/bars. This nurse observed resident as he stood up from floor each time independently. Resident also continues to wander into other resident's rooms. This nurse continues to redirect resident as needed. On [DATE], there was a doctor's order for [MEDICATION NAME] (an antianxiety drug) 0.5 mgs by mouth PRN every 6 hours for metabolic [MEDICAL CONDITION]. On [DATE] at 1:49 PM, a nurse's note (written by Nurse #2) indicated this nurse walked past sunroom and observed resident outside in courtyard dragging patio furniture inside. Resident redirected and brought inside. Resident was sitting at front desk at this time. New order for [MEDICATION NAME] 0.5mg by mouth every 6 hours PRN for anxiety or behaviors and Trazadone (antidepressant drug) 50 mg by mouth at bedtime for sleep. The Medication Administration Record (MAR) indicated that Resident #1 was administered [MEDICATION NAME] 0.5 mgs by mouth on [DATE] at 6:23 PM by Nurse #2 due to inappropriate wandering in facility and throwing objects. On /[DATE] at 3:30 PM, Nurse #2 was interviewed. She stated that she administered [MEDICATION NAME] to Resident #1 since he went to other resident's room and was messing with the resident's

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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F 0758

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 1)

[MEDICAL CONDITION] tubing. Nurse #2 indicated that she redirected the resident after she found him in another resident's room and brought him to the nurse's station and had given him his harmonica to play. The nurse's note did not indicate that non-pharmacological intervention was tried prior to administering a PRN [MEDICATION NAME]. On [DATE] at 6:44 PM, a nurse's note (written by Nurse #2) revealed that Resident #1 was observed standing in room [ROOM NUMBER] opening drawers. This nurse approached resident and redirected him. Resident brought to nurse's station with this nurse and given his harmonica. Resident playing harmonica at the nurse's station at this time. The Medication Administration Record (MAR) indicated that Resident #1 was administered [MEDICATION NAME] 0.5 mgs by mouth on [DATE] at 8:31 AM by Nurse #1 due to inappropriate wandering in facility and throwing objects and was effective. On [DATE] at 9:53 AM, Nurse #1 was interviewed. She stated that she administered the PRN [MEDICATION NAME] to Resident #1 due to wandering to other resident's rooms. She also indicated that the resident could not be redirected due to the confusion. The nurse's note did not indicate that non-pharmacological intervention was tried prior to administering a PRN [MEDICATION NAME]. On [DATE] at 12:37 AM, a nurse's note revealed that Resident refused his medications upon multiple attempts. This nurse observed resident lowering self-down to floor in hallway. Resident attempted to spread out a sheet on floor and lay down. This nurse assisted resident up and into room [ROOM NUMBER]. At approximately 9:30 PM this nurse observed resident attempting to go into other resident's rooms. Re-directed resident as needed. Wander guard is intact to resident's ankle. On [DATE], there was a doctor's order for [MEDICATION NAME] 0.5 mgs intramuscular (IM) and [MEDICATION NAME] (an antipsychotic drug) 5 mgs IM for restlessness and agitation x (times) 1 dose. The Medication Administration Record (MAR) indicated that Resident #1 was administered [MEDICATION NAME] 5 mgs IM on [DATE] at 1:00 PM by Nurse #1. The MAR did not indicate if the medication was effective or not. On [DATE] at 9:53 AM, Nurse #1 was interviewed. She remembered administering the [MEDICATION NAME] IM to Resident #1, but she could not remember the exact incident. She stated that she should have documented it in her notes the indication for the PRN [MEDICATION NAME]. When asked if she had tried non-pharmacological approach prior to administering [MEDICATION NAME], Nurse #1 stated that Resident #1 could not be redirected at all, he was so confused. Nurse #1 also stated that she didn't know why she documented no behavior on the behavior monitoring for [DATE]. On [DATE] at 3:01 PM, a nurse's note (written by Nurse #1) revealed Resident with increased behaviors, trying to ambulate without assistance, and trying to put self on the floor. Attending Physician here to assess resident and new orders at this time to administer [MEDICATION NAME] 0.5 mg IM and [MEDICATION NAME] (antipsychotic drug) 5mg IM x 1 dose. The Medication Administration Record (MAR) indicated that Resident #1 was administered [MEDICATION NAME] 0.5 mgs IM on [DATE] at 3:30 PM by Nurse #1. The MAR did not indicate if the medication was effective or not. On [DATE] at 9:53 AM, Nurse #1 was interviewed. She remembered administering the [MEDICATION NAME] IM to Resident #1, but she could not remember the exact incident. She stated that she should have documented it in her notes the indication for the [MEDICATION NAME]. When asked if she had tried non-pharmacological approach prior to administering the [MEDICATION NAME], Nurse #1 stated that Resident #1 could not be redirected at all, he was so confused. Nurse #1 also stated that she didn't know why she documented no behavior on the behavior monitoring for [DATE]. The Behavior monitoring documented on the MAR on [DATE] between 12:45 PM to 2:45 PM indicated that Resident #1 did not have any behaviors. The nurse's note did not indicate that non-pharmacological intervention was tried prior to administering the [MEDICATION NAME] and [MEDICATION NAME] injection. On [DATE], there was a doctor's order for [MEDICATION NAME] 1 mg by mouth twice a day and [MEDICATION NAME] 5 mgs IM every 8 hours PRN for restlessness and agitation. On [DATE] at 4:23 PM, a nurse's note (written by Nurse #1) revealed that the attending physician was in the building with new orders to start [MEDICATION NAME] 1mg po BID and [MEDICATION NAME] 5mg IM every 8 hours PRN. On [DATE] at 9:53 AM, Nurse #1 was interviewed. Nurse #1 stated that Resident #1's behaviors were mostly crawling on the floor, combative at times during care and wandering to other resident's rooms. He also would try to ambulate without assistance. A psychiatric note dated [DATE] was reviewed. The note revealed that Resident #1 was referred due to agitation, aggression and dementia versus [MEDICAL CONDITION]. The note indicated the staff reported that Resident #1 slept well last night but has not every night and was crawling on the floor and into another resident's room. He was reaching for things and was high risk for falls in his broda chair and family plan to take him home once stabilized. He was combative with agitation and aggression requiring [MEDICATION NAME] and [MEDICATION NAME] IM. Resident was dozing in his broda chair in his room, having eaten 25% of breakfast but wakes to loud voice. He was able to answer some questions appropriately and was oriented to person and time. He reported feeling sad at times, sleeping at night and was not really agitated or nervous. Nursing notes were reviewed for chronic behavior/mood issues with none reported. For agitation and aggression with impulsivity, will add [MEDICATION NAME] (used to treat [MEDICAL CONDITION] activity and [MEDICAL CONDITION] disorder) with titration. Increasing [MEDICATION NAME] for [MEDICAL CONDITION] and will add [MEDICATION NAME] po PRN. It does appear that he was waxing and waning with [MEDICAL CONDITION] and will try to calm his impulsivity but not sedate him but realize that he will be sleepy for a couple of days with changes and plan to discontinue scheduled [MEDICATION NAME] when able if [MEDICATION NAME] if effective. Plan for [MEDICATION NAME] 250 mgs po 3 times a day for impulsivity/aggression with [MEDICAL CONDITION], increase [MEDICATION NAME] 100 mgs at bedtime for [MEDICAL CONDITION] and PRN [MEDICATION NAME] 0.5 mgs every 6 hours as needed for agitation/[MEDICAL CONDITION] x 14 days. On [DATE] at 2:55 PM, a nurse's note revealed that Resident #1 was seen by a psychiatric Nurse Practitioner with new orders for [MEDICATION NAME] 250 mgs 3 times a day, [MEDICATION NAME] 0.5mg every 6 hours PRN and increase [MEDICATION NAME] to 100 mg at bedtime. Resident #1's laboratory works were reviewed. Resident #1 was admitted to the facility on [DATE] with NA (Sodium) level of 137 (normal value ,[DATE]); Chloride level of 103.5 (normal value ,[DATE]); Blood Urea Nitrogen (BUN) level of 15 (normal value ,[DATE]) and creatinine level of 1.08 (normal value 0XXX,[DATE].27). On [DATE], NA level was 144, Chloride level of 104, BUN level of 27 and creatinine level of 1.68. On [DATE] at 3:29 PM, a nurse's note (written by Nurse #1) indicated that the Nurse Practitioner (NP) had reviewed the laboratory results for Resident #1. New order to encourage po fluids 240 cubic centimeter (cc) 3 time a day between meals for increased creatinine level and to repeat BMP on [DATE]. On [DATE] at 3:05 PM, a nurse's note (written by Nurse #2) indicated that at approximately 2:30 PM, a therapist reported while walking down 100 hall, the therapist heard a thud. Resident observed sitting on floor holding head. Vital signs and neuro status were within normal limits. Range of motion at baseline. Resident complained of headache. A small skin tear noted to right thumb. On [DATE], the laboratory results were reviewed. The NA level was 137, Chloride was 99, BUN was 21 and creatinine was 1.57. On [DATE] at 4:10 PM, a nurse's note (written by Nurse #2) revealed that the laboratory results were reviewed and the Nurse Practitioner (NP) was notified of white blood cell count (WBC) of 13.4 and status [REDACTED]. On ,[DATE] at 2:06 PM, a nurse's note revealed that an interdisciplinary team (IDT)/Clinical at- risk meeting was conducted. Resident #1 was discussed in IDT meeting secondary to fall. Will continue to provide interventions to reduce injury from falls and will continue to monitor. On [DATE] at 12:55 PM, the Director of Nursing (DON)was not available, so the MDS Nurse was interviewed. The MDS Nurse reported that the IDT, consist of the department heads, meets once a week on Thursdays to discuss, falls, pressure ulcer, weight loss, and [MEDICAL CONDITION] medications. She stated that on [DATE], the IDT had met and discussed Resident #1's fall that occurred on [DATE]. She indicated that the team did not discuss the use of the [MEDICAL CONDITION] medication for Resident #1 that day. She indicated that falls, decreased po intake and sleepiness were possible adverse drug reaction of [MEDICAL CONDITION] medications but she didn't think that the resident's fall, decreased po intake and sleepiness were due to the [MEDICAL CONDITION] medications. On [DATE] at 5:48 PM, a nurse's note revealed Resident #1 status [REDACTED]. The urine culture result dated [DATE] was reviewed and the result no growth. On [DATE], a Nurse Practitioner note revealed that Resident #1 was out of bed sitting in his wheelchair. There was some difficulty with arousal, but he was able to drink some fluids. The chest x-ray result dated [DATE] did not show acute findings. On [DATE] at 12:41 PM, a nurse's note (written by the DON) revealed that family members were at window of sunroom to visit resident. Resident was very sleepy and was not responding as family beat on the window. Family brought food and staff will attempt to feed as resident is more awake. On [DATE] at 4:09 PM, a nurse's note indicated that this nurse was called to nurse's station. Resident #1 observed on floor in front of nurse's station. A small bump noted to right side of forehead. On [DATE] at 6:34 PM, a nurse's note indicated that Resident#1's family member had called and was requesting that the resident be seen by the facility doctor. The note indicated that the resident was encouraged po fluids throughout the shift with little intake. The laboratory results dated [DATE] revealed NA level of 150, Chloride level of 115.7, BUN of 53 and creatinine level of 2.18. Review of the Medication Administration Records (MAR) revealed that Resident #1 had received the [MEDICATION NAME] 1 mgs po twice a day (scheduled at 8 AM and 8 PM) from [DATE] (8 PM dose) through [DATE] (8 AM dose) except on [DATE] at 8 PM dose due to lethargic. On [DATE] at 3:22 PM, a nurse's note (written by Nurse #3) indicated that Resident #1 was assisted to broda chair this AM before breakfast. He was resistive to staff when staff provided care requiring assist of two. Multiple attempts made to fed breakfast. Took a couple bites and became agitated. The Physician came to assess the redness to the resident's left forearm

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F 0758 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) (LFA). Resident's eyes were closed. This nurse discussed decreased activity after scheduled medications with the physician. The physician would change [MEDICATION NAME] to PRN. Staff assisted resident to bed and this nurse called to room. Resident was noted pale, with pupils non-responsive, blood pressure (B/P) of ,[DATE] and oxygen saturation of 88%. Oxygen was administered and the physician was called to resident's room. [MEDICATION NAME] was ordered and administered. Laboratory results from this AM brought into room showing WBC 27,000. ,[DATE] NS was ordered and started 22 gauge to LFA. Urinalysis and chest X-ray were completed on [DATE] with negative results. B/P ,[DATE] and oxygen saturation 96% on 2 liters per minute (L/MIN). Due to poor response to fluids and inability to locate infection the resident was sent to hospital. On [DATE] at 12:05 PM, Nurse #3 was interviewed. She stated that she was assigned to Resident #1 on [DATE] when the resident was sent to the hospital. She indicated the morning of [DATE], the resident was combative during care and she administered the morning dose of [MEDICATION NAME]. Later that day, she was called to the resident's room and she found the resident very lethargic. She called the Physician who came to assess the resident. The Physician had ordered to administer [MEDICATION NAME] and the resident was sent to the hospital. Resident #1's meal intake records were reviewed. On [DATE], Resident #1 had ,[DATE]% intake for breakfast, lunch and dinner. On [DATE], there was no documentation of meal intake. On [DATE], he had ,[DATE] % intake for breakfast, and he refused lunch and dinner. On [DATE], there was no meal intake documented for breakfast and lunch and he had ,[DATE]% intake for dinner. On [DATE], he had ,[DATE]% meal intake for breakfast and dinner and no documented meal intake for lunch. On [DATE], he refused breakfast, ,[DATE]% intake for lunch and no documented intake for dinner. On [DATE], there was no documented intake for breakfast, had ,[DATE] % intake for lunch and ,[DATE] % intake for dinner. On [DATE], he had ,[DATE]% for breakfast, ,[DATE] % for lunch and dinner. On [DATE], he had refused breakfast and lunch and had ,[DATE] % dinner. On [DATE], he had ,[DATE]% intake for breakfast and refused lunch. The emergency medical services (EMS) records dated [DATE] were reviewed. The records revealed that Resident #1 was initially assessed by the EMS staff on [DATE] at 2:46 PM as being unresponsive, pale and with blood pressure of ,[DATE], pulse of 100, respiration of 14 and oxygen saturation of 98%. The 4-lead electrocardiogram (ECG) showed [MEDICAL CONDITION]. The assessment at 2:53 PM revealed that Resident #1 was unresponsive, pale, and with periods of apnea. At 3:22 PM, a bag valve mask (BVM) (also known as Ambu bag is a handheld device used to provide positive pressure ventilation to patient who are not breathing or not breathing adequately), a flow rate of 25 L/min was provided. The EMS narrative note indicated that at the facility, EMS assessed Resident #1, he was unresponsive, and the nursing home (NH) staff stated that we gave him [MEDICATION NAME] because we think we gave him too much [MEDICATION NAME]. Resident was loaded onto the stretcher and moved to the ambulance. Resident was found to be hypotensive, still completely unresponsiveness. Intravenous (IV) was in place from the NH. Normal Saline (NS) was hooked to that IV and was run with a pressure infuser. Resident had a weak carotid pulse. He was placed on Trendelenburg position (the body is laid supine or flat on the back on ,[DATE] degree incline with the feet elevated above the head). The resident had short periods of apnea; he was placed on oxygen. Another IV was obtained if needed. In route to the hospital, resident remained unconscious, blood pressure improved. Approximately 5 minutes from the hospital, the resident had a significant period of apnea and he was ventilated with a BVM and was successful. The hospital emergency department records dated [DATE] were reviewed. The records revealed that on EMS arrival, Resident #1 had some periods of apnea and he was bagged on the ambulance ride. He did get some rounds of [MEDICATION NAME] without improvement by EMS and NH staff. Per NH staff, they believed the resident got too much [MEDICATION NAME]. On arrival to the emergency room (ER), the resident was somnolent but breathing on his own. He was moving all extremities. He was non-verbal. He was provided respiratory support with repositioning and non-rebreather mask. Flumazenil (used to treat drowsiness by sedatives following surgery or drug overdose) was considered given likely benzodiazepine overdose however the risk of withdrawal [MEDICAL CONDITION] outweighs the benefits of this medication currently. If the resident begins to have apneic spells again or other complication, we will reevaluate the need of this drug. The active problems included metabolic [MEDICAL CONDITION] due [MEDICAL CONDITIONS], dehydration, infection, worsening kidney function and other factors including [MEDICATION NAME] use. On [DATE] at 3:30 PM, Nurse #2 was interviewed. She was assigned to Resident #1 on [DATE], [DATE], [DATE], and [DATE] on first shift. The Nurse stated that Resident #1 was pleasantly confused and easy to redirect during the day and was agitated during the evening. He would sit on the floor, hit, cursed, wandered to other resident's rooms and mess with their stuff. He was a mechanic and he would sit on the floor trying to fix the wheelchairs and beds. He was ambulatory and was able to feed himself. He plays his harmonica. On [DATE] at 4:01 PM, Nurse Aide (NA) #1 was interviewed. She stated that Resident #1 was confused and was resistive to care. She was assigned to him when he had a fall on [DATE]. He tried to walk and fall. NA #2 indicated that she could not remember him well, she could not remember his status on admission or if there were any decline in his physical or mental condition. On [DATE] at 4:05 PM, NA #2 was interviewed and stated that she could not remember him well. Resident #1 had been at the facility for short period of time. On [DATE] at 4:10 PM, Nurse #3 was interviewed. She was assigned to Resident #1 on [DATE], [DATE] and [DATE] on first shift. Nurse #2 stated that the resident was able to walk on admission but unsteady. He was confused, agitated and wandered in and out of other resident's rooms. He was on broda chair prior to discharge. Nurse #3 stated that she didn't notice a big change in resident's condition until [DATE]. On [DATE] at 9:53 AM, Nurse #1 was interviewed. She was assigned to Resident #1 on [DATE], [DATE], [DATE] and [DATE] on first shift. Nurse #1 stated that Resident #1's behaviors were mostly crawling on the floor, combative at times during care and wandering to other resident's rooms. He also would try to ambulate without assistance and would sit on floor. She stated that she had seen the resident standing by the bed but not walking. Nurse #1 reported that the resident was in the wheelchair or broad chair when out of bed. She indicated that she had monitored resident's behavior and adverse reaction of the [MEDICAL CONDITION] medications and documented on the MAR. On [DATE] at 10:22 AM, the MDS Nurse was interviewed. She stated that the indications for the use of the [MEDICAL CONDITION] medication for Resident #1 were agitation, aggression, and combativeness. She stated that trying to ambulate without assistance and trying to put self on floor were not acceptable indication for the use of the [MEDICAL CONDITION] medications. She also indicated that nurses were expected to try non-pharmacological interventions prior to administering PRN [MEDICAL CONDITION] medications like redirection and keeping him in commons areas and document in the resident's medical record. On [DATE] at 11:10 AM, the Physician was interviewed. He stated that Resident #1 had a lot of behaviors at the hospital and when he was admitted to the facility. He wandered to other resident's rooms, resistive to care, combative, and trying to pull the [MEDICAL CONDITION] tubing of another resident. He remembered starting the [MEDICATION NAME] 0.5 mgs as PRN and then 1 mg twice a day scheduled. He expected the staff to monitor the resident for sedation and to hold the [MEDICATION NAME] when the resident was showing signs of sedation. The Physician also stated that the staff had called him on [DATE] when the resident could not be redirected and was very combative and he ordered [MEDICATION NAME] and [MEDICATION NAME] IM. He added that he would not order [MEDICATION NAME] and [MEDICATION NAME] PRN for behaviors like ambulating without assistance and trying to put self on floor. The Physician indicated that he knew the staff were trying non-pharmacological approaches prior to administering PRN [MEDICAL CONDITION] medications but he expected them to document the approaches tried or attempted in the resident's medical records. The Physician stated that when a resident had experienced falls, decreased po intake and sleepiness, he would consider infection first and he would order laboratory works, urinalysis and culture, chest x-ray and blood works. He also stated that the use of [MEDICAL CONDITION] medications should also be considered as possible cause of falls, decreased po intake and sleepiness but you have to look at the whole picture. The Physician reported that when he saw the resident on [DATE], there was a change in resident's condition from his visit on [DATE]. The resident was groggy, he ordered [MEDICATION NAME] to try to wake him up, but that didn't work so he sent the resident out to the hospital. On [DATE] at 12:05 PM, a follow up interview was conducted with Nurse #3. She stated that she was assigned to Resident #1 on [DATE]. The NA was having difficulty in getting him to eat and drink. He would eat a bite or two and his alertness comes and goes. On [DATE] at 11:55 PM, interview with the Activity Director was conducted. She stated that Resident #1 was pleasantly confused on admission. He loved to play his harmonica. Due to the pandemic, she provided 1:1 activity to residents. She read devotions, paint nails, and crafts. She provided blocks to Resident #1 to fidget on. The Activity Director indicated that Resident #1 was a mechanic and his wife said to give him something to fidget on. She revealed that she had not provided any activities to him since he was asleep every time, she visited him in his room. She tried to visit different times of the day, but he was asleep.