VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

January 10, 2019

Ms. Jennifer Combs-Wilber, Administrator
Green Mountain Nursing And Rehabilitation
475 Ethan Allen Avenue
Colchester, VT 05446-3312

Dear Ms. Combs-Wilber:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 19, 2018**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 12/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

(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
E 000	.Initial Comments An unannounced onsite Emergency Preparedness review was completed by the Division of Licensing and Protection from 12/17/18- 12/19/18. The facility was found in substantial compliance with regulations related to Emergency Preparedness.	E 000	***The preparation and execution of this plan of correction does not constitute an admission or agreement by the provider as to the truth or accuracy of the alleged facts or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed solely for the purpose to meet the regulatory guidelines set forth by federal and state regulatory agencies.***	
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey was completed by the Division of Licensing and Protection from 12/17/18 -12/19/18. The following regulatory violations were identified.	F 000	It is the policy of GMNR to ensure a safe, clean, comfortable and homelike environment for residents throughout the facility.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584	To ensure the water is safe and comfortable for residents the water continues to be temped on a weekly and as needed., mechanical features of the hot water system will continue to be evaluated and adjusted accordingly to ensure the water is comfortable for residents. An appointment for baths will be changed to a different time according to resident wishes to ensure a comfortable shower or bath. Bathroom vent cover was evaluated and adjusted and cleaned as needed, ceiling tile was cleaned, stand fans have been wiped down, wall paper and paint projects are evaluated and scheduled for completion. Local plumbing company was contacted and multiple recommendations were made, those recommendations are being trialed and monitored to develop the best process to ensure water is safe and comfortable for the residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Combs-Weber | TITLE: NHA | (X6) DATE: 1/9/19

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 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility failed to ensure a safe, clean, comfortable and homelike environment for residents throughout the facility. This was evidenced by numerous needed cosmetic repairs through out the facility and water cold enough that one applicable resident refused to shower (Resident #14). The findings include the following: 1. Per interview with Resident #14 on 12/17/2018, voiced that s/he was unable to receive a shower that morning (scheduled shower day). S/he stated that the Licensed Nursing Assistant (LNA) had to transport her/him to the first-floor shower room because the water was too cold on the floor she resided on. The water on the first floor was also too cold, therefore for the resident refused the shower altogether.	F 584	All residents have a potential to be affected by this alleged deficient practice. The following systemic processes are in place to ensure that the alleged deficient practice does not occur, Formal Environmental rounds will be completed and documented on a weekly basis as well as following the work order system to ensure a safe, clean comfortable environment. Maintenance will continue to evaluate the temperature of the water throughout the facility on a weekly basis and as needed. Adjustments to the mechanics of the hot water systems will be done on a as needed basis to ensure the average water temperature is safe and comfortable for the residents. Maintenance will continue to clean bath and/or exhaust fans on the current semiannual schedule and as needed and identified during weekly environmental rounds. Maintenance will continue to clean ceiling tiles according to their current schedule and as needed and identified during weekly environmental rounds and work orders. Maintenance will continue to clean standing fans according to current schedule and as needed and identified during environmental rounds. F-584 POC accepted 1/9/19 M.Bertrand RN / S. Perry RN	

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F 584	Continued From page 2 Confirmation was made by the LNA responsible for Resident #14, that the water was too cold for a shower. She continued to voice that it is common for residents to not receive their scheduled showers due to cold water. The Administrator, confirmed that s/he was unaware that residents were not receiving showers due to the water temperature being too cold. 2. Per facility tour with the Maintenance Supervisor on 12/19/18 at 11:01 AM there were multiple areas in need of necessary housekeeping and maintenance services. In one bathroom a vent was dust covered and was not properly secured to the ceiling. There were ceiling lights that had dead insects inside the covers that were visible. Multiple areas in resident bedrooms and bathrooms along with the hallways had chipped paint and torn wallpaper. There was a door with a rough area near the latch. In resident bathrooms and in the common spa bathroom there were tiles that were chipped, cracked and/or missing entirely. Stand fans had visible dust and grime. The above findings were confirmed by the Maintenance Supervisor on 12/19/18 at approximately 11:35 AM.	F 584	To ensure the processes in place prevents occurrence of the alleged deficient practice, environmental rounds, completed work orders and water temperature logs will be documented on a weekly basis and submitted to the QAPI team for review and recommendations monthly. **Completion Date: 1/18/2019** F-584 POC accepted 1/9/19 M. Bertrand RN / S. Remy RN	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		

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F 656	Continued From page 3 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to develop or implement a person-centered comprehensive	F 656		

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F 656	Continued From page 4 care plan for 2 residents in the applicable sample, (Resident #23 and #38). Findings include: 1. Resident # 23 was observed in his/her room, awake, lying in a reclining chair or in bed in his/her room on 12/17, 12/18, and 12/19. S/he had no TV or music available. Per record review, the resident's care plan notes dated 11/5/2018, identify that the resident will be brought to activities when s/he is available. Activities evaluation dated 3/23/2018, identifies that the resident's current preferences include current news, family/friend visits, movies, TV, social parties, music, sensory, and will attend Catholic mass. Confirmation was made by the Unit Manager; that the resident does spend his/her days in his/her room. S/he also confirmed that they could do more to engage and get Resident #23 to activities. Confirmation was made by the Recreation Director on 12/19/18 at 11:00 AM, the resident is offered 1:1 stimulation activity, but s/he is not brought to activities, as identified on both the evaluation and person-centered care plan. S/he also confirmed that there are no group activities available for residents who have advanced cognitive disease. 2. Resident # 38 was observed in his/her room, awake, lying in a reclining chair or in bed on 12/17, 12/18, and 12/19. S/he did not leave the room or attend activities during the three days of survey. During interview with his/her guardian he/she voiced that the resident does not participate in activities, but s/he feels that the resident is lonely. Per record review, care plan notes dated on	F 656	**F 656** It is the policy of GMNR to develop or implement a person-centered comprehensive care plan. It stated in the report that the recreation director stated that there are no group activities available for residents who have advanced cognitive disease. The recreation director did not state this but did say that we don't have a dementia only sensory group. We do have groups that all residents could attend no matter what level they are at. When a resident is at a group activity and struggles or are purely sensory, we adapt the group activities to the needs of those residents. We provide music groups, baking groups, church groups, reminiscing groups, etc that can all be adapted and sensory based. Resident #23 did have a TV on her dresser, resident #23 generally is near roommates TV watching the same programing, she was provided sensory music by her bedside and was provided a DVD player for Christmas and a Color and Music DVD for sensory purposes which was turned on for her as well. Resident #23 was transitioned to hospice care effective 12/31/2018 and passed away on 1/5/19. Resident # 38: A schedule for programs to attend has been posted for the nursing staff as a reminder to ensure resident # 38 is up and ready to attend programs that are easily adapted for a resident who requires added support or sensory stimulation.	

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F 656	Continued From page 5 12/4/2018, identify that the resident is seen by the recreation staff on a 1:1 basis. The 1:1 visits are primarily due to Resident #38 being in bed during the group times and/or visits with his/her spouse. Confirmation was made by the Recreation Director, that the resident does not attend activities because s/he is in bed or with his/her spouse visiting at the time activities are occurring. Confirmation was also made that there have been no changes to the timing of activities and there are no group activities designed for residents with advanced cognitive disease.	F 656	All residents who have advanced cognitive disease have a potential to be affected by this alleged deficient practice. To ensure this alleged deficient practice does not occur staff have been given a schedule of programs for residents to be available to attend, 1:1's will continue to be provided for sensory stimulation. Staff will continue to be reeducated on the importance of having residents ready for programs that meet their needs and the utilization of the sensory based supplies on the unit. The recreation director and/or designee will continue to monitor and document attendance of programs for residents and ensure the programs meet the needs of the residents with advanced cognitive disease daily. Reports will be submitted monthly for 90 days to the QAPI team then quarterly thereafter. **Completion Date: 1/18/2019** POC F-656 accepted 1/9/19 M. Bertrand RN / S. Remy RN	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, resident/family/staff interview, and record review the facility failed to provide an ongoing program that supports the physical, mental, and psychosocial well-being for 2 residents in the applicable sample who are cognitively impaired, (Residents #23 and # 38). Findings include: 1. Resident #23 was observed on 12/17/2018 at	F 679		

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F 679	Continued From page 6 10:03 AM, in his/her room, in a reclining chair. The resident was assisted back to bed after being fed lunch. On 12/18/18 at 8:30 AM, s/he was observed lying in bed being fed breakfast. S/he was lying in the recliner at 10:15 AM and transferred back to bed after lunch. Staff assisted with meals and provided care but Resident #23, remained in her/his room throughout the day. An admission activities evaluation was completed on 3/23/2018, identifies that the resident's current preferences include current news, family and friend visits, movies, TV, social parties, music, sensory. The documentation also identifies that Resident #23 will attend Catholic mass. Confirmation is made by the Recreation Director that s/he conducts 1:1 visits with the resident, 1-2 times per week for 15-30 minutes per visit. The Recreation Director also confirms that the resident does not attend group activities to include social parties, music, and Catholic mass. The Director also confirmed that there are no group activities designed for residents with advanced dementia and other advanced cognitive impairments. The Unit Manager confirms on 12/19/2018, that the resident does not participate in activities and that they could do more to engage the resident. 2. On 12/17/2018 at 10:30 AM, Resident #38 was observed lying in a recliner in his/her room, looking up at the ceiling, and yelling out. At 11:30 AM s/he was observed being fed lunch by his/her guardian. Per interview with the resident's guardian on	F 679	**F 679** It is the policy of GMNR to provide an ongoing program that supports the physical, mental and psychosocial well-being. It stated in the report that the recreation director stated that there are no group activities available for residents who have advanced cognitive disease. The recreation director did not state this but did say that we don't have a dementia only sensory group. We do have groups that all residents could attend no matter what level they are at. When a resident is at a group activity and struggles or are purely sensory, we adapt the group activities to the needs of those residents. We provide music groups, baking groups, church groups, reminiscing groups, etc that can all be adapted and sensory based. Resident #23 did have a TV on her dresser, resident #23 generally is near roommates TV watching the same programing, she is being provided sensory music by her bedside and was provided a DVD player for Christmas and a Color and Music DVD for sensory purposes which are turned on for her as well. Resident #23 was transitioned to hospice care effective 12/31/2018 and passed away on 1/5/19 Because of her declining condition she did not attend Catholic mass services, she was however seen on a 1:1 by our volunteer Father Ranges	

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F 679	Continued From page 7 12/17/2018 at 1:44 PM, s/he stated that the resident does not participate in the activities provided but didn't think that s/he could at the stage of dementia. The guardian stated that they feel the resident is lonely. An Activities care plan note dated 11/20/2018, states that the resident is seen by the recreation staff on a 1:1 basis because s/he is in bed during the group times and/or is visiting with his/her spouse. The Recreation Director confirms that the resident is provided sensory stimulation activities, 1:1 visits, 1-2 times per week for 15-30 minutes each visit. S/he also confirms that the resident is often unavailable because s/he is in bed during group activities. S/he also confirms that there are no activities available for residents with advanced cognitive decline other than the 1:1 sensory stimulation that is offered 1-2 times per week.	F 679	Resident # 38 a schedule for programs to attend has been posted for the nursing staff as a reminder to ensure resident # 38 is up and ready to attend programs that are easily adapted for a resident who requires added support or sensory stimulation. All residents who have advanced cognitive disease have a potential to be affected by this alleged deficient practice. To ensure this alleged deficient practice does not occur staff have been given a schedule of programs for residents to be available to attend, 1:1's will continue to be provided for sensory stimulation. Staff will continue to be reeducated on the importance of having residents ready for programs that meet their needs and the utilization of the sensory based supplies on the unit as well ongoing dementia training that includes sensory stimulation. The recreation director and/or designee will continue to monitor and document attendance of programs for residents and ensure the programs meet the needs of the residents with advanced cognitive disease daily. Reports will be submitted monthly for 90 days to the QAPI team then quarterly thereafter. **Completion Date: 1/18/2019** F-679 POC accepted 1/9/19 M. Bertrand RN / S. Remy RN	
F 756 SS=D	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	F 756		

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F 756	Continued From page 8 (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 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: Based on staff interview and record review, the facility failed to ensure that the attending physician document, in 1 applicable resident's medical record (Resident # 7) that an 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. Findings include: There is no written rationale from the physician to extend Resident # 7's as need (PRN) psychoactive medication beyond 14 days. The Pharmacy Consultant recommended a specific	F 756	**F 756** It is the process of GMNR to ensure that the attending physician documents a rationale relating to a pharmacy consultant recommendation. The pharmacy recommendation for resident # 7 psychoactive medication has been addressed. All residents who have PRN psychoactive medications and whom are reviewed by the consultant pharmacist have a potential to be affected by this alleged deficient practice. To ensure the processes in place prevents this alleged deficient practice the DON and/or designee will review new orders on a weekly basis and consultant pharmacist will review on a monthly basis. DON and/or designee will review monthly pharmacy consults. Staff will be re educated on the process of psychoactive medications and consultant pharmacist reports. Audit documentation of the order reviews and consult documentation will be submitted to the QAPI team for review and recommendations monthly for 90 days then quarterly thereafter. **Completion Date: 1/18/2019** POC F-756 accepted 1/9/19 M. Bertrand RN / S. Levy, RD	

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F 756	Continued From page 9 duration for PRN Ativan (an ant-anxiety medication) or to change to a scheduled dose on 11/16/18. The order for Ativan is dated 10/8/18 and is open ended. The physician renewed the order on 12/6/18. There is no evidence that the facility or the physician has acted on the pharmacy recommendation. On 12/18/18 at 1:55 PM, the Director of Nursing (DON) confirmed that there is no evidence the physician acted on the 11/16/18 pharmacy consult recommendation to set a specific duration for the PRN Ativan or to change the hour of sleep dose to scheduled. The DON also confirmed there is no written rationale to extend the PRN medication beyond 14 days.	F 756		
F 758 SS=D	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;	F 758		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 12/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 10 §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 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: Based on staff interview and record review, the facility failed to ensure that as needed (PRN) orders for psychotropic drugs are limited to 14 days for 2 applicable resident (Resident # 7 and #38). Findings include: 1. There is no written rationale from the physician to extend Resident # 7's PRN psychoactive medication beyond 14 days. The Pharmacy Consultant recommended a specific	F 758	It is the policy of the facility to ensure that as needed (PRN) orders for psychotropic drugs are limited to 14 days. The psychotropic drug identified for resident #7 & & 38 were addressed. All residents who have a PRN order for psychotropic drugs have a potential to be affected by this alleged deficient practice. To ensure the processes in place prevents this alleged deficient practice the DON and/or designee will review new orders on a weekly basis and consultant pharmacist will review on a monthly basis. DON and/or designee will review monthly pharmacy consults. Staff will be reeducated on the process of psychoactive medications and consultant pharmacist reports. Audit documentation of the order reviews and consult documentation will be submitted to the QAPI team for review and recommendations monthly for 90 days then quarterly thereafter. **Completion Date: 1/18/2019** F-758 POC accepted 1/9/19 M. Bertrand RN / S. Perry RN	

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F 758	Continued From page 11	F 758		

duration for PRN Ativan (an anti-anxiety medication) or to change to a scheduled dose on 11/16/18. The order for Ativan is dated 10/8/18 and is open ended. The physician renewed the order on 12/6/18. There is no evidence that the facility or the physician has acted on the pharmacy recommendation.

On 12/18/18 at 1:55 PM the Director of Nurses (DNS) confirms there is no evidence the physician acted on 11/16/18 pharmacy consult recommendation to set a specific duration for the PRN Ativan or change the hour of sleep dose to scheduled.. DNS also confirms there is no written rationale from the physician to extend the PRN Ativan beyond 14 days.

2. Per review of physician orders for Resident #38 dated 12/18, directs staff to administer Risperidone 0.5 milligram (mg.) orally, daily, by mouth (PO) as needed (PRN) for agitation. Risperidone is a medication used to treat schizophrenia and bipolar disorder. The resident does have a diagnosis of dementia with behavioral disturbances.

Per review of the Medication Administration Record (MAR) on 12/13/18 at 6:13 PM, the resident was given Risperidone 0.5 mg PO for agitation. The physician order does not identify a stop date, limiting the use of the PRN medication for 14 days. Resident #38 received two (2) additional doses of the PRN Risperidone on 12/15/18 and 12/16/18. The physician orders also identify PRN orders for Tylenol for pain and Melatonin for sleep. Neither of the medications were utilized prior to the administration of the antipsychotic medication.

Confirmation was made by the Unit Manager

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F 758	Continued From page 12 (UM), on 12/19/18 that there was no stop date provided by the physician for the use of the PRN antipsychotic medication. The UM also confirmed that s/he was unaware that Risperidone is a medication that is included in the regulatory requirement.	F 758		