

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PIERRE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>950 EAST PARK STREET PIERRE, SD 57501</b>	
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F 000	<p><i>Addendum noted with an asterisk per 6/15 telephone to facility DON. SCISODDHF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 29354 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/5/15 through 5/7/15. Areas surveyed included abuse and neglect, pharmacy services, and nursing services. Golden LivingCenter - Pierre was found not in compliance with the following requirements: F279, F309, F329, F428, and F492.</p>	F 000	<p>Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.</p>	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170</p>	F 279	<p><b>F279</b> 1. All residents are at risk. Care plan for resident 2 has been reviewed and individualized to include acute behaviors and non-pharmacological interventions to manage these behaviors prior to</p>	<i>6/24/15</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jami Raske* TITLE *Executive Director* (X6) DATE *5/28/15*

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

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F 279	<p>Continued From page 1</p> <p>Based on interview, record review, and policy review, the provider failed to ensure one of one sampled resident (2) had the appropriate individualized comprehensive care plan related to acute behaviors, and when ever needed (PRN) psychoactive medications were documented with the appropriate interventions for nursing staff to attempt prior to administration of those medications.</p> <p>Findings include:</p> <p>1. Review of resident 2's complete medical record revealed:                  *She had been admitted on 7/12/13.                  *Her diagnoses included:                  -Cerebral vascular disease (a stroke resulting in left sided paralysis [weakness]).                  -Rheumatoid arthritis.                  -Hypertension (high blood pressure).                  -Depressive disorder.                  -Generalized anxiety disorder.                  *There had been no diagnoses of any psychosis or behavioral concerns.                  *She had a history of urinary tract infections.                  *She was alert and orientated to person, place, and time.</p> <p>Review of resident 2's following physician's orders revealed:                  *On 10/13/14 at 1646 (4:46 p.m.) Give Xanax (used for anxiety) 0.5 milligram (mg) by mouth two times a day related to generalized anxiety disorder.                  *On 1/11/15 at 14:16 (2:14 p.m.) Give Ativan (used for anxiety) 0.5 mg by mouth every 8 hours as needed for anxiety, and 0.5 mg one time for anxiety until 1/11/15 23:59 (11:59 p.m.).                  *On 1/14/15 at 17:35 (5:35 p.m.) Give Xanax 1 mg one tablet by mouth every 4 hours as needed</p>	F 279	<p>administration of psycho active medications. The facility does develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a residents medical, nursing, mental and psychosocial needs.</p> <p>2. The Director of Nursing Services (DNS) will in-service the interdisciplinary team to ensure that an individualized care plan is developed to address behaviors and non-pharmacological interventions that have been successful in the management of these behaviors, prior to the administration of as needed psychoactive medications. DNS will in-service all nursing staff to reference the individualized care plan for non-pharmacological interventions to assist in managing residents behaviors, prior to the administration of as needed psychoactive medications. In-service will be completed no later than June 3, 2015.</p> <p>3. The DNS or designee will audit <del>residents</del> residents care plans weekly X 4, then monthly X 3 to ensure that care plans are individualized with non-pharmacological interventions to assist with managing behaviors prior to the administration of psychoactive medications. Results of audits will be reported by the DNS and discussed at monthly Quality Assurance and Process Improvement (QAPI) meeting for further</p> <p>*behavior scisssohmf</p>	
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\*four scisssohmf

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F 279	<p>Continued From page 2 for anxiety. *On 1/15/15 at 17:21 (5:21 p.m.) Give Haldol 2 mg one tablet by mouth every four hours as needed for agitation.</p> <p>Review of resident 2's revised 4/25/15 comprehensive care plan revealed: *She had intact cognition (alert and orientated to person, place and time). *Her short term memory was impaired, and her long term care memory was intact. *She was understood and was able to understand. *She had not exhibited any indicators of delirium (confusion). *There had been minimal signs and symptoms of moods and depression. She had diagnoses of depression and anxiety. There were no hallucinations (seeing objects or persons that were not there) or delusions (misbeliefs). *There was a history of the following behaviors: -Refused personal care by staff. -Verbal (yelling) behaviors towards others, however she was generally pleasant with staff and care. *She used an anti-anxiety medication as needed for the diagnosis of anxiety; she used anti-depressant medication for the diagnosis of depression; she used antipsychotic medication as needed for agitation. *There were no non-pharmacological ( no medication) interventions documented in her care plan. *Moods, behaviors, and medications were to have been monitored and reviewed monthly per the Behavior Monitoring Team.</p> <p>Interview on 5/5/15 at 9:40 a.m. with the Minimum Data Set (MDS) assessment registered nurse</p>	F 279	<p>review and recommendations and/or continuation/discontinuation of audit.</p> <p>X [REDACTED] SC/SDDO/HMF</p>	

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F 279	<p>Continued From page 3 regarding resident 2 revealed: *She was unsure why there were no non-pharmacological interventions documented on her care plan. *There were no individualized interventions used for those individuals with behaviors. *Only if the staff knew that a specific intervention had worked with the resident would those interventions have been added to the resident's care plan. *All interventions placed on the Kiosk (electronic charting area) would have been generic and used for all the residents.</p> <p>Interview on 5/6/15 at 9:40 a.m. with the director of nursing, the executive director, and the MDS nurse regarding the concerns with resident 2's comprehensive care plan revealed: *They agreed the care plan should have been more individualized. *The non-pharmacological interventions should have been listed on the care plan to ensure the staff knew what interventions were successful when those behaviors began.</p> <p>Review of the provider's undated Care Plan policy revealed: **Care plans must set realistic, specific, and achievable goals that are individualized for each resident. The care plan must be updated as there are changes in the resident's condition. Changes may be health related, mood, and behavior related, ADL (activities of daily living) functioning related, activities related, dietary related, medication related etc. (and so on). In addition, interventions related to resident falls, skin integrity (condition of the skin), resident to resident altercations (verbal or physical conflict), or new MD [physician] orders must be added to the care</p>	F 279		

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F 279	Continued From page 4 plan as the event occurs. *Changes may be due to a decline or improvement in the resident's condition. *When adding handwritten intervention to the typed care plan, a date and the person making the update initials are required next to the added interventions. *When an intervention no longer applies to a resident, the item is "yellowed" out with a yellow highlighter. This also requires the date and initials."	F 279			
F 309 SS=D	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure the physical, mental, and psychosocial needs were met for one of one sampled resident (1) during a change in condition by: *Psychotropic (mood altering) medications used without adequate rationale. *Notification to family during a change in the resident's condition and new medication orders. *Nursing assessment for the resident for pain. *Individualized comprehensive care plan for interventions.	F 309	<b>F309</b>  1. All residents are at risk. DNS is currently working with Consulting Pharmacist and physician to develop a plan for gradual dose reduction of the antipsychotic medication for resident 1 and family has been notified of this plan. The as needed antipsychotic medication, Haldol, for resident 1 has been discontinued related to no adequate rationale. The care plan for resident 1 has been reviewed and individualized to address non-pharmacological interventions to assist in management of behaviors prior to the use of psychoactive medications. The facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  2. The DNS will in-service licensed nurses regarding the resident change in condition guidelines to include family* and physician. <i>SCSDDHMF</i>	<i>6/24/15</i>	

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F 309	<p>Continued From page 5</p> <p>*Medication dosage parameters (defined limits) by a physician for antipsychotic medication usage. Findings include:</p> <p>1. Observation and interview on 5/5/15 from 10:15 a.m. through 10:40 a.m. on the memory care unit revealed resident 1 was seated in a wheelchair by the table. She had been visiting with her son, and had been smiling and calm. After the son left, she picked up the newspaper and began to look at it. At that time the surveyor sat down beside her, and she answered questions appropriately about who had just visited her. She stated she felt good.</p> <p>Interview at the above time with certified nursing assistant (CNA)/medication aide C regarding resident 1 revealed: *CNA C worked the day shift and was usually on the memory care unit. *Resident 1: -Liked to take a bath. Would take one bath and one shower each week. -Was always cold. -Most of the time she was pleasant. -She had displayed behaviors from time to time that included being resistive to care and "yelling" out. -She had displayed some behaviors last Monday (April 27) which "meant she had a bladder infection." -She was cooperative with toileting. -She was cooperative with perineal (peri)-care (private area). -Usually continent of bladder ( could hold her urine until toileted) but did have a few times when she would be incontinent. -Usually cooperative with care unless she had not</p>	F 309	<p>notification. DNS will also in-service nurses on adequate rationale for use of psychotropic medications and ensuring parameters are obtained from a physician for antipsychotic medication usage. DNS will in-service the nurses on the pain assessment guidelines. The DNS will in-service the interdisciplinary team to ensure that an individualized care plan is developed to address behaviors and ensure non-pharmacological interventions are developed. In-service will be completed no later than June 3, 2015.</p> <p>*four SC/SDDOHMF</p> <p>3. The DNS or designee will complete audits of residents medical records weekly X 4, then monthly x 3 to ensure the residents physical, mental &amp; psychosocial needs are met during a change in condition. Results of audits will be reported by the DNS and discussed at monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>* [REDACTED] SC/SDDOHMF</p>	

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F 309	<p>Continued From page 6</p> <p>slept well the night before or had been tired from doing restorative therapy.</p> <p>-Ate independently, some times needed cueing.</p> <p>-Fluids were offered throughout the shifts.</p> <p>Interview on 5/5/15 at 10:42 a.m. with CNA D regarding resident 1 revealed she had not gone to restorative therapy on April 27 due to being tired. Resident 1 had been more resistant with care before the medication had begun for the UTI (urinary tract infection [bladder]).</p> <p>Observation on 5/5/15 at 2:00 p.m. in the memory care unit revealed resident 1 was asleep in a recliner in the day room.</p> <p>Review of resident 1's complete medical record revealed:</p> <p>*She had been admitted from home to the hospital on 2/5/15 with low blood pressure, dehydration, abnormal urinalysis, osteoporosis (progressive bone disease), and recent transischemic attack (TIA) (stroke like symptoms). Her medical record revealed she had become more confused at home, and had fallen at home on January 28, 2015. On February 3, 2015 she had been started on Ativan (antianxiety medication), had a UTI, and was started on an antibiotic. The family had reported during the previous two weeks she had become upset, mean, her personality had changed, she would become upset, and paranoid (suspicious of everyone). She had not acted like herself.</p> <p>*The hospital history and physical indicated she had orthostatic hypotension (low blood pressure upon standing) in the clinic, with hypertension (high blood pressure) at the hospital with a history of fluctuating (changing) blood pressures. She had recurrent UTIs. She had a history of</p>	F 309		
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F 309	<p>Continued From page 7</p> <p>dementia (memory impairment/confusion) with recent worsening confusion. The outpatient antibiotic therapy had failed, so she was admitted to the hospital on intravenous (IV) antibiotic. The hospital medications included Seroquel (antipsychotic) and Haldol (antipsychotic)</p> <p>*She had been admitted from the hospital to the facility on 2/6/15. The admission orders were:</p> <ul style="list-style-type: none"> <li>-Admit to Alzheimer's unit (memory care unit).</li> <li>-Diagnoses of UTI, hypertension, orthostatic hypotension, TIA, and dementia with behavioral disturbances.</li> <li>-Psychoactive medications of lorazepam 0.25 milligrams (mg) every six hours as needed (prn) and lorazepam 0.5 mg every six hours prn for anxiety.</li> <li>-Antibiotic ciprofloxacin for seven days.</li> </ul> <p>Review of resident 1's 2/6/15 admission clinical health status form revealed:</p> <p>*She was drowsy, had long and short term memory problems, had no indicators of depression, anxiety, sad mood/adjustment to new conditions, no behavioral symptoms, was frequently incontinent of bladder, had history of hypotension and hypertension, shuffled with her gait (walking), dependent on staff for provision (assisted with) of fluids, and received diuretics (eliminate excess fluid) and cardiovascular agents (heart medications).</p> <p>*She was at risk for falls for the past two weeks and had intermittent confusion, had fallen in the past three months, had balancing problems while walking and standing, was on medications that could contribute to falls, and had previous diseases that contributed to falls.</p> <p>*There was no documentation regarding her mood and behaviors.</p>	F 309		
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F 309	<p>Continued From page 8</p> <p>Review of the 2/6/15 Immediate Plan of Care revealed:</p> <ul style="list-style-type: none"> <li>*Is at risk for falls related to use of anti-anxiety medications.</li> <li>*Pain and pain symptoms risks related to UTI. Evaluate need to provide pain medications prior to treatment or therapy.</li> <li>*Dehydration/fluid maintenance risks related to UTI and diuretic.</li> <li>*Behavioral symptom risks related to wandering, being verbally abusive, physically abusive, socially abusive, and resisting care.</li> </ul> <p>Review of the 2/11/15 care plan revealed:</p> <ul style="list-style-type: none"> <li>*4/28/15 - "Resident transitions from the ACU [Alzheimer's (memory) care unit] due to cognitive (memory) decline and physical functioning decline."</li> <li>*Interview on 5/5/15 at 10:13 a.m. with the director of nursing (DON) revealed resident 1:             <ul style="list-style-type: none"> <li>-Was still on the memory care unit.</li> <li>-The above care plan information pertained to her previous roommate."</li> </ul> </li> <li>**"Has severely impaired cognition. Interventions: Explain all procedures and reason before performing. Monitor/report change in residents ability to understand others. Provide clear, simple instructions."</li> <li>**"Uses anti-psychotic medication daily for behaviors and antianxiety medication for diagnosis of anxiety.             <ul style="list-style-type: none"> <li>-Interventions: encourage participation in facility events and activities. monitor for changes in mental status. Monthly medication review per consulting pharmacist. Moods, behaviors are documented and monitored per care tracker. Redirect resident when exhibiting behaviors."</li> <li>-There were no interventions on how the staff were to redirect the resident when exhibiting</li> </ul> </li> </ul>	F 309		
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F 309	<p>Continued From page 9 behaviors.</p> <p>*"At risk for pain related to Osteoporosis.</p> <p>-Interventions: Will maintain adequate level of comfort as evidenced by no s/sx [sign/symptoms] of unrelieved pain or distress, or verbalizing satisfaction with level of comfort.</p> <p>-Interventions: Evaluate need for routinely scheduled medications[meds] rather than PRN [when needed]pain med administration. Evaluate need to provide medications prior to treatment or therapy. Offer non-pharmacological (not using medication) pain relief strategies: reposition, ROM (range of motion), massage, W/P (whirlpool) bath, quiet environment. utilize pain monitoring tool to evaluate effectiveness of interventions."</p> <p>Review of the 2/13/15 Minimum Data Set (MDS) assessment revealed:</p> <p>*The Brief Interview for Mental Status (BIMS) had a score of one. (That score indicated severe mental impairment fifteen was an alert and oriented score).</p> <p>*There were no mood indicators marked.</p> <p>*She had:</p> <p>-Physical and behavioral symptoms marked one indicating behavior occurred one to three days during that assessment period.</p> <p>-Verbal behavior symptoms were directed toward others was marked two which indicated behavior occurred four to six days but less than daily.</p> <p>*She required:</p> <p>-Extensive assistance of two staff for bed mobility and transferring.</p> <p>-Extensive assistance of one staff person for ambulation, dressing, toilet use, and personal hygiene.</p> <p>*She used a walker and a wheelchair.</p> <p>*She was unsteady.</p>	F 309		
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F 309	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>*Active diagnoses included orthostatic hypotention, UTI, and non-Alzheimer's dementia.</li> <li>*Pain management was marked zero for having received scheduled pain medication, prn pain medications or was offered and declined, and received non-medication intervention for pain.</li> <li>*Fall history was marked yes.</li> <li>*Skin tears was marked yes.</li> <li>*Medications she received included antipsychotic, antianxiety, antibiotic, and diuretic.</li> </ul> <p>Review of resident 1's 2/20/15 Care Area Assessment (CAA) summary revealed:</p> <ul style="list-style-type: none"> <li>*Urinary incontinence: "Dx (diagnosis) of UTI, currently on antibiotics. At risk for UTI, decline in continence status."</li> <li>*Psychosocial Well-Being: "Resident will start to settle in and get used to this new living environment and the new medications will begin to help reduce behaviors."</li> <li>*There was no documentation as to how staff were going to assist her with the new living arrangements.</li> <li>*Behavioral Symptoms: "Resident is new to facility living and really angry that she is here. Goal is that once resident gets comfortable with this setting and with her new perceptions the resident will have no more behaviors."</li> <li>*Falls: At risk for falls related to history of falls, unsteady balance, psychotropic med use."</li> <li>*Dehydration/Fluid Maintenance: "Admitted to the facility with a diagnosis of UTI, potential for dehydration/fluid maintenance risk."</li> <li>*Psychotropic Drug Use: "Uses antipsychotic medication for behaviors related to dementia. At risk for falls and adverse side effects; has not exhibited either since admit to the facility.</li> <li>-Consulting pharmacist conducts monthly medication review.</li> </ul>	F 309		
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F 309	<p>Continued From page 11</p> <p>-Moods, behaviors and medications are monitored and reviewed monthly per Behavior Monitoring Team."</p> <p>Review of the interdisciplinary notes, physician's orders, physician's progress notes, mood/behavior sheets, medication administration record (MAR), and pharmacy consultant report from February 6, 2015 through May 5, 2015 revealed:</p> <p>*February 6 through 28, 2015:</p> <p>-Interdisciplinary notes:</p> <p>- 2/6/15 at 19:18 (7:18) p.m. - "Per hospital report, resident was given some Haldol last evening due to anxiety and behaviors. Resident however does not answer questions appropriately due to confusion."</p> <p>- 2/6/15 at 22:00 (10:00) p.m. - "Alert and oriented to self but confused. No agitation noted this shift but has been questioning the lights and noises and who the other person (roommate) in her room is."</p> <p>- 2/7/15 at 3:12 a.m. - "Resident is agitated. She continued to yell at the CNA [certified nursing assistant] and nurse, telling us to get out of her room. She is confused and disoriented. The skin tear was cleansed with dermal cleanser, 3 steri strips were applied and then covered. Resident did finally calm down after about a 1/2 hour and CNA was able to assist her to ambulate with gait belt and assist of one person to the bathroom. Complained of pain when the skin tear was being cleaned, otherwise she has not complained of any other pain or discomfort tonight."</p> <p>- 2/7/15 at 22:00 (10:00) p.m. - "Alert and oriented to self with confusion and forgetfulness. Med (medication) compliant."</p> <p>- 2/8/15 at 23:04 (11:04) p.m. - "Was pleasant and cooperative during dinner meal and starting</p>	F 309		

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F 309	<p>Continued From page 12</p> <p>at 1930 (7:30) she became uncooperative and combative."</p> <p>- -2/8/15 at 3:20 a.m. - "Resident was combative with CNA during cares and would not let her do the blood pressure."</p> <p>- -2/9/15 at 17:21 (5:21) p.m. - "Resident had a very pleasant morning. No behavioral issues from resident this shift."</p> <p>- -2/10/15 at 17:30 (5:30) p.m. - Resident was verbally abusive to other resident at her dining table and the resident's daughter. Different staff tried to engage her in more positive conversation, but resident remained negative in her communication. Continued to make negative comments but not as constant.</p> <p>- -2/11/15 at 13:57 (1:57) p.m. - Her physician notified of the increased behaviors. Resident has been swinging at staff, hollering at staff and other residents. "New orders received 1) Haldol [antipsychotic] 1 MG (milligram) IM (intramuscular) every 1 hour as needed for agitation, 2) Seroquel [antipsychotic] 25 MG 1 tablet by mouth twice a day. Pharmacy notified of new orders."</p> <p>-There was no documentation that the family had been informed of the new physician's orders.</p> <p>- -2/12/15 through 2/28/15 no further documentation of behavioral problems.</p> <p>The Resident Behavior Log revealed the following: *2/8/15 was verbally abusive once and physical behavior once. *2/9/15 was verbally abusive once. *2/10/15 was verbally abusive once and rejected care once. *2/11/15 was verbally abusive once. *No further behaviors documented. *2/11/15 physician's telephone orders revealed:</p>	F 309		

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F 309	<p>Continued From page 13</p> <p>-Seroquel tablet give 25 mg by mouth two times a day related to dementia with behavioral disturbance.</p> <p>-Haldol solution 5 mg/ml inject 1 mg intramuscularly every one hour as needed for agitation.</p> <p>Her February 6 through 28, 2015 MAR revealed:</p> <ul style="list-style-type: none"> <li>*No documentation on 2/7/15 at 3:12 a.m. for pain medication or pain interventions given when she had complaints of pain during the dressing change.</li> <li>*Had received nine doses of the antibiotic.</li> <li>*Seroquel had been started on 2/11/15.</li> <li>*Acetaminophen (pain med) had been given once on 2/25/15.</li> <li>*Haldol was given on 2/11/15.</li> <li>*Lorazepam (anti-anxiety med) 0.25 mg given once on 2/12/15.</li> <li>*Lorazepam 0.5 mg given once on 2/8/15, 2/10/15, and 2/12/15.</li> </ul> <p>The March 1 through 31, 2015 Interdisciplinary notes revealed:</p> <ul style="list-style-type: none"> <li>*3/29/15 at 16:46 (4:46) p.m. - "Resident had fallen."</li> <li>*3/21/15 verbal behavior once.</li> <li>*3/8/15 received pain medication. No documentation of prn antipsychotic or antianxiety meds given.</li> </ul> <p>The 3/3/15 physician's orders revealed resident 1 had received Seroquel 25 mg BID, Haldol 5 mg/ml inject 1 mg intramuscularly every 1 hour as needed for agitation, and lorazepam 0.25 mg and 0.5 mg every 6 hours prn as needed for anxiety. The 3/3/15 physician's progress notes revealed "She was hospitalized earlier in February with a urinary tract infection increasing confusion and</p>	F 309		
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F 309	<p>Continued From page 14</p> <p>general decline. She is now in a nursing home and seems to be settling in okay. When she first got there she was very aggressive and having a lot of behavioral issues with her dementia. We started her on Seroquel which has calmed her down nicely."</p> <p>The April 1 through 30, 2015 Interdisciplinary notes revealed:                      *4/26/15 at 22:07 (10:07) p.m. - "Resident is alert and orient to person."                      *4/27/15 at 11:17 a.m. - "Resident was swinging and attempting to bite CNA during cares. Attempted oral Ativan (antianxiety) and resident spit it right back out. Continued to holler, swing and bite at staff members so Haldol 1 MG was given IM."                      *4/28/15 at 7:40 a.m. - "Resident was agitated, swinging, hollering and attempting to bite staff during AM cares. Haldol 1 MG was given IM."                      *4/29/15 at 11:35 a.m. - "Resident was anxious, agitated, swinging at staff attempting to bite staff during AM cares. Haldol 1 MG was given IM with no further behaviors noted at 9:00 a.m. Resident was agitated, hollering, swinging at staff and other residents at 11:30 a.m. resident was given Haldol 1 MG IM with no further behaviors noted."                      *4/29/15 at 14:39 (2:39) p.m. - "Message left for Dr. [name of physician] in regards to residents increase in agitation and families request for and UA to be drawn."                      *The April 1 through 30, 2015 resident behavior log revealed:                      -4/17/15 rejected care once.                      -4/27/15 verbal behavior once and physical behavior twice.                      -4/29/15 verbal behavior once and physical behavior once.                      -There was no further documentation of</p>	F 309			

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F 309	<p>Continued From page 15 behaviors.</p> <p>-There was no documentation the family had been informed of increased behaviors or of the prn medications given to the resident.</p> <p>-There was no documentation of non-pharmacological interventions attempted by the staff.</p> <p>The April 2015 MAR revealed: *Started antibiotic on 4/29/15. *Received pain medication on 4/25/15 and 4/27/15. No further documentation of pain medication or pain interventions provided. *Received Haldol on 4/27/15, 4/28/15, and twice on 4/29/15.</p> <p>-The 4/10/15 physician's progress notes revealed "Yesterday she was having elevated blood pressure reading and she was more confused. Her mental status has improved. Her behavior lately has been much better at the nursing home. She is pleasantly demented but much better than she was previously as far as agitation is concerned. Assessment Dementia with behavioral disturbance."</p> <p>Review of May 1 through 5, 2015 Interdisciplinary notes revealed: *5/2/15 at 16:41 (4:41) p.m. - "Received a call from Dr. [name of physician] today and he had reviewed the C&amp;S (culture and sensitivity) of UA (urine analysis) and wanted to know if resident was being treated for a UTI. I did let him know resident had been started on Cipro (antibiotic). He gave direction that since resident seemed to be improving he would not make changes but wanted Dr. [name of physician] updated on Monday." *May 1 through 5, 2015 there were no documented behaviors on the residents behavior</p>	F 309		
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F 309	<p>Continued From page 16 log. *Had received the antibiotic. *Had not received any pain medication or prn antianxiety or antipsychotic medications. *Review of the February, March, and April 2015 monthly pharmacy medication regimen review summary revealed: -The psychotropic medications had not been addressed. -The pharmacist had marked the box with a check for "No recommendations" for February, March, and April 2015.</p> <p>Interview on 5/5/15 at 3:45 p.m. with physician B revealed he: *Should have ordered parameters for the prn Haldol instead of ordering the medication to be given every 1 hour prn. *Felt given the resident's situation the psychoactive medications were appropriate. *Had ordered the medications over the telephone without assessing the resident.</p> <p>Interview on 5/6/15 from 9:04 a.m. through 9:42 a.m. with consulting pharmacist E revealed: *Non-pharmacological interventions should have been attempted prior to administration of an antipsychotic medication. *She would have done an assessment on the medications and talked to the director of nursing and staff, so she knew the medications. *She would have monitored for falls, side effects, and attempted a reduction in the medications after the resident had settled into the new environment of the nursing home. *It happened a lot with residents who might have had a UTI that caused behaviors. *There should have been documented dose limits or parameters with the prn Haldol.</p>	F 309		

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F 309	<p>Continued From page 17</p> <ul style="list-style-type: none"> <li>*Interventions needed to be implemented before ordering antipsychotic medications.</li> <li>*Haldol should never be used. It was a Black Box (warning to alert consumer about safety concerns) drug.</li> <li>*She would have asked for a discontinuance of the Haldol.</li> <li>*She had been made aware the previous pharmacist had not made any recommendations for the psychoactive meds.</li> <li>*She felt each resident's meds needed to be individualized, especially for Alzheimer residents.</li> <li>*It depended on the assessment, behaviors, and pain a resident had prior to initiating an antipsychotic medication.</li> <li>*She felt it was important the pharmacist talked to the DON and staff regarding individualizing each situation.</li> <li>*She felt there was no physician order for the appropriate diagnoses for the antipsychotic medications.</li> <li>*Usually the family was notified with psychotropic medications.</li> <li>*Nurses should clarify orders for prn psychotropic medications with the physician before administering.</li> </ul> <p>Interview on 5/6/15 at 9:50 a.m. with the DON, the administrator, and the MDS/registered nurse revealed:</p> <ul style="list-style-type: none"> <li>*There was not a policy for the temporary care plan.</li> <li>*There was no paper log for pain assessments.</li> <li>*Resident 1 had displayed behaviors 5 days after admission.</li> <li>*There were no parameters for the prn Haldol.</li> <li>*There was no follow-up on any pain assessments.</li> <li>*There were no diagnoses for the use of the</li> </ul>	F 309		
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F 309	<p>Continued From page 18 antipsychotic medications.</p> <p>*There was no documentation the family had been notified of the resident's change in condition even though the family visited daily.</p> <p>*The family was aware of the Seroquel but that had not been documented.</p> <p>*There was no documentation the family had been notified of the prn antipsychotic IM med that had been given.</p> <p>*Agreed there was no diagnosis for the use of the antipsychotic Haldol.</p> <p>*The behavior monitoring team consisted of the DON, MDS nurse, and the social service designee to review medication interventions. The information was communicated to the staff.</p> <p>*The facility reviewed psychotropic med use in the quality assurance meetings that were held.</p> <p>Review of the Geriatric Dosage Handbook, 16th Edition, 2011, revealed:</p> <p>*Pages 813-815 for the use of Haldol:</p> <p>-Warnings/Precautions: [U.S. Boxed Warning]: Elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death compared to placebo (fake med). -"Haldol is not approved for the treatment of dementia-related psychosis. Hypotension may occur. May be sedating." -Geriatric dosage: Nonpsychotic patient, dementia behavior (unlabeled use): Initial: Oral 0.25-0.5 mg 1-2 times/day. Increase dose at 4 to 7 day intervals by 0.25 -0.5 mg intervals (twice daily, 3 times/day, etc) as necessary to control response or side effects.</p> <p>*Pages 1509-1510 for the use of Seroquel:</p> <p>-[U.S. Boxed Warning]: Elderly patients with dementia-related psychosis treated with antipsychotic are at an increased risk of death compared to placebo.</p>	F 309		
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F 309	<p>Continued From page 19</p> <p>-May induce orthostatic hypotension. -May be sedating.</p> <p>Review of the provider's undated Admission/Discharge Criteria for the Alzheimer's Care Unit revealed: **"A primary diagnosis of Alzheimer's or other related cognitive disorder was established." **"The resident may be demonstrating behaviors associated with dementia such as memory dysfunction (immediate, recent and remote); poor judgment; disorientation to time, place and person; decreased attention span; mood fluctuations; wandering and exit seeking; expression of anxiety centering on a specific fantasy; catastrophic reactions."</p> <p>Review of the provider's 11/12/14 Notification of Change in Resident Health Status policy revealed: **"To ensure that proper notifications are made when a resident has a change in health status." **"The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is: -Acute illness or a significant change in the resident's physical, mental, or psychosocial status. -A need to alter treatment significantly (a need to discontinue an existing form of treatment due to adverse consequences, or commence a new form of treatment to deal with a problem (the use of any medical procedure, or therapy that has not been used on that resident before)."</p> <p>Review of the provider's 3/24/15 Clinical Health Status-Change of Condition Guideline revealed: **"This process will assist in driving a thorough</p>	F 309		
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F 309	<p>Continued From page 20</p> <p>evaluation of resident/patient conditions on admission, quarterly and with significant change of condition.</p> <p>*The process for identification of change in condition includes gathering objective data and documentation, assessment findings, resident/patient response, and physician and family notification. Communication both written and verbal, are integral part of actions needed for change of condition.</p> <p>*Monitoring/Compliance: Documentation in the electronic record supports MD/family notification is completed timely."</p> <p>Review of the provider's 5/4/15 Antipsychotic Medication Review policy revealed: **"To ensure that the Medical Record of any Resident who receives antipsychotic medication contains documentation supporting the appropriateness and necessity for the use of the drug." **"Review the physician's orders for a complete order that includes: -Dose, frequency, appropriate diagnosis, specific manifestations/behaviors. -Review to ensure that a consent form or documentation noting the risks and benefits for the use of an antipsychotic medication have been discussed with the Resident/Responsible party. -Review to ensure that the Pharmacy Consultant has reviewed the medication program at least monthly and made recommendations for dose reductions, as appropriate."</p> <p>Review of the provider's 2/9/15 Pain Assessment and Management policy revealed: **"It is the policy of [name of company] to promptly assess patient/resident pain levels and to provide relief of symptoms whenever feasible, using a</p>	F 309		
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F 309	<p>Continued From page 21</p> <p>patient/resident-centered and interdisciplinary approach.</p> <p>*Patients/residents will be assessed for pain utilizing standardized pain scales and evaluations upon admission (within 24 hours), quarterly, after a fall, and as needed, based on their exhibiting symptoms of pain or upon report of new onset of pain."</p> <p>Review of the provider's May 2012 Medication Monitoring - Documentation and Communication of Consultant Pharmacist Recommendations policy revealed "The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapy are communicated to those with authority and/or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion."</p> <p>Review of the provider's May 2012 Medication Monitoring - Medication Regimen Review policy revealed:</p> <p>*"The consultant pharmacist identifies:</p> <ul style="list-style-type: none"> <li>-The prescribed dose is appropriate to the resident's clinical status.</li> <li>-The duration of therapy is indicated and is appropriate for the resident.</li> <li>-When possible, non-pharmacological interventions are considered before initiating a new medication.</li> <li>-Medical condition and response to drug therapy are evaluated to assure the appropriateness of the medication regimen.</li> <li>-Continuity of administration or routine medications.</li> <li>-Presence of a clinical condition that might warrant initiation of medication therapy." </li></ul>	F 309		
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F 329 SS=D	<p><b>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on interview, record review, and policy review, the provider failed to have an appropriate diagnosis, indications, and documentation of behaviors for one of one sampled resident (2) who had been given multiple medication doses of Haldol (antipsychotic), Ativan (anti-anxiety), and Xanax (also an anti-anxiety). Findings include:</p>	F 329	<p><b>F329</b></p> <p>1. All residents are at risk. Orders have been received to discontinue resident 2 as needed order for Ativan and Haldol. Resident 2 has an appropriate diagnosis to support the use of the current psychoactive medication ordered. No corrective action could be taken regarding indication for use of the as needed psychoactive medications previously administered or missing documentation regarding previous behaviors. All resident's drug regimen is free from unnecessary drugs.</p> <p>2. The DNS will in-service the licensed professional nurses regarding the need to have an appropriate diagnosis for psychotropic medication use and to ensure documentation of behaviors requiring the use of psychotropic medications. In-service will be completed no later than June 3, 2015.</p> <p>3. The DNS or designee will conduct audits of resident's receiving psychoactive medications weekly X 4, then monthly X 3; [REDACTED]</p> <p>Results of audits will be reported by the DNS or designee and discussed at monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>X [REDACTED] [REDACTED]</p>	6/24/15
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\*four  
see page 214  
[REDACTED]

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F 329	<p>Continued From page 23</p> <p>1. Review of resident 2's complete medical record revealed: *She had been admitted on 7/12/13. *Her diagnoses included: -Cerebral vascular disease (she had a stroke resulting in left sided paralysis). -Rheumatoid arthritis. -Hypertension (high blood pressure). -Depressive disorder. -Generalized anxiety disorder. *There had been no diagnoses of any psychosis or behavioral concerns. *She had a history of urinary tract infections. *She was alert and orientated to person, place, and time.</p> <p>Review of resident 2's physician's orders revealed: *On 10/13/14 at 1646 (4:46 p.m.) Give Xanax 0.5 milligrams (mg) by mouth two times a day related to generalized anxiety disorder. *On 1/11/15 at 14:16 (2:14 p.m.) Give Ativan give 0.5 mg by mouth every 8 hours as needed for anxiety and 0.5 mg one time for anxiety until 1/11/15 23:59 (11:59 p.m.). *On 1/14/15 at 17:35 (5:35 p.m.) Give Xanax 1 mg give one tablet by mouth every 4 hours as needed for anxiety. *On 1/15/15 at 17:21 (5:21 p.m.) Give Haldol 2 mg one tablet by mouth every four hours as needed for agitation.</p> <p>Review of resident 2's January 2015 medication administration record (MAR) revealed: *From January 1 through January 10 she was administered Xanax 0.5 mg twice a day. *She was administered Ativan 0.5 mg orally on January 11, 14, and 15. *She was administered Haldol 2 mg orally on</p>	F 329	<p><i>* (continued from page 23, # 3). for appropriate diagnosis or indicator for use and documentation of resident behaviors. sckdbrh/mf</i></p>	
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F 329	<p>Continued From page 24 1/19/15.</p> <p>Review of resident 2's January 2015 Progress Notes revealed:</p> <p>*On 1/2/15 at 19:04 (7:04 p.m.) the nurse had administered Milk of Magnesia for constipation.</p> <p>*On 1/3/15 at 21:20 (9:20 p.m.) "PRN (when ever needed) administration was: Effective she said she had a small bm (bowel movement) today and refused lax (laxative)."</p> <p>*There was no nursing documentation on 1/1/15, and from 1/3/15 until 1/7/15.</p> <p>*On 1/7/15 at 17:17 (5:17 p.m.) "Resident was positive for UTI (urinary tract infection). Resident will start on first dose this evening."</p> <p>*On 1/8/15 at 15:11 (3:11 p.m.) "Continues on antibiotic for UTI Less confused. Pleasant and cooperative."</p> <p>*On 1/11/15 at 13:51 (1:51 p.m.) "Resident has had increased anxiety all shift. Resident has had to have assist of 1 with her all shift due to wandering and resident not sitting down and wanting to go home. Resident has not gotten rough with staff but both meals this shift but would not sit still very shortly after the meal. Resident has been up pacing in the halls all shift. Dr. (name of her physician) was tried to be called and left messages for him regarding her with no return phone call. On call Dr. (name of physician) called and new orders for resident to have Ativan prn every 8 hours as needed. Also to hold her alprazolam (Xanax) when she is receiving her Ativan PRN UA (urinalysis) C&amp;S (culture and sensitivity) to be obtained. Labs (laboratory) including CBC-Diff, CRP, blood cultures, and Comp panel. Resident received her prn dose of Ativan 0.5 mg around 1330 (1:30 p.m.)."</p> <p>*On 1/11/15 at 16:39 (4:30 p.m.) "Dr. (name of on-call physician) called back regarding lab draws</p>	F 329		
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F 329	<p>Continued From page 25</p> <p>[blood tests]. Resident to have a dose of Potassium and to have her potassium and CBC-Diff rechecked tomorrow. Resident received her Potassium. Resident still up and down she will lay in bed for a little bit. Resident still seeing different things."</p> <p>*On 1/13/15 at 0910 (9:10 a.m.) "Give Ativan 0.5 mg by mouth every 8 hours as needed for anxiety."</p> <p>*On 1/14/15 at 10:54 a.m. "Ativan Give 0.5 mg by mouth every 8 hours as needed for anxiety. Resident is quite agitated."</p> <p>*On 1/14/15 at 17:47 (5:47 p.m.) Give Xanax 1 mg one tablet by mouth every 4 hours as needed for anxiety.</p> <p>*On 1/14/15 at 21:28 (9:28 p.m.) "Xanax 1 mg Give 1 tablet by mouth every 4 hours as needed for anxiety. PRN Administration ineffective. Resident continues to be anxious. She is not easily redirected. She continues to try and get up on her own."</p> <p>*On 1/19/15 at 06:36 (6:36 a.m.) "Haldol 2 mg by mouth every 4 hours as needed for agitation Give 0.5 mg by mouth. Resident agitated Haldol 2 mg give by mouth."</p> <p>*On 1/19/15 at 7:55 a.m. "PRN administration was effective. Resident is calmly sitting in her w/c at the dining room table."</p> <p>Review of resident 2's January 2015 Behavior Detail Report revealed: *There were no behaviors documented on January 7, 8, 9, 10, 11, and 12. *The only behavior documented was on 1/13/15 at 9:52 a.m. when there had been verbal behaviors towards others. A one-to-one activity had been provided and was documented as effective. *There were no behaviors documented for</p>	F 329			

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F 329	<p>Continued From page 26 January 15, 16, 17, 18, and 19.</p> <p>Review of resident 2's February 2015 MAR revealed there had been no prn anti-anxiety or anti-psychotic medications administered.</p> <p>Review of resident 2's March 2015 MAR revealed: *On 3/21/15 there had been multiple doses of oral Haldol, Ativan, and Xanax given to her in a seventeen hour period as follows: -At 2:05 a.m. Xanax 1 mg. -At 7:28 a.m. Haldol 2 mg. -At 10:19 a.m. Xanax 1 mg. -At 11:48 a.m. Haldol 2 mg. -At 3:27 p.m. Haldol 2 mg. -At 2:15 p.m. Ativan 0.5 mg. -At 5:22 p.m. Xanax 1 mg. -At 7:25 p.m. Haldol 1 mg. *She had a total of 8 mg of Haldol, 3 mg of Xanax, and 0.5 mg of Ativan in a seventeen hour period.</p> <p>Review of resident 2's March 2015 Behavior Detail Report revealed the only behaviors documented on 3/21/15 was wandering throughout the facility at 1:46 p.m., behaviors not directed towards others and resident's behaviors did not include self-abusive acts or sex acts at 7:56 p.m. There was no thorough documentation for the justification of the multiple doses of the anti-psychotic and anti-anxiety medications that she had received on 3/21/15.</p> <p>Review of resident 2's April 2015 MAR revealed she continued to receive Ativan and Xanax as needed. Both anti-anxiety medications. She had received Ativan 0.5 mg on April 12 and 25. She had received Xanax 1 mg twice on April 7, once</p>	F 329		
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F 329	<p>Continued From page 27 on April 21, 26, and 30.</p> <p>Review of resident 2's April 2015 Progress Notes revealed on 4/25/15 at 9:21 p.m. She was crying while urinating, and she stated it burned, and she had pelvic pain. UA was obtained, and she was positive for a UTI and was started on Bactrim (antibiotic).</p> <p>Review of resident 2's April 2015 Behavior Detail Report revealed there had been no behaviors documented for April.</p> <p>Review of resident 2's May 2015 MAR revealed she had not received any anti-anxiety or anti-psychotic medication.</p> <p>Review of resident 2's February 2015 pharmacy medication regimen review summary revealed: *The consulting pharmacist indicated the resident had been on duplicate therapy of Xanax and Ativan. *There was no documentation the pharmacist recommendation had been addressed and followed-up on.</p> <p>Review of resident 2's revised 4/25/15 comprehensive care plan revealed: *She had intact cognition (alert and orientated). *Her short term memory was impaired, and her long term care memory was intact. *She was understood and was able to understand. *She had not exhibited any indicators of delirium (incoherent thought or speech). *There was minimal signs and symptoms of moods and depression. Does have a diagnoses of depression and anxiety. There were no hallucinations (seeing person or objects not really</p>	F 329		
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F 329	<p>Continued From page 28 there) or delusions (misbelief). *There was a history of the following behaviors: -Refused care by staff. -Verbal (yelling) behaviors towards others. She was generally pleasant with staff and care. *She used an anti-anxiety medication as needed for the diagnosis of anxiety; she used anti-depressant medication for the diagnosis of depression; she used antipsychotic medication as needed for agitation. *There were no non-pharmacological ( no medication) interventions documented in her care plan. *Moods, behaviors, and medications were to have been monitored and reviewed monthly per the Behavior Monitoring Team.</p> <p>Interview on 5/5/15 at 9:40 a.m. with the Minimum Data Set (MDS) assessment registered nurse regarding resident 2 revealed: *She was unsure as to why there were no non-pharmacological interventions documented on her care plan. *There were no individualized interventions used for those individuals with behaviors. *Only if the staff knew that specific interventions had worked with the resident would those interventions have been added to the residents care plan. *All interventions placed on the Kiosk (where staff would electronically chart) would be generic and used for all the residents.</p> <p>Interview per telephone on 5/6/15 at 9:04 a.m. with consulting pharmacist E regarding resident 2's PRN anti-psychotic and anti-anxiety medication revealed: *She stated dealing with residents with behaviors was a "vicious cycle"; it took up staff time, and</p>	F 329		
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F 329	<p>Continued From page 29</p> <p>then the staff would forget to document the incidents.</p> <p>*She agreed the medication was excessive on 3/21/15, and that Ativan and Xanax would have been duplicate drug therapy.</p> <p>*She had stated the previous pharmacist said the recommendation had been rejected. It had been resent to the physician for further evaluation, but there had been no documentation provided at the time of the survey.</p> <p>*The provider would have been responsible for any follow-up after the pharmacist had made a recommendation.</p> <p>*The documentation provided by the nursing staff should describe exactly what behaviors the resident had been experiencing at the time the medication was administered.</p> <p>*An appropriate nursing assessment should have been completed to ensure the behaviors had not been a secondary reaction to a medical diagnosis.</p> <p>*The monthly medication review would have included:</p> <ul style="list-style-type: none"> <li>-Speaking with the staff.</li> <li>-Evaluating the labs.</li> <li>-Reviewing all the medications.</li> <li>-The PRN medications should have been addressed, she would find out why those medications were administered, and what was the outcome of the administration of those medications.</li> <li>-There should never have been any PRN psychotics administered to the residents.</li> </ul> <p>Interview on 5/6/15 at 9:50 a.m. with the director of nursing (DON), the MDS registered nurse, and the administrator regarding resident 2 revealed:</p> <p>*There had been no follow-up documentation found by the staff for the pharmacy consultant</p>	F 329		
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F 329	Continued From page 30 medication review on February 2015. *The DON stated the recommendation had been rejected, but she could not locate that information during the survey. *She agreed the Xanax and the Ativan were duplicate medication therapy. *They agreed the Haldol, Xanax, and Ativan had been excessive, and there was no clinical rationale for the administration of all those medications.  Review of the provider's May 2012 Documentation and Communication of Consultant Pharmacist Recommendations revealed: **The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents medication therapy are communicated to those with authority and/or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion. *The consultant pharmacist documents potential or actual medication-related problems, irregularities, and other medication regimen review findings appropriate for prescriber and/or nursing review. *Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. In the event of a problem requiring the immediate attention of the prescriber, the responsible physician or physician's designee is contacted by the consultant pharmacist or the facility, and prescriber response is documented on the consultant pharmacist review record or elsewhere	F 329			

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F 329	<p>Continued From page 31 in the resident's medical record.</p> <p>*Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to recommendation direct to him/her in a timely manner, the Director of Nursing and/or the consultant pharmacy may contact the Medical Director.</p> <p>*The consultant pharmacist compiles, analyzes, and presents aggregate (total quantity) data about recommendations, response to recommendations, and outcomes as part of the pharmacy CQI (committee quality improvement) program in the facility."</p> <p>Review of the provider's May 2012 Medication Regimen Review revealed:</p> <p>**The consultant pharmacist performs a comprehensive review of each resident's medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing and the attending physician and if appropriate, the medical director and/or the administrator.</p> <p>*In performing medication regimen reviews, the consultant pharmacist incorporates federally mandated standards of care, in addition to other applicable professional standards.</p> <p>*The consultant pharmacist identifies irregularities through a variety of sources including: Medication Administration Records (MAR); prescriber's orders; progress notes of prescriber, nurses, and/or consultants; the</p>	F 329		
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F 329	<p>Continued From page 32</p> <p>Resident Assessment Instrument (RAI); laboratory and diagnostic test results; behavior monitoring information; the facility staff; the attending physician, and from interview, assessing, and/or observing the resident. The consultant pharmacist's evaluation includes, but is not limited to reviewing and/or evaluating the following:</p> <ul style="list-style-type: none"> <li>-A written diagnosis, indication, or documented objective findings support each medication order.</li> <li>-As needed (PRN) orders include indications for use.</li> <li>-Indications for use and therapeutic goals are consistent with current medical literature and clinical practice guidelines.</li> <li>-Documentation by physician, nurse and/or consultants indicating progress toward or eminence [distinct] goals of therapy.</li> <li>-Laboratory results, diagnostic studies, or other medication therapy measurements are obtained by staff/physician and acted upon.</li> <li>-Duplication of medication orders includes a written rationale for the duplication and evidence of monitoring for both efficacy (intended result) and cumulative (increasing in quantity) adverse medication effects.</li> <li>*Recommendations are acted upon and documented by the facility staff and or the prescriber.</li> <li>-Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing.</li> <li>-If there is potential for serious harm and the attending physician does not concur, or the attending physician refuses to document an explanation for disagreeing, the director of nursing and the consultant pharmacist contact the medical director."</li> </ul>	F 329		
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F 329	<p>Continued From page 33</p> <p>Review of the providers 5/4/15 Antipsychotic Medication Review policy revealed:</p> <ul style="list-style-type: none"> <li>*The purpose of the policy was to ensure that the medical record of any resident who received antipsychotic medication contained documentation supporting the appropriateness and necessity for the use of the drug.</li> <li>*Review of the following: <ul style="list-style-type: none"> <li>-Physician's orders for a complete order that would include appropriate diagnosis, and specific manifestations/behaviors.</li> <li>-Review the care plan for the following information: The antipsychotic medication and the reason for the medication. Side effects, behaviors, and suggested interventions.</li> <li>-Review that behaviors are being monitored and documented on Care Tracker and/or behaviors sheet that is easily accessible to staff.</li> <li>-Review nursing notes for documentation of daily side effect monitoring and follow-up to side effects.</li> <li>-Review to ensure the appropriate assessments are completed every six months.</li> <li>-Review the social services notes: If resident is stable, perform monthly documentation that reflects the behaviors and outcomes of the behavior management programs. If the resident is unstable, perform weekly documentation reflecting new behaviors, or increased behaviors, and medication changes. For all residents documentation of non-pharmacological interventions and whether effective or not effective.</li> <li>-Review to ensure that the pharmacy consultant has reviewed the medication program at least monthly and has made recommendation for does reductions, as appropriate."</li> </ul> </li> </ul> <p>Review of the Drug Information Handbook, 18th</p>	F 329		
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F 329	<p>Continued From page 34</p> <p>Ed., 2009-2010, pp. 69, pp. 720-721, and pp. 905-906 revealed:</p> <p>*Xanax used in the elderly should have initial doses of 0.125 mg to 0.25 mg twice daily, increase daily by 0.125 mg/day. The smallest effective dose should be used. Titrate gradually, if needed. A benzodiazapine (psychoactive drug class).</p> <p>*Haldol is used in the management of schizophrenia, control of tics, non-schizophrenia psychosis, may be used for severely agitated or delirious patients, and psychosis/agitation related to Alzheimer's dementia. Black Box warning for use in the elderly due to increased risk of death. Elderly use in antipsychotic patient, dementia, behavior (unlabeled use): Initial dose: Oral: 0.25 mg to 0.5 mg 1-2 times daily, increase dose four to seven day intervals by 0.25 mg to 0.5 mg. Monitor Parameters such as vital signs and mental status.</p> <p>*Ativan: Use cautiously in the elderly and cross-sensitivity with other benzodiazepine.</p> <p>Review of Patricia A Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 350, revealed: "Accurate documentation is one of the best defenses for legal claims associated with nursing care. To limit nursing liability nursing documentation must indicate clearly that a patient received individualized, goal-directed nursing care based on the nursing assessment. The record must describe exactly what happened to a patient and follow agency standards. This is best achieved when you chart immediately after providing care. Even, though nursing care may have been excellent, in a court of law "care not documented is care not provided."</p>	F 329		

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F 428 F 428 SS=D	Continued From page 35 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on record review, interview, and policy review, the provider failed to ensure one of one pharmacist medication regimen review for one of one sampled resident (2) was appropriately followed-up with the physician for duplicate medication therapy for Xanax and Ativan. Findings include:  1. Review of resident 2's February 2015 medication regimen review summary revealed there had been a pharmacist recommendation to address duplicate medication therapy for Xanax and Ativan.  Interview on 5/5/15 at 10:00 a.m. with the director of nursing regarding the above finding revealed she was unsure if the duplicate therapy had been addressed with resident 2's physician.  Interview per telephone on 5/6/15 at 9:04 a.m. with consulting pharmacist E regarding resident	F 428 F 428	<b>F428</b>  1. All residents are at risk. The consulting pharmacist recommendation from February 2015 has been readdressed and followed up on for resident 2. New order received to discontinue the as needed antianxiety medication, Ativan. The facility does ensure that all residents have a drug regimen review at least monthly by a licensed pharmacist with appropriate follow-up completed by the DNS.  2. The Consulting Pharmacist, ED & DNS will review the medication regimen review policy and what the requirements are to ensure follow-up is completed on a timely basis. In-service will be completed no later than June 3, 2015. * FOUR SC/SDDDH/MF 3. The DNS or designee will complete [REDACTED] audits monthly x 4 to ensure that the pharmacy medication regimen review is completed monthly and follow-up is conducted appropriately with the physician. Results of the audits will be reported by the DNS and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.  * [REDACTED] SC/SDDDH/MF	6/24/15

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F 428	<p>Continued From page 36</p> <p>2's when ever needed (PRN) anti-psychotic and anti-anxiety medication revealed:</p> <p>*She stated dealing with residents with behaviors was a "vicious cycle"; it took up staff time, and then the staff would forget to document the incidents or behaviors.</p> <p>*She agreed the Ativan and Xanax would have been duplicate drug therapy.</p> <p>*She had stated the previous pharmacist said the recommendation had been rejected. It had been resent to the physician for further evaluation, but there had been no documentation provided at the time of the survey.</p> <p>*The provider would have been responsible for any follow-up after the pharmacist had made a recommendation.</p> <p>*The monthly medication review would have included:</p> <ul style="list-style-type: none"> <li>-Speaking with the staff.</li> <li>-Evaluating the labs.</li> <li>-Reviewing all the medications.</li> <li>-The PRN medications should have been addressed, should find out why those medications were administered, and what was the outcome of the administration of those medications.</li> <li>-There should never have been any PRN psychotics administered.</li> </ul> <p>Interview on 5/6/15 at 9:50 a.m. with the director of nursing, the MDS nurse, and the executive director regarding resident 2's February 2015 pharmacy consult revealed:</p> <p>*There had been no follow-up documentation found by the staff for the pharmacy consultant medication review on February 2015.</p> <p>*The director of nursing stated the recommendation had been rejected, but she could not locate that information during the</p>	F 428		

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F 428	<p>Continued From page 37 survey. *The Xanax and the Ativan were duplicate medication therapy.</p> <p>Review of the provider's May 2012 Documentation and Communication of Consultant Pharmacist Recommendations revealed: **The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapy are communicated to those with authority and/or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion. *The consultant pharmacist documents potential or actual medication-related problems, irregularities, and other medication regimen review findings appropriate for prescriber and/or nursing review. *Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. In the event of a problem requiring the immediate attention of the prescriber, the responsible physician or physician's designee is contacted by the consultant pharmacist or the facility, and prescriber response is documented on the consultant pharmacist review record or elsewhere in the resident's medical record. *Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to recommendation direct to him/her in a timely manner, the Director of Nursing and/or the consultant pharmacy may contact the Medical</p>	F 428		
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F 428	Continued From page 38 Director. *The consultant pharmacist compiles, analyzes, and presents aggregate (total quantity) data about recommendations, response to recommendations, and outcomes as part of the pharmacy CQI (committee quality improvement) program in the facility."  Review of the provider's May 2012 Medication Regimen Review revealed: *"The consultant pharmacist performs a comprehensive review of each resident's medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing and the attending physician and if appropriate, the medical director and/or the administrator. *In performing medication regimen reviews, the consultant pharmacist incorporates federally mandated standards of care, in addition to other applicable professional standards. *The consultant pharmacist identifies irregularities through a variety of sources including: Medication Administration Records (MAR); prescriber's orders; progress notes of prescriber, nurses, and/or consultants; the Resident Assessment Instrument (RAI); laboratory and diagnostic test results; behavior monitoring information; the facility staff; the attending physician, and from interview, assessing, and/or observing the resident. The consultant pharmacist's evaluation includes, but is not limited to reviewing and/or evaluating the	F 428			

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F 428	Continued From page 39 following: -A written diagnosis, indication, or documented objective findings support each medication order. -As needed (PRN) orders include indications for use. -Indications for use and therapeutic goals are consistent with current medical literature and clinical practice guidelines. -Documentation by physician, nurse and/or consultants indicating progress toward or eminence (recognized) goals of therapy. -Laboratory results, diagnostic studies, or other medication therapy measurements are obtained by staff/physician and acted upon. -Duplication of medication orders includes a written rational for the duplication and evidence of monitoring for both efficacy (intended result) and cumulative (increasing in quantity) adverse medication effects. *Recommendations are acted upon and documented by the facility staff and or the prescriber. -Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. -If there is potential for serious harm and the attending physician does not concur, or the attending physician refuses to document an explanation for disagreeing, the director of nursing and the consultant pharmacist contact the medical director."	F 428		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD  The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles	F 492	<p><b>F492</b></p> <p>1. All residents are at risk. The facility will ensure that timely notification of law enforcement is completed per the regulations at the time of the specific incident.</p>	6/24/15

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F 492	Continued From page 40 that apply to professionals providing services in such a facility.  This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on interview, record review, and South Dakota Codified Law review, the provider failed to ensure a timely notification to law enforcement for one of one sampled resident (1) who had been involved in an incident at the facility that involved a "snapchat" photo (a picture or video taken on a person's cell phone) of the resident that was shared with another individual over in the Internet. Findings include:  1. Review of the provider's 4/25/15 twenty-four hour incident report regarding resident 1 revealed: *The executive director had received a phone call from an anonymous caller on 4/24/15. The caller had not wanted to identify herself and had wanted to remain anonymous. The caller stated she had received a "snapchat" picture and video of a resident in the bathtub from certified nursing assistant (CNA) F. The caller did not know the residents name but said she had seen body parts and would have been able to identify the resident. The caller stated a current employee had sent the "snapchat" picture to her. The caller had been asked to forward the information to the executive director, the caller informed the executive director she did not have the picture of the resident but had saved the texted messages from the "snapchat." *There was an initial interview with CNA F on 4/24/15. The CNA had been suspended on 4/24/15 at 2:30 p.m. pending a five day	F 492	2. The ED will in-service all staff on the requirements of a resident incident/event reporting process. In-service will be completed no later than June 3, 2015.  3. The ED or designee will perform random audits of any incidents weekly x 4, then monthly x 3 to ensure that the requirements of timely notification to proper authorities is completed per the Elder Justice Act. Results of the audits will be reported by the ED or designee and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.  * [REDACTED] SC/SDDCH/ME	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PIERRE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>950 EAST PARK STREET</b> <b>PIERRE, SD 57501</b>		
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F 492	<p>Continued From page 41 investigation.</p> <p>*The Department of Social Services had not been notified.</p> <p>*The local ombudsman was notified on 4/25/14.</p> <p>*Law enforcement was not notified.</p> <p>Telephone interview on 5/7/15 at 1:00 p.m. with the executive director regarding timely notification of law enforcement in relationship to the above incident revealed:</p> <p>*She had not notified law enforcement after she had found out about the incident on 4/24/15.</p> <p>*She was unsure if the above incident was considered abuse.</p> <p>*Her main focus was making sure the resident was cared for, and notification to the South Dakota Department of Health had occurred.</p> <p>*She had not made the determination the incident had to be reported to law enforcement until she had completed her investigation of the above incident.</p> <p>Review of the South Dakota Codified Law 22-46-10 revealed: " Mandatory reporting of abuse or neglect by staff and by person in charge of residential facility or entity providing services to elderly or disabled adult--Violation as misdemeanor. Any staff member of a nursing facility, assisted living facility, adult day care center, or community support provider, or any residential care giver, individual providing homemaker services, victim advocate, or hospital personnel engaged in the admission, examination, care, or treatment of elderly or disabled adults who knows, or has reasonable cause to suspect, that an elderly or disabled adult has been or is being abused or neglected, shall, within twenty-four hours, notify the person in charge of the institution where the</p>	F 492			

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F 492	Continued From page 42 elderly or disabled adult resides or is present, or the person in charge of the entity providing the service to the elderly or disabled adult, of the suspected abuse or neglect. The person in charge shall report the information in accordance with the provisions of § 22-46-9. Any person who knowingly fails to make the required report is guilty of a Class 1 misdemeanor." Source: SL 2011, ch 119, § 2.  Review of South Dakota Codified Law 22-46-9 revealed: "Mandatory reporting of abuse or neglect to state's attorney, Department of Social Services, or law enforcement officer--Violation as misdemeanor. Any person who is a: (4) State, county, or municipal criminal justice employee or law enforcement officer, who knows, or has reasonable cause to suspect, that an elder or disabled adult has been or is being abused or neglected, shall, within twenty-four hours, report such knowledge or suspicion orally or in writing to the state's attorney of the county in which the elder or disabled adult resides or is present, to the Department of Social Services, or to a law enforcement officer. Any person who knowingly fails to make the required report is guilty of a Class 1 misdemeanor." Source: SL 2011, ch 119, § 1.	F 492			