



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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E-mail: fsb@dhw.idaho.gov

November 29, 2017

David Welker, Administrator
Clearwater of Cascadia
1204 Shriver Road
Orofino, ID 83544-9033

Provider #: 135048

Dear Mr. Welker:

On **November 14, 2017**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **October 18, 2017**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F0323 -- S/S: G -- 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/supervision/devices**
- **F0329 -- S/S: D -- 483.45(d)(e)(1)-(2) -- Drug Regimen Is Free From Unnecessary Drugs**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 8, 2017**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

As noted in the Bureau of Facility Standards' letter of **September 18, 2017**, following the survey of **August 28, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for imposition of a civil monetary penalty, Denial of Payment for New Admissions effective **November 28, 2017** and termination of the provider agreement on **February 25, 2018**.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

David Welker, Administrator
November 29, 2017
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If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **December 9, 2017**. If your request for informal dispute resolution is received after **December 9, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



Debby Ransom, RN, RHIT, Supervisor
Long Term Care

David Welker, Administrator
November 29, 2017
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DR/lj

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

PRINTED: 02/26/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2017
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(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	
{F 000}	INITIAL COMMENTS An on-site revisit survey was conducted from November 13, 2017 to November 14, 2017. The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator David Scott, RN Abbreviations Include: a.m - morning cm - Centimeters CNA - Certified Nursing Assistant CNC - Clinical Nurse Consultant DON - Director of Nursing ER - Emergency Room LPN - Licensed Practical Nurse MAR - Medication Administration Record MDS - Minimum Data Set mg - Milligram PRN - as needed RN - Registered Nurse	{F 000}			
{F 323} SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side	{F 323}		12/7/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/06/2017

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 323}	<p>Continued From page 1</p> <p>or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to adequately supervise residents to prevent falls. This was true for 2 of 6 residents (#18 and #20) reviewed for falls and resulted in harm to Resident #18, who required sutures for a laceration sustained when she fell from her wheelchair while sleeping. Findings include:</p> <p>1. Resident #18 was admitted to the facility on 8/31/15 with diagnoses that included difficulty walking, muscle weakness, unsteadiness while standing, and lack of coordination. The resident was 91-years of age.</p> <p>An 8/24/17 quarterly Minimum Data Set (MDS) assessment documented Resident #18 experienced severe cognitive impairment, routinely felt tired or had little energy, required extensive assistance of 1 staff for transfers and locomotion, was able to perform surface-to-surface transfers only with the</p>	{F 323}	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, The Facility does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F 323</p> <p>Resident #18 has been reassessed by interdisciplinary (ID) team. A new fall risk assessment was completed. Orders and care plan have been updated to reflect current status. Alarms have been checked for placement and function.</p>		

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{F 323}	<p>Continued From page 2 assistance of 1 staff, and required a wheelchair for mobility.</p> <p>An 8/24/17 Fall Risk Evaluation documented Resident #18 was at risk for falls due to intermittent confusion, wheelchair dependence for mobility, balance difficulty while standing, decreased muscular coordination, medications, 1 - 2 "predisposing diseases," and 1 fall within the preceding 3 - 6 months.</p> <p>Resident #18's October 2017 Physician's Orders included:</p> <ul style="list-style-type: none"> * Carvedilol, 1.5 milligrams (mg) twice daily for hypertension. * Lisinopril, 20 mg, once daily for hypertension. * Docusate Sodium, 100 mg twice daily for constipation. * Pressure alarm to the bed that staff were to check each shift for function and placement. * There was no physician's order for an alarm to the resident's wheelchair on the October 2017 Physician's Orders. <p>The 2018 Nursing Drug Handbook documented potential adverse reactions to Carvedilol included fatigue, somnolence, and syncope (fainting); potential adverse reactions to Lisinopril included fatigue; and potential adverse reactions to Docusate Sodium included somnolence.</p> <p>October 2017 Medication Administration Records documented Resident #18 received Carvedilol, Lisinopril, and Docusate Sodium as ordered each day of the month.</p> <p>A Fall Scene Investigation Report documented</p>	{F 323}	<p>Staff have been instructed to offer to lay her down if sleeping in her wheelchair. Resident #20 is no longer residing in facility.</p> <p>Residents at risk for falls could be affected. Fall risk assessments have been reviewed. Orders and care plans have been updated to current status. Alarms have been checked for placement and function.</p> <p>Facility staff have been educated in fall prevention. Re-education was provided by the director of nursing (DON) and/or Clinical Resource RN to include but not limited to, checking alarms for placement and function, observing residents and implementing interventions if sleeping in wheelchairs, following the fall prevention care plan, and walking rounds to validate fall prevention plan is implemented. The system is amended to include walking rounds at the beginning of each shift to validate fall prevention plan is implemented.</p> <p>Walking rounds will be completed by assigned members of the care management team every week day x 8 weeks. Audit will include verification of alarms placement and function, as well as noting residents that may be sleeping while up in wheelchair. Findings will be documented on the Performance Improvement (PI) tool starting the week of 12-4-17. Any concerns will be reported immediately to licensed nurse for</p>		

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{F 323}	<p>Continued From page 3</p> <p>that on 10/31/17 at 10:28 am Resident #18 fell forward and onto the floor while sleeping in a wheelchair near a nurse's station. The Report documented a wheelchair alarm in use at the time experienced a "delayed reaction" and that Resident #18 sustained a 3 centimeter (cm) by 4 cm laceration to her left forehead.</p> <p>Witness Statements by Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs) attached to the Fall Scene Investigation Report, each dated 10/31/17 at unspecified times, documented:</p> <p>* LPN #1 - "I was charting ... [at the] nurses station [and] the Activity Director had walked by [and] said Resident #18 is on the floor, as I looked up [staff was assisting the resident and] I saw a large amount of blood." The Witness Statement did not mention an alarm.</p> <p>* CNA #2 - "I was in [the] restroom. When I came out I seen (sic) both nurses around Resident #18 [and] her chair alarm [was] going off."</p> <p>* LPN #3 - "I was sitting at the nurses station and heard someone fall to the ground. I stood up and saw Resident #18 on the ground. Myself (sic) and another nurse went to go attend (sic) to her when we noticed she had a 4 cm [by] 3.5 cm abrasion to her forehead." The Witness Statement did not mention an alarm.</p> <p>* CNA #4 - "[I] was in a room doing patient care [and] heard a (sic) alarm. [I] came out [and] saw the resident ... on the floor."</p> <p>An SBAR (Situation-Background-Assessment -</p>	{F 323}	<p>corrective action. Results of audit and follow up actions will be reported in QAPI/stand down meeting.</p> <p>DNS and/or designee will audit documentation related to alarm checks and residents who have a history of sleeping in their wheelchair every week x 8 weeks. Any concerns will be addressed immediately and discussed with the Quality Assurance/Performance Improvement (QAPI) committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p>Date of Compliance: 12/07/2017</p>		

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{F 323}	<p>Continued From page 4</p> <p>Request) Communication Form, dated 10/31/17 at 10:25 am, documented Resident #18 "fell out [of] her wheelchair, hit her head on the ground, and is bleeding." The SBAR documented Resident #18 exhibited a decreased level of consciousness, increased confusion or disorientation, and was receiving antibiotics for a UTI.</p> <p>An Interdisciplinary Progress Note, dated 10/31/17 at 10:38 am, documented, Resident #18 was sitting near nurses station ... sleeping at time of fall. Resident #18 had leaned forward and fell onto the floor, landing on the left forehead. Resident #18 was immediately surrounded by staff. The nurse applied pressure to laceration. The Physician was notified, and said to immediately send Resident #18 to ER. Resident #18 returned to facility at 1:30 pm.</p> <p>A hospital treatment report, dated 10/31/17, documented Resident #18 presented with a "head laceration ... She was sleeping in her wheelchair when she started to pitch forward ... she fell out of the wheelchair and struck her head on the ground. A large laceration was noted on her forehead. Currently she reports some mild discomfort in the forehead." The report documented 11 sutures were required to close the 3 cm by 5 cm chevron-shaped laceration.</p> <p>A Fall Prevention Care Plan, dated 5/24/17, included an undated/unsigned intervention to equip the resident's wheelchair with a pressure alarm to alert staff to attempted self-transfers. The Care Plan also included a handwritten intervention, dated 11/3/17, that documented, If Resident #18 is lethargic or sleeping in a</p>	{F 323}			

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{F 323}	<p>Continued From page 5 wheelchair offer to lay her down for a nap.</p> <p>On 11/13/17 at 3:35 pm, Resident #18 was observed in bed with a chevron-shaped scar on her left forehead. When asked whether she remembered the 10/31/17 incident, Resident #18 stated she experienced a "headache for 3 or 4 days" afterward. When asked whether the headache was related to her fall, the resident stated, "I think so."</p> <p>On 11/14/17 at 8:15 am, the Director of Nursing (DON) stated breakfast in the dining room used by Resident #18 finished at 8:30 am to 8:45 am. The DON stated Resident #18 was asleep in her wheelchair for "about a half hour" following breakfast on 10/31/17 when the fall occurred. When asked how the facility determined the amount of time Resident #18 was asleep prior to the fall, the DON stated, "There's no way to know for sure." The DON stated it was "normal" for Resident #18 to sleep in her wheelchair, and "normal" for staff to allow residents to sleep in wheelchairs for up to 30 minutes before offering to take residents to their rooms to nap or toilet. The DON stated the resident's wheelchair pressure alarm was set for a "few seconds" delay before sounding to allow time for the resident to reposition herself as needed, and that nursing staff were educated to offer a nap or toileting to any resident observed sleeping in a wheelchair for 30 minutes or more. The DON stated the education was provided through a "read and sign" document the facility's Clinical Nurse Consultant (CNC) would provide for surveyor review.</p> <p>On 11/14/17 at 8:35 am, LPN #1, who was at the</p>	{F 323}			

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{F 323}	<p>Continued From page 6</p> <p>nurse's desk at the time of Resident #18's 10/31/17 fall, stated the resident's wheelchair pressure alarm did not sound for "one-to-two minutes" after Resident #18 struck her head on the floor. LPN #1 stated she did not recall receiving education to toilet or offer a nap to residents sleeping in their wheelchairs for 30 minutes or more following the 10/31/17 incident.</p> <p>On 11/14/17 at 8:45 am, the facility's Clinical Nurse Consultant (CNC) provided a Mandatory Inservice Training Attendance Roster, dated 11/3/17, with Resident #18's name and a single sentence that read, "Recent fall 10/31/17 - if lethargic or sleeping in w/c [wheelchair] please offer to lay down for nap." The document was signed by 6 of the facility's 23 CNAs and 4 of the facility's 15 nurses.</p> <p>On 11/15/17, the facility provided a Witness Statement, dated 11/14/17, that documented Resident #18 was toileted on 10/31/17 at 10:00 am; a CNA Tracking Form that documented Resident #18 was toileted during day shift at an unspecified time on 10/31/17; a second Witness Statement, dated 11/14/17, that documented Resident #18's wheelchair pressure alarm began sounding "about 30 seconds" after the resident fell and injured her head; and an Interdisciplinary Progress Note that documented a pressure alarm was placed on Resident #18's wheelchair after she fell at the facility on 3/9/17.</p> <p>2. Resident #20 was admitted to the facility on 10/20/17, and readmitted on 11/7/17, with diagnoses that included dementia with behavioral disturbance, muscle weakness, idiopathic neuropathy, history of falling, and repeated falls.</p>	{F 323}			

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{F 323}	Continued From page 7 A Patient Transfer Form, dated 10/20/17, documented facility staff were to "implement fall precautions" for Resident #20 upon his admission to the facility. Physician's Orders documented staff were to place pressure alarms to Resident #20's wheelchair and bed; monitor the placement and function of those alarms each shift; implement "fall precautions;" transfer the resident with a forward-wheel walker and gait belt; and provide two-staff assistance for "sit to stand" transfers. An admission Care Plan, dated 10/20/17, documented Resident #20's bed and wheelchair were to be equipped with alarms and his room was to be equipped with a "perimeter motion" alarm. Staff were to check each alarm's placement and function every shift. A Fall Prevention Care Plan, dated 10/30/17, included a 10/20/17 intervention directing staff to equip Resident #20's bed with a perimeter mattress and "alarm to bed and wheelchair to alert staff of attempts to self-transfer. Check function and placement [every] shift." An Interdisciplinary Progress Note, dated 10/20/17 at 9:30 pm, documented Resident #20 "rolled out of bed" at 8:45 pm. The Note documented the resident's bed was in a low position and "alarms [were] placed at this time to help prevent future falls." An unsigned and undated Daily Skilled Nurse's Note documented an undefined bruise was observed on Resident #20's left pectoral area,	{F 323}			

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{F 323}	<p>Continued From page 8</p> <p>and noted, "Resident #20 did have fall night before, bruise looks consistent [with] fall."</p> <p>An Interdisciplinary Progress Note, dated 10/24/17, documented Resident #20 fell onto his right side on 10/20/17 and a bruise was observed on 10/22/17 to the resident's left chest that was "probably associated" with the 10/20/17 fall. The bruise was described on 10/23/17 as purple with slight yellowing at the edges and measuring 9 cm by 6 cm.</p> <p>A Fall Scene Investigation Report, dated 10/30/17, documented Resident #20 was in bed at the start of night shift; toileted at 1:30 am; and found on the floor across his room next to roommate's bed on his right side at 3:00 am. No injury was noted at the time. The Report documented Resident #20's alarm was still in his wheelchair rather than on the bed and that Resident #20 was "laid down on day shift before dinner." The Fall Scene Investigation Report did not address the perimeter-motion alarm or staff monitoring of the alarm's function and placement each shift as ordered by the physician and directed by the resident's care plan.</p> <p>On 11/14/17 at 9:00 am, the DON stated an alarm was placed on Resident #20's bed following the 10/20/17 fall; an alarm was not placed on Resident #20's bed on 10/20/17 because the resident was only admitted that day and because "an alarm is considered a restraint." The DON stated CNAs were responsible for monitoring the placement and function of Resident #20's bed and wheelchair alarms at shift change, which occurred at 6:30 am and 6:30 pm. The DON did not respond when informed</p>	{F 323}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/14/2017
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(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	
{F 323}	Continued From page 9 Resident #20 was observed in bed prior to dinner at 5:30 pm on 10/29/17 and discovered on the floor of his room on 10/30/17 at 3:00 am, a period of at least 9.5 hours during which the resident's alarm was not in place as the physician ordered and according to the care plan.	{F 323}			
{F 329} SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the	{F 329}		12/7/17	

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{F 329}	<p>Continued From page 10</p> <p>medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to monitor whether psychotropic medications were effective. This was true for 2 of 5 residents (#19 and #20) reviewed for psychotropic medications. Findings include:</p> <p>1. Resident #20 was admitted to the facility on 10/20/17, and readmitted on 11/7/17, with diagnoses that included dementia with behavioral disturbance and cognitive communication deficit.</p> <p>November 2017 Physician's Orders documented Resident #20 was to receive Divalproex Sodium (Depakote) 250 milligrams (mg) twice daily for dementia with behaviors, initiated 10/20/17.</p> <p>An October 2017 Medication Administration Record (MAR) documented Resident #20 received Depakote 250 mg twice daily as ordered by the physician, except for night shift dosages scheduled for 10/20, 10/23, and 10/24/17.</p> <p>A Behavior and Mood Management Care Plan, dated 10/26/17, documented Resident #20 exhibited inappropriate behaviors related to dementia and that staff were to "observe for</p>	{F 329}	<p>F 329</p> <p>Resident #19 has been reviewed by the ID team for effectiveness of psychoactive medications. Care plan directs staff to document number and describe the nature of behaviors observed. Behavior symptom monitoring flow records are updated and in place.</p> <p>Resident #20 is no longer residing in facility.</p> <p>Residents with psychoactive medications could be affected. Care plans have been reviewed and updated, as needed, to direct staff to document the number and describe the nature of behaviors observed. Behavior symptom monitoring flow records are updated and in place.</p> <p>New admissions and re-admissions could be affected. Initial care plans direct staff to document number and nature of behaviors observed. Behavior symptom monitoring flow records will be implemented upon admission, as indicated.</p>		

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{F 329}	<p>Continued From page 11 medications' effectiveness or possible side effects."</p> <p>A 10/26/17 Interdisciplinary Progress Note documented, "Behavior [Monitoring] - New Admit: Resident #20 is very confused [and] irritable. He is physically aggressive [and] verbally aggressive [with] staff. He refuses care [and] medications. He is currently taking Depakote [with] no adverse effects at this time. Will continue to monitor ..."</p> <p>An Admission Care Plan, dated 11/7/17, documented staff were to monitor the effectiveness of Resident #18's Depakote in treating "target[ed] behaviors."</p> <p>An Admission/Readmission Clinical Health Status Assessment, dated 11/7/17, documented Resident #20 did not have a history of mood disorder, rejecting cares, or any behavioral symptoms.</p> <p>The November 2017 MAR documented staff administered Depakote 250 mg to Resident #20 from 11/7/17 through survey on 11/14/17.</p> <p>Daily Skilled Nurse's Notes, dated 11/2/17 and 11/8/17 through 11/12/17 were blank in the Behavior Problems section.</p> <p>The November 2017 Behavior Symptom Monitoring Flow Record did not document staff monitored the resident's behaviors from 11/7/17 through 11/12/17.</p> <p>On 11/14/17 at 9:22 am, the facility's Resident Services Coordinator stated Resident #20's clinical record did not contain documentation that</p>	{F 329}	<p>Care management staff have been educated in behavior management and monitoring. Re-education was provided by the DON, Resource Liaison, and/or Clinical Resource RN to include but not limited to, completion of pre-admission review on potential new residents for medication and behavior monitoring needs, review of re-admission resident records to validate continuity of care plan as indicated, and post admission review in clinical meeting. In addition, licensed nurses have been educated to review admission orders, initiate care plans, and behavior symptom monitoring flow records, as indicated. The system is amended to include preadmission/readmission review for behavioral medication necessity/plan and post admission review in clinical meeting.</p> <p>DON, Resident Liaison, and/or designee will audit residents with psychoactive medications for documentation related to effectiveness of medication, as well as audit care plans and behavior symptom monitoring flow records for individualized plan every week x 8 weeks. Findings will be documented on the PI tool starting the week of 12-4-17. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate. Date of Compliance: 12/07/2017</p>		

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{F 329}	<p>Continued From page 12</p> <p>staff monitored the resident's behaviors related to Depakote as physician ordered and care planned.</p> <p>2. Resident #19 was re-admitted to the facility on 5/14/16 with diagnoses that included bipolar disorder and depression.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 9/8/17, documented Resident #19 was cognitively intact and did not exhibit symptoms of depression.</p> <p>Resident #19's October 2017 MAR documented she received Sertraline 150 mg daily for depression beginning 8/28/17.</p> <p>Resident #19's Care Plan, dated 7/9/15, documented a potential for inappropriate behaviors related to depression. The care plan goal was Resident #19 would have reduced episodes of sadness, negative and accusatory statements toward staff, and irritability. The interventions did not direct staff to document the number or describe the nature of these behaviors.</p> <p>A Mood State Care Plan, dated 10/3/17, documented Resident #19 experienced depression. Care Plan goals included an improved mood as evidenced by a decrease in social isolation, irritability, excessive complaining to staff, crying episodes, and hoarding. Interventions did not direct staff to document the number or nature of behavioral episodes related</p>	{F 329}			

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{F 329}	<p>Continued From page 13 to depression.</p> <p>An October 2017 Behavior Symptom Monitoring Flow Record provided staff an area to document episodes of increased irritability, crying, negative comments to staff about past care, self-isolation, and the hoarding of items in her room. The first entry was dated 10/23/17.</p> <p>A Social Service progress note, dated 11/10/17, documented the physician increased Resident #19's Sertraline on 8/25/17 due to complaints about feeling sad.</p> <p>On 11/14/17 at 11:15 a.m., when asked if there were behavior monitors in place prior to 10/23/17, the Social Service Director stated, "No, there are no previous monitors." When asked when Resident #19 started the medication, the Social Service Director stated, "A long time."</p>	{F 329}		