



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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November 2, 2018

Michael Blauer, Administrator
St Luke's Elmore Long Term Care
Po Box 1270
Mountain Home, ID 83647-1270

Provider #: 135006

Dear Mr. Blauer:

On **October 12, 2018**, a survey was conducted at St Luke's Elmore Long Term Care by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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) and on or before the "Opportunity to Correct." **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.

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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 **November 12, 2018**. Failure to submit an acceptable PoC by **November 12, 2018**, may result in the imposition of penalties by **December 5, 2018**.

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; and
- 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 23, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 10, 2019**. A change in the seriousness of the deficiencies on **November 23, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **January 12, 2019** includes the following:

Denial of payment for new admissions effective **January 12, 2019**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 12 2019**, if substantial compliance is not achieved by that time.

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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 12, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. 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>

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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 **November 12, 2018**. If your request for informal dispute resolution is received after **November 12, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive style with a large initial 'D'.

Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/lj

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

PRINTED: 01/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2018
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from October 9, 2018 through October 12, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil RN, Team Coordinator Laura Thompson, RN Susan Devereaux, RN</p> <p>Abbreviations:</p> <p>DM = Diabetes Mellitus DON = Director of Nursing EMR = Electronic Medical Record GDR = Gradual Dose Reduction HTN = Hypertension LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligram mL=milliliter PRN = as needed RN = Registered Nurse RCA = Resident Care Assistant</p>	F 000		
F 656 SS=E	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's</p>	F 656		11/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/10/2018
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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 656	<p>Continued From page 1</p> <p>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to develop and follow resident-specific care plans.</p>	F 656	The Director of Nursing is ultimately responsible to ensure resident-specific care plans are developed and followed.		

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F 656	<p>Continued From page 2</p> <p>This was true for 5 of 10 residents (#1, #5, #12, and #64) whose care plans were reviewed. The residents' care plans did not address the use of psychotropic medications, wheelchair positioning, preference to sleep in a recliner, and follow aspiration precaution interventions. This failure created the potential for residents to receive inappropriate or inadequate care with a subsequent decline in health. Findings include:</p> <p>A facility policy Nursing Assessment, effective 06/30/18, stated an individualized plan-of-care will be formulated as soon as possible upon admission and updated based on ongoing assessment and patient needs. The policy stated the plan of care will include goals and interventions established in collaboration with the patient, family/significant other/guardian, and care providers. The policy also stated an RN will review and revise the plan as warranted in collaboration with the other disciplines. This policy was not followed.</p> <p>1. Resident #5 was admitted to the facility on 8/21/17, with multiple diagnoses including dementia with psychosis, anxiety, and sundowning (late-day confusion).</p> <p>Resident #5's physician orders, dated 7/13/18, directed staff to provide Alprazolam (an antianxiety medication) 0.5 mg by mouth nightly and 0.25 mg every morning. On 8/23/18, an order for Alprazolam 0.5 mg daily as needed was added to Resident #5's medication regimen. On 8/30/18, the morning dose was increased to 0.5 mg of Alprazolam.</p> <p>Resident #5's care plan, dated 5/22/18,</p>	F 656	<ul style="list-style-type: none"> - Residents' #1, #5, #6 and #12 care plans were reviewed and updated to reflect use of psychotropic medications, wheelchair positioning, preference to sleep in a recliner, and following of aspiration precautions as appropriate based on individual resident needs. - Resident #64 was discharged prior to receiving the final survey report - Currently admitted residents' care plans were reviewed and updated to ensure specific behaviors, interventions and preferences. - Care Plan Communication tool reviewed and updated to clarify expectation of inclusion of specific behaviors, interventions and preferences. Staff educated on new communication tool and expectations via a variety of methods- including but not limited to postings in the unit and staff meetings - A Behavioral Monitor flow sheet for residents on psychotropic medications developed to include behaviors related to depression. Staff educated on expectations for Behavioral Monitor flow sheet completion via a variety of methods- including but not limited to postings in the unit and staff meetings. - A Sleep Monitor flow sheet and Sleep Hygiene Care Plan developed. Staff educated on expectations for Sleep Monitor flow sheet and Sleep Hygiene Care Plan completion via a variety of methods- including but not limited to postings in the unit and staff meetings. <p>QAPI</p> <ul style="list-style-type: none"> - The Medical Director/PCP, MDS 		

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F 656	<p>Continued From page 3</p> <p>documented the antianxiety medication was to help with Resident #5's "worries" she experienced over her children and family. The care plan did not identify specific behaviors Resident #5 exhibited related to her anxiety.</p> <p>On 10/11/18 at 3:30 PM, the DON and RCA stated the medication was for anxiety but could not identify the specific behaviors exhibited.</p> <p>2. Resident #64 was admitted to the facility on 10/1/18, with multiple diagnoses including unspecified dementia with behavioral disturbance.</p> <p>Physician orders, dated 10/1/18, documented Resident #64 was to receive Citalopram (an antidepressant) 20 mg by mouth daily, Lamictal (used to stabilize mood or for seizures) 100 mg by mouth daily, and Lorazepam (an antianxiety) 0.5 mg by mouth 3 times daily as needed.</p> <p>A care plan, dated 10/11/18, documented Resident #64 had major depressive disorder and was prescribed an antidepressant medication. The care plan documented the activities Resident #64 enjoyed and the common side effects of the medication, however, the care plan did not indicate the behaviors exhibited related to her depression. The care plan did not address the Lorazepam or the Lamictal.</p> <p>On 10/11/18 at 3:30 PM, the DON stated Resident #64's Lamictal was used as a mood stabilizer. The DON stated Resident #64 asked for the Lorazepam when she wanted it because she was cognitively intact.</p>	F 656	<p>Coordinator, and Director of Nursing to meet at least monthly to review resident's Problem List, Orders, Care Plans, Monitors and MDS for consistency.</p> <p>- Health Information to audit Behavioral and Sleep monitors weekly x1 month, then monthly x3 months- results of audit to be shared monthly with facility leadership and reviewed quarterly at Elmore Long Term Care Quality Safety Council.</p>		

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F 656	<p>Continued From page 4</p> <p>3. Resident #12 was admitted to the facility on 9/12/18, with multiple diagnoses including dementia without behavioral disturbance and insomnia.</p> <p>A physician progress note, dated 9/13/18, documented Resident #12 had a diagnosis of dementia, likely Alzheimer's, with behaviors.</p> <p>Resident #12's physician orders, dated 10/5/18, directed staff to provide Trazodone (an antidepressant/sedative) 50 mg nightly.</p> <p>Resident #12's Care Plan did not identify insomnia. There was no documentation of sleep monitoring in Resident #12's medical record.</p> <p>On 10/13/18 at 10:15 AM, the DON stated the facility did not monitor Resident #12's hours of sleep.</p> <p>4. Resident #1 was admitted to the facility on 7/25/14, with diagnoses which included Parkinson's, depression, and dementia.</p> <p>On 10/09/18 at 3:36 PM, Resident #1 was tilted back in his wheelchair at a table in the common area, with his feet dangling (no foot rests, and his legs could not reach the floor). At 3:39 PM, staff offered Resident #1 a shake drink, but did not reposition him.</p> <p>On 10/11/18 at 10:27 AM, Resident #1 was observed in the common area for a bowling activity. He was seated in his wheelchair and his feet did not reach the floor.</p> <p>Resident #1's care plan did not address a tilting</p>	F 656			

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F 656	Continued From page 5 wheelchair or positioning in the wheelchair, ie. a foot rest. On 10/11/18 at 4:40 PM, the Compliance Director stated Resident #1 refused the foot rests, so when he is tilted back, his feet did not touch the floor. She stated he just received a new wheelchair and it was not yet in the care plan. The Compliance Director was unsure of when Resident #1 received the new wheelchair. On 10/12/18 at 9:39 PM, the DON stated the expectation was Resident #1's refusal of wheelchair footrests and positioning were in the care plan. On 10/12/18 at 12:20 PM, RN #1 stated Resident #1's feet were usually on the floor or on the legs of the table, she had not seen them dangling. She stated he has had his new wheelchair for a couple months now.	F 656			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure physician orders and care plans were followed	F 684	The Director of Nursing is ultimately responsible to ensure physician orders and care plans are followed.	11/23/18	

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F 684	<p>Continued From page 6</p> <p>for 2 of 11 residents (#3 and #7) whose records were reviewed. Resident #7's blood glucose physician orders were not followed and Resident #3's aspiration precautions were not followed. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include:</p> <p>1. Resident #7 was admitted to the facility on 8/27/18, with diagnoses which included dementia with behavioral disturbance, Type II DM, HTN, and a history of stroke.</p> <p>An H&P, dated 8/28/18, documented Resident #7 received Lantus (long-acting insulin) injections each morning, Januvia (an oral diabetic medication) 50 mg once daily, and Humalog (a short-acting insulin) injections according to a sliding scale with each meal and at bedtime. The American Diabetes Association, website accessed 10/17/18, defines sliding scale as a set of instructions for adjusting insulin based on blood glucose test results, meals, or activity levels.</p> <p>Resident #7's MAR included an order for Humalog injection 2 times a day based on a sliding scale. The order was to check Resident #7's blood glucose at bedtime and 3:00 AM. The order stated if Humalog was given at bedtime to correct a high blood sugar, according to the ordered sliding scale, Resident #7's blood glucose was to be checked again at 3:00 AM.</p> <p>This order was not followed. Examples include:</p>	F 684	<ul style="list-style-type: none"> - Resident #7 orders for blood glucose monitoring and treatment were reviewed with the nurses providing care to ensure understanding of providers order and expectations of following orders for care. - Resident's #3 bed was raised to 30-degrees immediately upon identification. - Currently admitted residents' requiring aspiration precautions were reviewed to ensure precautions were in place according to identified resident needs. - Currently admitted residents' care plans were reviewed to ensure safety precautions required were accurately reflected. In addition safety precautions in use were added to the shift to shift communication tool. - Staff were educated on expectations to follow provider orders and the inclusion of items such as blood sugar checks and safety precautions on the shift to shift communication tool via a variety of methods- including but not limited to postings in the unit and staff meetings QAPI - Charge nurse to audit the bed positioning of residents with aspiration precautions each shift to ensure proper positioning. Any identified opportunities will be immediately corrected and reported to the Director of Nursing for proper follow up. - Audits of resident records for residents who require blood glucose monitoring and treatment, to ensure provider orders are followed, to be conducted weekly x1 month and then monthly x3 months - 		

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F 684	<p>Continued From page 7</p> <p>- On 9/2/18 at 9:21 PM, Resident #7 did not receive a Humalog injection. Her blood glucose was rechecked at 12:30 AM on 9/3/18, when it should not have been done per the orders, and it was not at 3:00 AM.</p> <p>- On 9/11/18 at 8:08 PM, Resident #7 received and injection of 1 unit of Humalog. At 2:52 AM, her blood glucose was not checked per physician order.</p> <p>At 4:36 PM on 10/11/18, the DON reviewed Resident #7's record and confirmed the blood glucose and insulin orders and stated they were not followed.</p> <p>2. Resident #3 was admitted to the facility on 10/1/16, with diagnoses which included dementia, seizures, osteoporosis (brittle bones), constipation, thyroid disorder, and HTN.</p> <p>A Speech Evaluation, dated 6/13/18, documented Resident #3 was a high aspiration risk due to her progressive dementia and age. Aspiration is the risk of breathing foreign objects into the airway which can be food, saliva, or stomach contents when swallowing.</p> <p>Resident #3's care plan included Aspiration Precautions, initiated on 6/13/18. The care plan included interventions to keep her at a 90 degree angle for all oral intake and keeping the head of her bed greater than 30 degrees.</p> <p>On 10/9/18 at 11:10 AM and 1:52 PM, Resident #3 was observed laying in her bed and the head of her bed was flat.</p>	F 684	<p>results of audit to be shared monthly with facility leadership and reviewed quarterly at Elmore Long Term Care Quality Safety Council.</p>		

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F 684	Continued From page 8 On 10/11/18 at 10:30 AM, Resident #3 was observed laying in her bed and the head of her bed was flat.	F 684			
F 690 SS=D	On 10/11/18 at 4:36 PM, the DON confirmed Resident #3's care plan included elevating the head of her bed for aspiration precautions. She stated if the head of the bed was not elevated staff were not following the care plan. Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		11/23/18	

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F 690	Continued From page 9 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure the bowel protocol was followed and implemented for 1 of 2 residents (Resident #5) reviewed for bowel and bladder care. This had the potential to place residents at risk for fecal impaction and bowel blockage. Findings include: The facility's Bowel and Bladder Program policy, revised 4/9/18, directed staff to notify the physician for no bowel movement in 5 days. Resident #5 was admitted to the facility on 8/21/17, with multiple diagnoses including constipation. A bowel continence care plan, dated 8/31/17, documented Resident #5's bowel movement pattern as one time a day 2 days apart. The care plan directed staff to refer to her medications for bowel care or call her physician to get an order if Resident #5 did not have a bowel movement by day 3. A physician order, dated 8/2/18, directed staff to provide Milk of Magnesia 30 mLs nightly as needed for constipation.	F 690	The Director of Nursing is ultimately responsible to ensure the bowel protocol is followed and implemented. - Facility policy PC11097 EL: Bowel and Bladder Program was reviewed and updated to align with care expectations identified in the Bowel Care Order set - Currently admitted residents' care plans were reviewed to ensure bowel and bladder care interventions accurately reflected the expectations of the Bowel and bladder care orders and policy. - Staff educated on the updated policy and expectations for bowel and bladder care via a variety of methods- including but not limited to postings in the unit and staff meetings. QAPI - Audits of resident records for residents who require bowel and bladder care, to ensure compliance with expectations outlined in policy are followed, to be conducted weekly x1 month and then monthly x3 months - results of audit to be shared monthly with facility leadership and reviewed quarterly at Elmore Long Term Care Quality Safety Council.		

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F 690	Continued From page 10 A Pharmacy Review, dated 9/13/18, documented Resident #5 had not had a bowel movement for 3-4 days twice in the last 2 weeks. The bowel movement records, dated 9/9/18 through 9/22/18, documented Resident #5 did not have a bowel movement between 9/10/18 and 9/14/18 (5 days) and between 9/18/18 through 9/22/18 (5 days.) The medication administration record between 9/9/18 and 9/22/18, documented one dose of Milk of Magnesia was provided on 9/14/18 at 10:21 AM. A Pharmacy Review, dated 10/9/18, documented there were up to 5 days between bowel movements. The consultant pharmacist documented Resident #5 had Milk of Magnesia ordered as needed but none was given when Resident #5 went 5 days between bowel movements. On 10/12/18 at 2:30 PM, the DON stated residents received bowel care medication after 3 days without a bowel movement and the physician was notified on day 4. She confirmed the care plan and physician orders were not followed for Resident #5.	F 690			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		11/13/18	

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F 756	<p>Continued From page 11 of the resident's medical chart.</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</p> <p>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, observation, and staff interview, the facility failed to ensure the pharmacy reported medication irregularities and were addressed by the</p>	F 756	<p>The Pharmacy Director is ultimately responsible to ensure the pharmacy reports medication irregularities. - Resident #1 erythromycin ointment was</p>		

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F 756	<p>Continued From page 12</p> <p>attending physician for an antibiotic ointment for 1 of 7 residents (Resident #1) whose medication records were reviewed for unnecessary medications and/or irregularities. This failure had the potential for Resident #1 to develop resistance to the antibiotic and result in lack of efficacy of future treatments for infections. Findings include:</p> <p>The facility's policy Medication Use in Long Term Care, effective 04/30/18, stated a pharmacy medication regimen review will occur for each skilled nursing facility patient at least monthly. The regimen review will include all prescribed medication orders and evaluated adequate indication for use, appropriateness of ongoing therapy, medical necessity, and duration. This policy was not followed.</p> <p>Resident #1 was admitted to the facility on 7/25/14, with diagnoses which included Parkinson's, depression, and dementia.</p> <p>Resident #1's MAR included an order for Erythromycin 5mg (0.5%) ophthalmic ointment weekly to both eyes, dated 10/5/16 2000, for prevention of conjunctivitis (pink eye). The antibiotic ointment was last administered 10/10/18 at 7:21 PM.</p> <p>On 10/09/18 at 12:10 PM and 3:36 PM, and on 10/10/18 at 9:00 AM, Resident #1 was not observed with visible signs of eye redness, swelling, or drainage.</p> <p>On 10/11/18 at 2:34 PM, the Pharmacy Director stated he was unable to find documentation regarding the discontinuation or the need for</p>	F 756	<p>discontinued by provider order</p> <ul style="list-style-type: none"> - Currently admitted residents' medication orders were reviewed to ensure irregularities were identified and addressed by the provider. - Staff were educated on the need to identify irregularities and alert the provider during the monthly pharmacy medication regimen review via one to one conversation. <p>QAPI</p> <ul style="list-style-type: none"> - Pharmacy to report identification of and follow up to, medication irregularities during the monthly and/or initial review for new medications to the Long Term Care Quality Safety Council - New orders reviewed timely for appropriateness - Pharmacy to report any irregularities identified and follow-up actions taken from the above mentioned reviews monthly to the Long Term Care Quality Safety Council 		

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F 756	Continued From page 13 continuation of the antibiotic ointment. He stated he had a discussion with the Consultant Pharmacist regarding the notation of "None" for antibiotics on the monthly review. The Pharmacy Director stated there was a diagnosis of conjunctivitis in 2014, but no notes were found in the EMR. The Pharmacy Director stated the expectation was the continued use of the antibiotic ointment should have been addressed. On 10/12/18 at 11:28 AM, the Compliance Director stated the facility policy does not address long term use of antibiotics. On 10/12/18 at 3:42 PM, the DON stated the expectation was the antibiotic ointment was reviewed related to 4 years of continued use.	F 756			
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758		11/23/18	

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F 758	<p>Continued From page 14 in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy and procedure review, it was determined the facility failed to ensure a.) residents' behaviors and potential side effects of psychotropic medications were routinely monitored b.) there was a clear indication for use of PRN psychotropic medication c.) non-pharmacological approaches were</p>	F 758	<p>The Medical Director is ultimately responsible to ensure that resident's behaviors and potential side effects of psychotropic medications are routinely monitored, there is a clear indication for use of PRN psychotropic medications, non-pharmacological approaches are attempted prior to use of PRN</p>		

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F 758	<p>Continued From page 15</p> <p>attempted prior to the use of PRN medications d.) physician orders for PRN antianxiety medications were time limited and e.) residents received PRN psychotropic medications only when clinically indicated for the treatment of specific conditions. This was true for 7 of 7 residents (#5, #7, #9, #10, #11, #12, and #64) reviewed for unnecessary medications. This created the potential for harm should residents receive psychotropic medications that were unnecessary, ineffective, or used for excessive duration, and placed them at risk for adverse reactions from psychotropic medications. Findings include:</p> <p>The facility's policy for Medication Use in Long Term Care, revised 4/25/18, documented psychoactive medications are prescribed when necessary to treat specific medical conditions. When prescribed:</p> <ul style="list-style-type: none"> * The psychotropic medications will have a documented indication for the medication in the medical record. * Psychoactive medication orders for PRN use will be limited to 14 days in duration. If there is a continued clinical need the prescriber will document in the medical record justification for continued use. * Each behavior monitoring record will identify the specific symptoms for which the drug is being used. The documentation of the behavior will be quantitative and objective. * Each resident will have care plan interventions specific to their mood, behavior, and activity. 	F 758	<p>medications, physician orders for PRN antianxiety medication are time limited, and residents receive PRN psychotropic medications only when clinically indicated for the treatment of specific conditions.</p> <ul style="list-style-type: none"> - Resident #12 care plan was updated to include insomnia, sleep monitoring and specific targeted behaviors related to the diagnosis and use of psychotropic medication. - Care plans for currently admitted residents with prn orders for psychotropic medications were reviewed and updated to ensure inclusion of specific non-pharmacological interventions to be used prior to medication administration. - Residents #5, 7, 9, 10, 11, and 12 medical records were reviewed to ensure diagnosis and indications for use for psychotropic medications were included in the documentation. Resident #64 was discharged prior to receiving the final report - Orders for PRN psychotropic medication were reviewed for currently admitted residents to ensure appropriate time limits as required by regulation and provider orders. - A Behavioral Monitor flow sheet for residents on psychotropic medications developed to include specific targeted behaviors related to the diagnosis, medications given, indications for use, why the resident received additional medications, behaviors monitored, non-pharmacological approaches, side effects, effectiveness, episodes per shift to identify patterns, and depressive 		

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F 758	<p>Continued From page 16</p> <p>* Pharmacy medication regimen review will evaluate prescribed medications orders for an adequate indication for use, appropriateness of ongoing therapy, medical necessity, adverse drug reaction and side effects, and adequate monitoring of therapy.</p> <p>1. Resident #12 was admitted to the facility on 9/12/18, with multiple diagnoses including dementia without behavioral disturbance and insomnia.</p> <p>A physician's Inpatient Progress Note, dated 9/13/18, documented Resident #12 had a diagnosis of dementia, likely Alzheimer's, with behaviors.</p> <p>Resident #12's admission MDS assessment, dated 9/19/18, documented she was severely cognitively impaired, had moderately severe depression, exhibited behavioral symptoms not directed toward others, and received antipsychotic medications and antianxiety medications daily.</p> <p>Resident #12's physician orders, dated 10/5/18, directed staff to provide Risperdal (antipsychotic) 1 mg by mouth nightly and Trazodone (antidepressant/sedative) 50 mg nightly. The physician orders did not include the diagnosis for the medications.</p> <p>A care plan, dated 10/11/18, identified mood/behaviors and dementia with behavioral symptoms for Resident #12 and directed staff to monitor for side effects related to her antipsychotic medication. The care plan</p>	F 758	<p>behaviors. Staff educated on expectations for Behavioral Monitor flow sheet completion via a variety of methods- including but not limited to postings in the unit and staff meetings.</p> <p>- A Sleep Monitor flow sheet and Sleep Hygiene Care Plan developed. Staff educated on expectations for Sleep Monitor flow sheet and Sleep Hygiene Care Plan completion via a variety of methods- including but not limited to postings in the unit and staff meetings.</p> <p>QAPI</p> <p>Medical Record audits of residents with prn psychotropic medication orders will be reviewed monthly to ensure frequency, effectiveness, and appropriateness of the prescribed medication, during the monthly drug regimen review. Results of audits to be shared with Long Term Care Quality Safety Council.</p> <p>- The Medical Director/PCP, MDS Coordinator, and Director of Nursing to meet at least monthly to review resident's Problem List, Orders, Care Plans, Monitors and MDS for consistency.</p> <p>- Health Information to audit Behavioral and Sleep monitors weekly x1 month, then monthly x3 months- results of audit to be shared monthly with facility leadership and reviewed quarterly at Elmore Long Term Care Quality Safety Council.</p>		

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F 758	<p>Continued From page 17</p> <p>documented she could become tearful and bang her fist on the table because she could not live at home with her husband. The care plan did not provide specific behaviors for diagnosis of and use of an antipsychotic medication.</p> <p>Resident #12's Care Plan did not identify insomnia. There was no documentation in Resident #12's record her sleep was monitored.</p> <p>On 10/13/18 at 10:15 AM, the DON stated the facility did not monitor Resident #12's hours of sleep.</p> <p>2. Resident #5 was admitted to the facility on 8/21/17, with multiple diagnoses including dementia with psychosis, anxiety, and sundowning (late-day confusion.)</p> <p>Resident #5's annual MDS assessment, dated 8/21/18, documented she had moderately impaired cognition, had mild depression, exhibited delusional thoughts, verbal behavioral symptoms directed toward others, and received antianxiety medications daily.</p> <p>Resident #5's physician orders, dated 7/13/18, directed staff to provide Alprazolam 0.5 mg by mouth nightly and 0.25 mg every morning. On 8/23/18, an order for Alprazolam 0.5 mg daily PRN was added to Resident #5's medication regimen. On 8/30/18, the morning dose of Alprazolam was increased to 0.5 mg. The physician orders did not include the diagnosis for the medications.</p> <p>Resident #5's MAR documented the routine dose of Alprazolam was for anxiety. The PRN order for</p>	F 758			

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F 758	<p>Continued From page 18</p> <p>Alprazolam documented "This is an extra dose when she needs it."</p> <p>Resident #5's care plan, dated 5/22/18, documented interventions for sundowning behaviors, agitation, and psychosis. The care plan documented the antianxiety medication was to help with Resident #5's worries she experienced over her children and family. The care plan did not identify specific behaviors exhibited by Resident #5 related to her anxiety.</p> <p>A Mood/Behavior of Cognitively Impaired care plan, dated 10/9/18, directed staff to monitor for side effects related to antianxiety medications.</p> <p>A Behavioral/Psychopharmacological Review, dated 9/6/18, documented Resident #5 received Alprazolam 0.5 mg two times daily and 0.5 mg daily as needed. The review documented Resident #5's targeted behaviors were delusions, hallucinations concerning family and/or children, yelling at/threatening staff, residents, and visitors, wandering, exit seeking, and crying/yelling for help.</p> <p>Resident #5's Behavior Monitoring flowsheets, dated 7/14/18 through 10/11/18, documented Resident #5 exhibited disorientation, anxiety, was unwilling to follow instruction, yelling, screaming, restless, fearful, resistive to care, multiple requests, crying, and tearful.</p> <p>Resident #5's behavior monitoring did not indicate whether medications were given, what the indications were, what behaviors were being monitored, or why Resident #5 received the additional Alprazolam or the effectiveness of the</p>	F 758			

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F 758	<p>Continued From page 19</p> <p>anti-anxiety medication. The documentation did not provide non-pharmacological interventions for staff to attempt prior to providing the PRN dose of Alprazolam.</p> <p>The targeted behaviors identified for monitoring on the Behavioral/Psychopharmacological Review were inconsistent with the behaviors exhibited on the behavior monitoring.</p> <p>On 10/11/18 at 3:30 PM, the DON and RCA stated the medication was for anxiety but could not identify the specific behaviors exhibited.</p> <p>3. Resident #64 was admitted to the facility 10/1/18, with multiple diagnoses including unspecified dementia with behavioral disturbance.</p> <p>Resident #64's admission MDS assessment, dated 10/1/18, documented she was cognitively intact, had mild depression, had no behaviors, and received antidepressant medication daily and antianxiety medications almost daily, 5 out of 7 days.</p> <p>Physician orders, dated 10/1/18, documented Resident #64 was to receive Citalopram (an antidepressant) 20 mg by mouth daily, Lamictal (a mood stabilizer) 100 mg by mouth daily, and Lorazepam (an antianxiety medication) 0.5 mg by mouth 3 times daily as needed. The orders did not include a diagnosis for the medications.</p> <p>The MAR documented the indication for Citalopram was major depressive disorder and the indication for Lamictal was seizure prevention. The MAR did not provide a diagnosis</p>	F 758			

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F 758	<p>Continued From page 20 for Lorazepam which was provided to Resident #64 eleven times between 10/1/18 and 10/12/18. The MAR did not provide the indications for use or the effectiveness of the Lorazepam.</p> <p>A care plan, dated 10/11/18, documented Resident #64 had major depressive disorder and was prescribed an antidepressant medication. The care plan documented the activities Resident #64 enjoyed and the common side effects of the medication, however, the care plan did not indicate the behaviors exhibited due to depression. The care plan did not address the Lorazepam or the Lamictal.</p> <p>Resident #64's Behavior Monitoring flowsheet included sections to document whether she was able to express her needs, her feelings, her thoughts, and her ability to understand. The entries, from 10/1/18 through 10/11/18, documented Resident #64 was calm, cooperative, able to express her feelings, needs, thoughts, and understood others.</p> <p>Resident #64's behavior monitoring flowsheet did not include what medications were given, what the indications were, what behaviors were being monitored, and how many episodes were exhibited each shift. The monitoring flowsheet also did not include why Resident #64 requested Lorazepam or the effectiveness of the medication.</p> <p>On 10/11/18 at 3:30 PM, the DON stated Resident #64 was cognitively intact and would request the lorazepam when she needed it. The DON stated the staff did not ask Resident #64 the reason she was requesting the antianxiety</p>	F 758			

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F 758	<p>Continued From page 21 medication.</p> <p>4. Resident #11 was admitted to the facility on 6/9/17, with multiple diagnoses including major depressive disorder, unspecified dementia with behavioral disturbance, and visual hallucinations.</p> <p>Resident #11's Significant Change MDS assessment, dated 9/13/18, documented severe cognitive impairment, mild depression, hallucinations, she received antipsychotic and antidepressant medications daily.</p> <p>Resident #11's physician orders directed the staff to provide Zyprexa (an antipsychotic) disintegrating tablet 15 mg by mouth nightly and Prozac (an antidepressant) 20 mg by mouth daily. The orders did not provide a diagnosis for the medications or the initial date of the orders.</p> <p>Resident #11's care plan, dated 5/29/18, documented a diagnosis of depression exhibited by lack of motivation to participate in activities, being tearful, paranoid thoughts or ideas, expressions of self-harm, or refusing to eat. The care plan documented Resident #11 was taking medication to help with the delusions and hallucinations.</p> <p>A Mood/Behavior of Cognitively Impaired care plan, dated 10/9/18, directed staff to monitor for side effects related to antianxiety medications.</p> <p>A monthly Long-term Care Pharmacy Review, dated 6/15/18, documented Resident #11 continued to see worms and spiders in her food, picked bugs off her clothing and the floor, saw men in her room and talked with people that were</p>	F 758			

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F 758	<p>Continued From page 22 not present.</p> <p>A monthly Long-term Care Pharmacy Review, dated 8/14/18, documented Resident #11's fear and paranoia were improved and her fear of men, paranoia, delusions, and hallucinations were improved with the combination of the antidepressant and antipsychotic medications.</p> <p>A monthly Long-term Care Pharmacy Review, dated 9/12/18, documented Resident #11's fear of men, paranoia, delusions, and hallucinations were improved with the combination of the antidepressant and antipsychotic medications.</p> <p>A Behavioral/Psychopharmacological Review, dated 9/6/18, documented Resident #11 received Zyprexa 5 mg nightly and Prozac 20 mg daily. The review documented Resident #11 continued to experience mild hallucinations but none that prevented care and nutrition as before.</p> <p>The facility's Behavior Monitoring flowsheet documented whether Resident #11 was able to express her needs, her feelings, her thoughts, and her ability to understand. The entries completed each shift, from 7/14/18 through 10/11/18, documented Resident #11 was calm, cooperative, able to express her feelings, needs, thoughts, and understood others. The Behavior Monitoring flowsheet did not document episodes of hallucinations or delusions.</p> <p>The behavior monitoring did not indicate what medications were given, what the indications for the medications were, what behaviors were being monitored, how many episodes were exhibited each shift, or provide non-pharmacological</p>	F 758			

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F 758	<p>Continued From page 23 interventions to staff.</p> <p>On 10/11/18 at 3:30 PM, the DON stated that Resident #11 has continued to have hallucinations and delusions but they are not upsetting to her now.</p> <p>5. Resident #7 was admitted to the facility on 8/27/18, with diagnoses which included dementia with behavioral disturbance, Type II DM, HTN, and a history of stroke.</p> <p>An H&P, dated 8/28/18, documented Resident #7 was living in an Assisted Living Facility when she was sent to the local ER due to combativeness, striking other residents at the facility. Resident #7 was admitted to the hospital and subsequently admitted to the facility. The H&P stated Resident #7's combativeness continued at the hospital and she was treated with Seroquel 75 mg twice daily. The note documented the plan was to ensure the combativeness was well controlled and then attempt a reduction in the dose of Seroquel.</p> <p>A physician progress note, dated 8/30/18, stated Resident #7 had not demonstrated behaviors which were a challenge to staff previously. The physician documented a plan to initiate a gradual medication reduction of Seroquel beginning 9/3/18.</p> <p>The MAR audit report, dated 10/12/18, for Resident #7 documented she received Seroquel 75 mg twice daily from 8/27/18 to 9/2/18. On 9/3/18, Resident #7 received 2 routine doses of Seroquel 50 mg and a 1 time dose of 50 mg, a total of 150 mg. Resident #7's Seroquel dose was reduced on 9/3/18, however, she received</p>	F 758			

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F 758	<p>Continued From page 24</p> <p>an additional 1 time dose on that day, which equaled her original dose. On 9/4/18, Resident #7's Seroquel was increased back to 75 mg twice a day. The physician's plan to initiate a gradual medication reduction of Seroquel was not documented after the attempt on 9/3/18.</p> <p>Resident #7's care plan, dated 9/7/18, identified the need for management of her behaviors related to her dementia. The care plan documented Resident #7 may become physical when she is upset, banging her fist on the wall, or yelling at others. It also stated Resident #7 may become frustrated and angry when her daughter and/or husband leave without her after a visit, it is too noisy, or she believes people are lying to her. Interventions included redirection to another activity which involved music or games, removing Resident #7 from other residents if she was yelling at them, or have a staff member sit and talk quietly with her in a quiet place.</p> <p>Resident #7's record included a Behavior Monitoring flowsheet. The flowsheet included sections for documentation of the date and time, resident behaviors, expressed needs, the ability to express feelings, needs, and thoughts, and the resident's ability to understand others. The flowsheet for Resident #7 was dated 8/28/18 to 10/11/18. Staff entries varied from 1 to 5 times a day.</p> <p>The Behavior Monitoring flowsheet included the following:</p> <ul style="list-style-type: none"> - On 8/30/18 at 6:38 PM, Resident #7's behavior was described as "angry," she was able to express her feelings, needs, and thoughts, and 	F 758			

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F 758	<p>Continued From page 25</p> <p>understood others. There was no further description documented of how she displayed her anger. There was no documentation of interventions by staff.</p> <p>- On 9/1/18 at 3:00 PM, Resident #7's behavior was described as "restless" and "impulsive." There was no further description of her behaviors. There was no documentation of interventions by staff.</p> <p>- On 9/2/18 at 10:00 AM, Resident #7's behavior was described as "Cries/tearful." There was no further description of her behaviors. There was no documentation of interventions by staff.</p> <p>- On 9/5/18 at 5:00 PM, Resident #7's behavior was described as "Anxious; Resistive to care; Restless." There was no further description of her behaviors. There was no documentation of interventions by staff.</p> <p>- On 9/8/18 at 6:34 PM, Resident #7's behavior was described as "Angry; Anxious," she was able to express her feelings, needs, and thoughts, and understood others. There was no further description documented of how she displayed her anger. There was no documentation of interventions by staff.</p> <p>- On 9/10/18 at 6:49 PM, Resident #7's behavior was described as "Anxious; Angry; Cooperative," she was able to express her feelings, needs, and thoughts, and understood others. There was no further description documented of how she displayed her anger or anxiety. There was no documentation of interventions by staff.</p>	F 758			

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F 758	<p>Continued From page 26</p> <p>- On 9/17/18 at 6:08 PM, Resident #7's behavior was described as "Angry; Anxious," she was able to express her feelings, needs, and thoughts, and understood others. There was no further description documented of how she displayed her anger or anxiety. There was no documentation of interventions by staff.</p> <p>- On 9/18/18 at 6:11 PM, Resident #7's behavior was described as "Angry; Anxious," she was able to express her feelings, needs, and thoughts, and understood others. There was no further description documented of how she displayed her anger or anxiety. There was no documentation of interventions by staff.</p> <p>- On 9/29/18 at 3:00 PM, Resident #7's behavior was described as "Cooperative; Restless; Anxious." There was no further description documented of how she displayed her behaviors. There was no documentation of interventions by staff.</p> <p>- On 10/7/18 at 5:22 PM, Resident #7's behavior was described as "Angry; Anxious," she was able to express her feelings, needs, and thoughts, and she understood others. There was no further description documented of how she displayed her anger or anxiety. There was no documentation of interventions by staff.</p> <p>- On 10/8/18 at 1:00 PM, Resident #7's behavior was described as "Anxious; Restless." There was no further description documented of how she displayed her anxiety or restlessness. There was no documentation of interventions by staff.</p> <p>At 10:35 AM on 10/12/18, the DON stated when</p>	F 758			

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F 758	<p>Continued From page 27</p> <p>Resident #7 was admitted the physician changed her from Haldol (an antipsychotic medication) to Seroquel. The DON stated a GDR was attempted but was unsuccessful. She stated when Resident #7 has behaviors staff will assess for pain or other causes. The DON stated the Behavior Monitoring flowsheet was completed once a shift. She confirmed the flowsheet did not include a further description for a specific mood and did not document interventions by staff.</p> <p>6. Resident #9 was admitted to the facility on 10/1/18, with diagnoses which included CHF, Alzheimer's disease, HTN, and Type II DM.</p> <p>Resident #9's physician orders, dated 10/1/18, included Cymbalta 60 mg daily for neuropathic pain (a disease of the sensory system) and Ativan 0.5 mg every 6 hours as needed for anxiety. There was no documentation in Resident #9's record she had diagnoses of neuropathy or anxiety.</p> <p>On 10/11/18 at 2:16 PM, the Pharmacy Director stated there was a Clinical Pharmacist who conducted monthly medication reviews. He stated he reviewed indications for medications with diagnoses and also looked for off-label indications. The Pharmacy Director stated if there was a discrepancy between indications for use and diagnoses he will review the record further. He confirmed Resident #9's record did not included diagnoses for neuropathy, depression, or anxiety.</p> <p>On 10/11/18 at 4:24 PM, the DON was asked about Resident #9's order for Ativan and what behaviors are staff monitoring for and she stated</p>	F 758			

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F 758	<p>Continued From page 28</p> <p>Resident #9 becomes tearful and repetitive if anxious. She confirmed there were no diagnoses of neuropathy, depression or anxiety on Resident #9's list of diagnoses.</p> <p>7. Resident #10 was admitted to the facility on 9/6/18, with diagnoses which included malaise, hemiplegia (paralysis of one side of the body), HTN, and Type II DM.</p> <p>Resident #10's physician orders included Trazodone (an antidepressant/sedative medication) 100mg nightly starting 9/6/18 and Melatonin (an herbal sleep aid) 3 mg nightly for sleep trouble, starting 10/5/18.</p> <p>A consent for Psychoactive Medication, dated 09/16/18, documented the Trazadone was for sleep.</p> <p>Resident #10's care plan, dated 9/26/18, included interventions to increase his participation to maximize rehabilitation benefits, have consistent daily scheduling, and reduce the risk of escalation. The care plan included monitoring for side effects related to Resident #10's antidepressant medication including drowsiness, dry mouth, sedation, and agitation. The care plan included direction to report to the nurse and physician if the medication assisted with sleep and if any negative side effects were observed.</p> <p>On 10/12/18 at 9:35 AM, the DON stated "We do not do a true monitor where staff note how many hours residents are awake/asleep." She stated the EMR documented whether sleep was adequate in the flow sheets, then the nurses write a note if the resident is up or having trouble</p>	F 758			

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F 759	Free of Medication Error Rts 5 Prcnt or More SS=D	F 759		11/9/18	
	<p>CFR(s): 483.45(f)(1)</p> <p>§483.45(f) Medication Errors. The facility must ensure that its-</p> <p>§483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a medication error rate less than 5 percent. This was true for 2 of 33 medications (6.06%) administered during medication pass and effected 2 of 5 residents (#65 and #114) observed during medication pass. This failed practice placed residents at risk of not receiving medications as ordered by the physician and had the potential to lessen the effectiveness of the medications administered. Findings include:</p> <p>1. Resident #114 was admitted to the facility on 9/27/18, with multiple diagnoses including gastroesophageal reflux disease.</p> <p>Resident #114's physician orders, dated 9/27/18, included Protonix (an acid reflux medication) 40 mg by mouth every morning before breakfast [served at 7:45 AM - 8:45 AM].</p> <p>On 10/12/18 at 8:45 AM, RN #1 was observed as she administered morning medications to Resident #114, which included the medication Protonix. Resident #114 had finished her breakfast and was sitting in the activity room.</p>		<p>The Director of Nursing is ultimately responsible to ensure a medication error rate less than 5 percent.</p> <ul style="list-style-type: none"> - Protonix standard administration time reviewed and changed to default to 1700 to allow for peak effectiveness of medication, and minimized delays due to increased resident needs prior to breakfast. <p>QAPI</p> <ul style="list-style-type: none"> - Monthly audit of medication rates to be conducted monthly and results reported to facility leadership and reviewed quarterly at the Long Term Care Quality Safety Council. 		

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F 759	Continued From page 30 2. Resident #65 was admitted to the facility on 10/8/18, with multiple diagnoses including gastroesophageal reflux. Resident #65's physician's order, dated 10/8/18, documented the resident was to receive Protonix 40 mg by mouth every morning before breakfast. On 10/12/18 at 9:11 AM, RN #1 was observed as she administered morning medications to Resident #65, which included Protonix. Resident #65 had finished her breakfast and was sitting in her wheelchair in her room. On 10/12/18 at 9:30 AM, RN #1 stated she did not know why the Protonix for Resident #114 and Resident #65 were scheduled for 8:00 AM. RN #1 stated Protonix was usually scheduled for 7:00 AM. On 10/12/18 at 2:35 PM, the DON stated sometimes the medication delivery times in the EMR changed. The DON stated the Protonix should be given during the 7:00 AM medication pass.	F 759		