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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically to the facility on 11/01/2019. A revised 2567 was sent electronically to the facility on 11/4/19.	F 000		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and	F 661		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 661	Continued From page 1	F 661		

non-medical services.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 38 residents. The sample included 14 residents. Based on interviews and record reviews the facility failed to document the discharge plans, current needs, and a summary of the discharge for Resident (R)37, sampled for discharge.

Findings included:

- The "Physician's Order Sheet" for R37, signed 06/25/19, documented diagnoses of muscle weakness, congestive heart failure (condition with low heart output and the body becomes congested with fluid), and atrial fibrillation (rapid, irregular heart beat).

The Admission "Minimum Data Set" (MDS) dated 06/12/19 documented a "Brief Interview for Mental Status" score of 13, which indicated intact cognition. She required supervision to extensive staff assistance with her "Activities of Daily Living" (ADLs). She received speech, occupational, and physical therapies for five of the seven days in the look back period.

The Discharge MDS dated 07/29/19 documented a BIMS score of 12, which indicated moderately impaired cognition. She required supervision with her ADLs.

The discharge "Care Plan" dated 06/12/19 documented R37 used a walker for ambulation and was receiving therapy to decrease her assistance needs. She planned to discharge to an assisted living facility after completion of therapy.

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F 661	Continued From page 2 The nurse's progress note dated 07/26/19 documented a request to R37's physician for discharge from the facility to an assisted living facility. The electronic medical record (EMR) lacked documentation for R37's current care needs or a summary of her discharge to the assisted living facility. On 10/29/19 at 04:10 PM Administrative Nurse E stated the nursing staff review the discharge summary with the residents and families prior to their discharge. A discharge summary is documented in the residents' EMR. On 10/29/19 at 04:34 PM Administrative Nurse D stated she expected nurses to document a discharge summary in the residents' EMR. The facility's "Admission, Transfer, And Discharge" policy dated 10/02/19 documented "Interdisciplinary Notes" contain the time and date of the discharge, mode of transportation, who accompanied the resident, reason for the transfer, the resident's vital signs, mental and physical condition to include skin integrity, and disposition of medication and personal belongings. The facility failed to document the discharge plans, her current needs and a summary of the discharge to an assisted living facility for R37.	F 661		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		

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§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 38 residents. The sample included 14 residents. Based on record review, observation, and interviews, the facility failed to ensure Resident (R) 18's assistive appliance was placed to prevent worsening of contractures of the left hand.

Findings included:

-The "Electronic Medical Record" (EMR) from the "Diagnosis" tab documented diagnoses of stiffness of joints (sensation of difficulty moving a joint or the apparent loss of range of motion of a joint) and hypertension (elevated blood pressure).

The Admission "Minimum Data Set" (MDS), dated 12/12/18, documented a "Brief Interview Status" (BIMS) score of eight which indicated moderate cognitive impairment. She required extensive assistance of two staff members for "Activities of

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Daily Living" (ADL). The MDS documented no nursing restorative splint assistance.

The Quarterly MDS, dated 09/12/19, documented no changes in status. The MDS also documented no nursing restorative splint assistance.

The "Care Area Assessment" (CAA) dated 12/14/18 for ADL's documented R18 required total assistance with all ADL's and physical and occupational therapy to evaluate and treat to determine if any improvement in ADL participation.

The "Care Plan " dated 12/20/19 for ADL's directed staff that R18 had a contracture to left hand on admission and potential for her right hand which was starting to draw up as well.

The "Occupational Therapy" (OT) progress notes signed 02/25/19 documented that nursing was instructed on applying and removing left hand splint techniques and left-hand splint wear schedule with good return demonstration carryover.

The clinical record lacked documentation for instructions related to wearing her splint.

The instructions for applying the left-hand splint were on a piece of paper hanging on the wall above R18's bed.

Observation on 10/24/19 at 11:40 AM revealed R18 sat in her wheelchair at a bedside table in the dining room, and fed herself lunch without assistance. The resident did not have a splint on her left hand.

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Observation on 10/28/19 at 01:49 PM revealed R18 lying in bed with eyes her closed, resting quietly with no distress and no left-hand splint noted on at this time.

On 10/28/19 at 02:03 PM during an interview with Consultant GG stated that nursing staff apply the splints for the residents once discharged from therapy after instructions and educattion are provided.

On 10/29/19 at 04:00 PM during an interview with Certified Nurse Aide (CNA) M, she stated that R18 did not wear a splint. She also said that the staff know who is on a nursing restorative program by the resident information documented in the electronic medical record.

On 10/29/19 at 04:11 PM during an interview with Licensed Nurse (LN) E, she stated she was not sure if R18 was to wear a splint on her upper extremity. LN E said splint documentation would be recorded in the point of care daily charting.

On 10/29/19 at 04:34 PM during an interview with Administrative Nurse D, she stated that R18 does wear a splint. Administrative Nurse D confirmed the EMR lacked any documentation to application and removal of the left-hand splint. She identified that it further lacked instructions as to the time frame R18 was to wear the splint.

The "Nursing Restorative Care Program" policy revised 10/22/19 documented the nursing interventions would promote resident's ability to adapt and adjust to independent and safe living, focus on achieving and maintaining optimal physical, mental and psychosocial functioning, improve or maintain function in physical abilities

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F 688	Continued From page 6 and ADL's and prevent further impairment. The facility failed to ensure R18 was wearing her left-hand splint to in order to prevent R18 from complications related to the presence and/or progression of a left hand contracture.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified census of 38 residents. The sample included 14 residents with four residents reviewed for falls. Based on observation, record review, and interviews the facility failed to implement an appropriate intervention, monitor for effectiveness of interventions, and review or attempt additional interventions aimed at preventing falls and injuries or pain related to falls for Resident (R) 29. Findings included: -The "Electronic Medical Record" (EMR) from the "Diagnosis" tab document diagnoses for R29 of hypertension (elevated blood pressure), atrial fibrillation (rapid, irregular heart beat) and congestive heart failure (a condition with low heart output and the body becomes congested with fluid).	F 689		

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The Significant Change "Minimum Data Set" (MDS) dated 04/01/19 for R29 documented a "Brief Interview for Mental Status" (BIMS) score of six which indicated severe impaired cognition. The MDS documented that R29 required extensive assistance of two staff members for transfer, bed mobility, dressing, and toilet use. The MDS also documented no falls since admission or prior assessment, had a fall with fracture prior to admission for R29.

The Quarterly MDS dated 09/28/19 documented a BIMS score of six which indicated severe impaired cognition. The MDS documented R29 required extensive assistance of one staff member for personal hygiene, bed mobility, transfer, dressing, toilet use, bathing, and locomotion on the unit. The MDS also documented two non-injury falls and one fall with injury during the look back period for R29.

The falls "Care Area Assessment" (CAA) for R29 dated 04/03/19 documented that she had a fractured right femur and has a history of falls related to her dementia process that include hallucinations, delusions, and poor safety awareness.

The "Fall Assessment" dated 09/29/19 recorded a score of 23 which indicated high risk for falls.

The "Care Plan" for falls with a start date of 02/20/19 indicated resident was a high fall risk with a previous fracture. The care plan recorded a goal of reducing risk of major injury that could impact the quality of life for R29. It also directed staff to offer R29 non-slip socks when getting into bed.

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A nurse note dated 03/23/19 at 08:45 PM documented R29 fell in her room when attempting to put her shirt on, lost her balance and landed on her right side. She complained of severe pain in right side. R29 was sent to the hospital for evaluation and diagnosed with a fractured right hip. The care plan was updated on return from the hospital with the intervention to check on the resident as soon as her company leaves to ensure her safety and orientation to the situation. It also directed to ensure an open pathway for mobilization without items/clutter on the floor.

A nurse's note dated 04/26/19 at 04:27 PM documented R29 was found lying in a fetal position on her right side, in the middle of the room, on the floor in front of her closet without any pants and shoes on. She reported to staff that she was trying to get something off the top shelf of her closet and lost her balance. R29 complained of right leg pain after fall. The care plan was updated with the intervention for staff to assist the resident when she was observed digging through her dressers, bedside table and closet.

A nurse's note dated 05/20/19 at 07:05 PM documented R29 was found laying on the floor on her back, her wheelchair was tipped over. She reported that she was reaching for her phone. An abrasion was noted on right side of her forehead along a 3.0 centimeter (cm) x3.0 cm raised area. R29 complained of her head hurting. R29 was transferred to the hospital for evaluation and returned to the facility. The care plan was updated with the intervention to place the phone within the resident's reach.

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A nurse's note dated 05/22/19 12:20 AM documented R29 was found sitting on the floor. She reported that she had rolled out of the bed. She was wearing regular socks. R29 complained of left wrist pain. Review of the medical record revealed no intervention was put in place for this fall.

The nurses notes recorded the resident had four more falls after the fall on 5/22/19.

A nurse's note dated 06/02/19 at 01:27 PM documented R29 was found kneeling on the floor next to her bed.

A nurse's note dated 08/06/19 at 03:14 AM documented R29 was found on the floor beside her bed. R29 was complaining of pain in her left leg and back pain.

A nurse's note dated 09/04/19 R29 at 12:42 PM recorded R29 was found on the floor at the bedside. R29 complained of back pain upon assessment.

A nurse's note dated 10/12/19 at 11:03 AM documented R29 was found on the floor in her room between her bed and wheelchair. R29 complained of back pain upon assessment and was sent to hospital for evaluation for possible compression fractures. She returned to facility no acute issues related to fall noted.

On 10/24/19 at 11:40 AM R29 was sitting in her wheelchair in the dining room feeding herself lunch..

On 10/28/19 at 01:36 PM R29 propelled herself in

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F 689	Continued From page 10 the wheelchair. On 10/29/19 at 04:00 PM during an interview with Certified Nurses Aide (CNA) M stated that R29 was a high fall risk and that she likes to wander in the hallways and look for her family . On 10/29/19 at 04:11 PM during an interview with Administrative Nurse E stated that a new intervention should be added to the care plan after each fall. On 10/29/19 at 04:34 PM during an interview with Administrative Nurse D stated that she is notified of the falls by email and that she is the person that updates the care plan with new interventions following a fall. The facility policy "Falls" dated 03/26/19 documented that residents will be identified for risk of falls and an intervention implemented to reduce falls. Residents with falls will be discussed weekly in risk management meeting to determine further possible interventions to prevent future fall. The facility failed to ensure that interventions were were implemented after each fall with the goal to prevent future falls and injuries, including pain, for R29 who had multiple falls, including a fall with injury.	F 689		
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.	F 756		

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§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 38 residents. The sample included 14 residents, with five sampled for unnecessary medication use. Based on observations, record reviews, and interviews

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the facility failed to ensure the consultant pharmacist (CP) identified and reported as well as follow up on recommendations for pulses and/or blood pressures outside of physician ordered parameters for Resident (R)28, R7 and R34.

Findings included:

- The "Electronic Medical Record" (EMR) for R28 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and atrial fibrillation (rapid, irregular heart beat).

The Annual "Minimum Data Set" (MDS) dated 12/29/18 documented a "Brief Interview for Mental Status" (BIMS) score of 12, which indicated moderately impaired cognition. She required supervision with her "Activities of Daily Living" (ADLs).

The ADL "Care Area Assessment" dated 01/09/19 documented R28's ADL potential was affected by her dementia and current increase in weakness.

The "Medication" care plan dated 10/07/19 documented R28's current medication regimen would ensure her current quality of life.

The EMR documented an order dated 12/5/18 for Losartan (medication used to treat hypertension) 100 milligrams (mgs.) daily for hypertension (elevated blood pressure) and hold the medication and call the physician if the resident's pulse is under 60 beats per minute.

The EMR documented an order for Amlodipine (medication used to treat hypertension) 5mgs.

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twice daily, dated 06/25/19.

The August 2019 CP's "Monthly Medication Review" (MRR) documented a request for physician ordered pulse parameters for the administration of the Amlodipine to coincide with the current Losartan order for holding the medication when the pulse was below 60 beats a minute. The physician agreed to this request.

Review of the "Medication Administration Record" from June 2019 through October 28, 2019 documented pulses below 60 on seven of 30 doses of Losartan in June, four of 31 doses of Losartan and seven of 62 doses of Amlodipine in July, four of 31 doses of Losartan and four of 62 doses of Amlodipine in August, two of the 30 doses of Losartan and five of the 60 doses of Amlodipine in September, and seven 28 doses of Losartan and seven of the 55 doses in October.

The EMR lacked documentation for the Losartan and Amlodipine being held or physician notification of the pulses outside of physician ordered parameters.

On 10/29/19 at 04:10 PM Administrative Nurse E stated medications are not given and the physician is called when pulses are outside of physician ordered parameters. The information is documented in the EMR.

On 10/29/19 at 04:34 PM Administrative Nurse D stated she expected nurses to hold medications if the pulses were outside of physician ordered parameters, and to notify the physician, as ordered. The information should be documented in the resident's EMR.

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On 10/30/19 at 11:52 AM Consultant HH stated she reviews residents' MARs for medications given outside of physician ordered parameters and reports consistent irregularities to the Director of Nursing.

The facility's "Drug Regimen Review" policy dated 06/10/19 documented the licensed pharmacist reviews residents' medication regimen to identify and possibly prevent potential clinically significant medication adverse consequences. Irregularities are directed to the Director of Nursing.

The facility failed to ensure the CP identified or acted upon recommendations for pulses outside of physician ordered parameters for R28 's Losartan and Amlodipine, which have the potential of causing irregular heartbeats, slowing heartbeats, or atrial fibrillation.
- The "Electronic Medical Record" (EMR) for R7 included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), and hypertension (elevated blood pressure).

The Annual "Minimum Data Set" (MDS) dated 5/4/19 documented a "Brief Interview for Mental Status" (BIMS) score of nine which indicated moderately impaired cognition. She required one person staff assistance with most Activities of Daily Living (ADLs).

R7's quarterly MDS dated 8/4/19 documented no change from the annual assessment.

The "Care Area Assessment" (CAA) for cognition dated 5/6/19 documented that R7 had severe cognitive impairment.

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The care plan for "Medications" dated 5/9/18 documented that R7 received multiple medications, and was at risk of side effects and/or complications due to polypharmacy (multiple medications). R7 took Atenolol (a medication to reduce blood pressure) for hypertension.

The EMR revealed an order dated 12/05/18 for Atenolol 25 milligram (mg) one tablet by mouth daily for hypertension. Hold the medication and call the physician if the systolic blood pressure is less than 90 or the pulse is equal to or below 60.

Review of the "Medication Administration Record" (MAR) tab of the EMR from 4/1/19 thru 10/29/19 lacked documentation that the physician was notified, or the Atenolol was held as ordered, when out of parameters for three of 29 days in October, two of 30 days in September, three of 31 days in August, five of 31 days in July, three of 30 days in June, two of 31 days in May, and five of 30 days in April.

The "Medication Regimen Review" (MRR) from 9/11/18 to 10/2/19 revealed that the consulting pharmacist (CP) failed to notify the facility of medication given out of parameters.

On 10/24/19 at 9:56 AM R7 walked in the hallway with her walker. She exhibited no behaviors.

On 10/29/19 at 12:33 pm R7 sat in the dining room and fed herself without difficulty.

On 10/29/19 at 4:00 PM Certified Nurse Aide (CNA) M stated that vital signs (measurement of blood pressure, pulse, respirations and pain) on the residents are obtained by the nurses, and

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CNAs can help.

On 10/29/19 at 4:11 PM Administrative Nurse E stated that vital signs on residents are taken by the nurse. Problems are reported to the Director of Nursing (DON), or the supervisor and the primary physician. When asked what should be done if the pulse or blood pressure are out of the ordered parameters, Administrative Nurse E stated that it depends on the physician, but the medication should be held, and the physician notified. This should be documented in the nurse's notes.

On 10/29/19 at 4:34 PM Administrative Nurse D stated that the nurses obtain vital signs on the residents. If the pulse or blood pressure are out of parameters, the nurse is to hold the medication until the physician is notified for orders, and a note is documented in ID notes that the physician was notified.

On 10/30/19 at 11:52AM Consultant HH stated that she reviews the MARs for medications given outside parameters and will report to the DON if she finds consistent irregularities.

The facility's policy "Drug Regimen Review" dated 6/10/19 documented the CP reviews residents' medication regimen monthly and as needed. In performing the monthly medication review the CP incorporates federally mandated standards of care.

The facility failed to ensure the CP identified and reported R7's blood pressure medication given outside parameters, and the lack of physicain notification related to the abnormal blood pressures. This had the potential for unnecessary

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medication to be administered, thus leading to possible harmful side effects to R7.

- The "Electronic Medical Record" (EMR) for R34 included diagnoses of atrial fibrillation (rapid, irregular heart beat), hypertensive heart disease (heart conditions caused by high blood pressure), and dementia (progressive mental disorder characterized by failing memory, confusion).

The Annual "Minimum Data Set" (MDS) dated 7/8/19 documented a "Brief Interview for Mental Status" score of five which indicated severely impaired cognition. She required one person staff assistance with most Activities of Daily Living (ADLs).

R34's quarterly MDS dated 10/8/19 documented no change from the annual assessment.

The "Care Area Assessment" (CAA) for "Cognition" dated 7/11/19 documented that R34 had severe cognitive impairment.

The care plan for "Medications" dated 7/12/19 documented that R34 takes multiple medications and was at risk of side effects and/or complications due to polypharmacy (multiple medications). R34 received Amlodipine, Losartan, metoprolol, and Terazosin (medicines to reduce blood pressure) for hypertension. R34 also had an alteration in cardiopulmonary function related to hypertension.

The EMR revealed an order dated 9/17/19 for Amlodipine 10mg (milligram) tablet daily for hypertension, call primary care physician (PCP) if systolic blood pressure (BP) greater than 180.

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The EMR revealed an order dated 6/28/19 for Losartan 100 mg-hydrochlolorothiazide 25 mg tablet daily for hypertensive heart disease, call PCP for systolic BP less than 90 or greater than 180, diastolic BP greater than 90 or less than 50.

The EMR revealed an order dated 6/28/19 for metoprolol tartrate 50 mg tablet two times a day for hypertensive heart disease, call PCP for systolic BP less than 90 or greater than 180, diastolic BP greater than 90 or less than 50.

The EMR revealed an order dated 9/17/19 for Terazosin 5 mg daily for hypertensive heart disease, hold if pulse less than 60 or systolic BP less than 90.

Review of the "Medication Administration Record" (MAR) tab of the EMR from 8/1/19 to 10/28/19 revealed that it lacked documentation that the physician was notified, or the amlodipine held as ordered when out of parameters for one of 28 days in October, nine of 30 days in September, and 14 of 30 days in August.

Review of the MAR tab of the EMR from 8/1/19 to 10/28/19 revealed that it lacked documentation that the physician was notified, or the losartan held as ordered when out of parameters for four of 28 days in October, 14 of 30 days in September, and 14 of 31 days in August.

Review of the MAR tab of the EMR from 8/1/19 to 10/28/19 revealed that it lacked documentation that the physician was notified, or the metoprolol held as ordered, when out of parameters for four of 28 days in October. The MAR also lacked documentation that blood pressure was taken on 60 opportunities in September and 62

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opportunities in August.

Review of the MAR tab of the EMR from 8/1 to 10/28/19 revealed that it lacked documentation that the physician was notified, or the Terazosin held as ordered when out of parameters for one day in October, and none in September or August.

The "Medication Record Review" (MRR) from 9/11/18 to 10/2/19 revealed that the CP failed to notify the facility of medication given out of parameters and the lack of docuemntation of physician notification. On 10/29/19 at 8:43 AM the resident walked in the hallways with her walker, singing at times. She was walking with a steady gate.

On 10/29/19 at 4:00 PM Certified Nurse Aide (CNA) M stated that vital signs (measurement of blood pressure, pulse, respirations and pain) on the residents are obtained by the nurses, and CNAs can help.

On 10/29/19 at 4:11 PM Administrative Nurse E stated that vital signs on residents are taken by the nurse. Problems are reported to the Director of Nursing (DON), or the supervisor and the primary physician. When asked what should be done if the pulse or blood pressure are out of the ordered parameters, Administrative Nurse E stated that it depends on the physician, but the medication should be held, and the physician notified. This should be documented in the nurse's notes.

On 10/29/19 at 4:34 PM Administrative Nurse D stated that the nurses obtain vital signs on the residents. If the pulse or blood pressure are out

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F 756	Continued From page 20 of parameters, the nurse is to hold the medication until the physician is notified for orders, and a note is documented in ID notes that the physician was notified. On 10/30/19 at 11:52AM Consultant HH stated that she reviews the MARs for medications given outside parameters and will report to the DON if she finds consistent irregularities. The facility's policy "Drug Regimen Review" dated 6/10/19 documented the CP reviews residents' medication regimen monthly and as needed. In performing the monthly medication review the CP incorporates federally mandated standards of care. The facility failed to ensure the CP identified the medications were given outside parameters, and the physician was not notified. This had the potential for unnecessary medication to be administered, thus leading to possible harmful side effects to R34.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		

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F 757	Continued From page 21 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 38 residents. The sample included 14 residents, with five sampled for unnecessary medication use. Based on observations, record reviews, and interviews the facility failed to withhold medications and notify the physician when pulses and/or blood pressures were outside of physician ordered parameters for Resident (R)28, R7, and R34. Findings included: - The "Electronic Medical Record" (EMR) for R28 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and atrial fibrillation (rapid, irregular heart beat). The annual "Minimum Data Set" (MDS) dated 12/29/18 documented a "Brief Interview for Mental Status" (BIMS) score of 12, which indicated moderately impaired cognition. She required supervision with her "Activities of Daily Living" (ADLs). The ADL "Care Area Assessment" dated 01/09/19 documented R28's ADL potential was affected by her dementia and current increase in weakness.	F 757		

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The "Medication" care plan dated 10/07/19 documented her current medication regimen ensure her current quality of life.

The EMR documented an order for Losartan (medication used to treat hypertension) 100 milligrams (mgs.) daily for hypertension (elevated blood pressure) and hold the medication and call the physician if the resident's pulse is under 60 beats per minute, dated 12/05/18.

Review of the "Medication Administration Record" from June 2019 through October 28, 2019 documented pulses below 60 on seven of 30 doses of Losartan in June, four of 31 doses of Losartan in July, four of 31 doses of Losartan in August, two of the 30 doses of Losartan in September, and seven of 28 doses of Losartan in October.

The EMR lacked documentation for the Losartan being held or physician notification of the pulses outside of physician ordered parameters.

On 10/29/19 at 04:10 PM Administrative Nurse E stated medications are not given and the physician is called when pulses are outside of physician ordered parameters. The information is documented in the EMR.

On 10/29/19 at 04:34 PM Administrative Nurse D stated she expected nurses to hold medications if the pulses were outside of physician ordered parameters, and to notify the physician, as ordered. The information should be documented in the resident's EMR.

The facility's "Medication Review And Education"

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policy dated 06/10/19 lacked documentation on the withholding of medications and the notification of physicians if pulses are outside of ordered parameters.

The facility failed to withhold the Losartan and notify the physician for pulses outside of physician ordered parameters for R28, which had the potential of causing irregular heartbeats, slowing heartbeats, or atrial fibrillation.
- The "Electronic Medical Record" (EMR) for R7 included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), and hypertension (elevated blood pressure).

The annual "Minimum Data Set" (MDS) dated 5/4/19 documented a "Brief Interview for Mental Status" (BIMS) score of nine which indicated moderately impaired cognition. She required one person staff assistance with most Activities of Daily Living (ADLs).

R7's quarterly MDS dated 8/4/19 documented no change from the annual assessment.

The "Care Area Assessment" (CAA) for cognition dated 5/6/19 documented that R7 had severe cognitive impairment.

The care plan for "Medications" dated 5/9/18 documented that R7 received multiple medications, and was at risk of side effects and/or complications due to polypharmacy (multiple medications). R7 takes Atenolol (a medication to reduce blood pressure) for hypertension.

The EMR revealed an order dated 12/05/18 for

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Atenolol 25 milligram (mg) one tablet by mouth daily for hypertension. Hold the medication and call the physician if the systolic blood pressure is less than 90 or the pulse is equal to or below 60.

Review of the "Medication Administration Record" (MAR) tab of the EMR from 4/1/19 thru 10/29/19 lacked documentation that the physician was notified, or the Atenolol was held as ordered, when out of parameters for three of 29 days in October, two of 30 days in September, three of 31 days in August, five of 31 days in July, three of 30 days in June, two of 31 days in May, and five of 30 days in April.

On 10/24/19 at 9:56 AM R7 walked in the hallway with her walker. She exhibited no behaviors.

On 10/29/19 at 12:33 pm R7 sat in the dining room and fed herself without difficulty.

On 10/29/19 at 4:00 PM Certified Nurse Aide (CNA) M stated that vital signs (measurement of blood pressure, pulse, respirations and pain) on the residents are obtained by the nurses, and CNAs can help.

On 10/29/19 at 4:11 PM Administrative Nurse E stated that vital signs on residents are taken by the nurse. Problems are reported to the Director of Nursing (DON), or the supervisor and the primary physician. When asked what should be done if the pulse or blood pressure are out of the ordered parameters, Administrative Nurse E stated that it depends on the physician, but the medication should be held, and the physician notified. This should be documented in the nurse's notes.

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On 10/29/19 at 4:34 PM Administrative Nurse D stated that the nurses obtain vital signs on the residents. If the pulse or blood pressure are out of parameters, the nurse is to hold the medication until the physician is notified for orders, and a note is documented in ID notes that the physician was notified.

The facility policy "Medication Review and Education" dated 6/10/19 failed to provide direction for monitoring high blood pressure medications.

The facility failed to hold the hypertensive medication when R7's blood pressure and/or pulses were outside of the physician ordered parameters. The facility also failed to notify the physician as ordered for R7. This had the potential for unnecessary medication administration, thus leading to possible harmful side effects.

- The "Electronic Medical Record" (EMR) for R34 included diagnoses of atrial fibrillation (rapid, irregular heart beat), hypertensive heart disease (heart conditions caused by high blood pressure), and dementia (progressive mental disorder characterized by failing memory, confusion).

The annual "Minimum Data Set" (MDS) dated 7/8/19 documented a "Brief Interview for Mental Status" score of five which indicated severely impaired cognition. She required one person staff assistance with most Activities of Daily Living (ADLs).

R34's quarterly MDS dated 10/8/19 documented no change from the annual assessment.

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The "Care Area Assessment" (CAA) for "Cognition" dated 7/11/19 documented that R34 had severe cognitive impairment.

The "Care Plan" for medications dated 7/12/19 documented that R34 takes multiple medications and was at risk of side effects and/or complications due to polypharmacy (multiple medications). R34 takes Amlodipine, Losartan, Metoprolol, and Terazosin (medicines to reduce blood pressure) for hypertension. R 34 also has an alteration in cardiopulmonary function related to hypertension.

The EMR revealed an order dated 9/17/19 for Amlodipine 10mg (milligram) tablet daily for hypertension, call primary care physician (PCP) if systolic blood pressure (BP) greater than 180.

The EMR revealed an order dated 6/28/19 for Losartan 100 mg-hydrochlolorothiazide 25 mg tablet daily for hypertensive heart disease, call PCP for systolic BP less than 90 or greater than 180, diastolic BP greater than 90 or less than 50.

The EMR revealed an order dated 6/28/19 for metoprolol tartrate 50 mg tablet two times a day for hypertensive heart disease, call PCP for systolic BP less than 90 or greater than 180, diastolic BP greater than 90 or less than 50.

The EMR revealed an order dated 9/17/19 for Terazosin 5 mg daily for hypertensive heart disease, hold if pulse less than 60 or systolic BP less than 90.

Review of the "Medication Administration Record" (MAR) tab of the EMR from 8/1/19 to 10/28/19 revealed that it lacked documentation the

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physician was notified, or the amlodipine held as ordered when out of parameters for one of 28 days in October, nine of 30 days in September, and 14 of 30 days in August.

Review of the MAR tab of the EMR from 8/1/19 to 10/28/19 revealed that it lacked documentation that the physician was notified, or the losartan held as ordered when out of parameters for four of 28 days in October 14 of 30 days in September, and 14 of 31 days in August.

Review of the MAR tab of the EMR from 8/1/19 to 10/28/19 revealed that it lacked documentation that the physician was notified, or the metoprolol held as ordered when out of parameters for four of 28 days in October 2019. The MAR lacked documentation that blood pressure was taken 60 times in September 2019 and 62 times in August 2019.

Review of the MAR tab of the EMR from 8/1 to 10/28/19 revealed that it lacked documentation that the physician was notified, or the Terazosin held as ordered when out of parameters for one day in October 2019, and none in September 2019 or August 2019.

On 10/24/19 at 8:39 AM R34 was sitting in her wheelchair in her room.

On 10/29/19 at 8:43 AM resident was walking in the hallways with her walker, singing at times. She was walking with a steady gate.

On 10/29/19 at 4:00 PM Certified Nurse Aide (CNA) M stated that vital signs (measurement of blood pressure, pulse, respirations and pain) on the residents are obtained by the nurses, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175305	A. BUILDING _____ B. WING _____	10/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE PRESBYTERIAN MANOR	1429 KASOLD DR LAWRENCE, KS 66049

(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 757	Continued From page 28	F 757		

CNAs can help.

On 10/29/19 at 4:11 PM Administrative Nurse E stated that vital signs on residents are taken by the nurse. Problems are reported to the Director of Nursing (DON), or the supervisor and the primary physician. When asked what should be done if the pulse or blood pressure are out of the ordered parameters, Administrative Nurse E stated that it depends on the physician, but the medication should be held, and the physician notified. This should be documented in the nurse's notes.

On 10/29/19 at 4:34 PM Administrative Nurse D stated that the nurses obtain vital signs on the residents. If the pulse or blood pressure are out of parameters, the nurse is to hold the medication until the physician is notified for orders, and a note is documented in ID notes that the physician was notified.

The facility policy "Medication Review and Education" dated 6/10/19 failed to provide direction for monitoring high blood pressure medications.

The facility failed to hold the hypertensive medication as ordered when R7's blood pressure and/or pulses were outside of the physician ordered parameters. The facility also failed to notify the physician. This had the potential for unnecessary medication administration, thus leading to possible harmful side effects.