| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey and complaint survey started on 10/04/10 and completed on 10/06/10, the sample included 2 residents for complete review, 7 residents for focused review and 1 closed record. The sample included 2 additional residents to verify specific concerns. | F 000 | | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported | F 225 | F225<br>1. Incident for resident involved was identified as past non-compliance as resident deceased. Mandatory staff in-services were completed by SSD on resident rights, abuse, and proper reporting procedures on 11/24/09 and 5/12/10. Staff educated during staff meetings on 9/10/09 and 9/8/10.<br>2. All residents have the potential to be affected.<br>3. A) Mandatory in-service will be provided by SSD and DON on the abuse policy, reporting and investigation on 11/3/10. All staff will be required to be present or to watch the taped video by 11/10/10. B) Abuse policy will be posted and staff required to read and sign that it was read. C) Posters will be posted in all facility areas regarding timely notifications of abuse to administration. D) QA coordinator will perform random interview of staff regarding abuse policy and reporting one week following the in-service, monthly X3, and 6 months following the in-service. | 11/10/10 |

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

Stephanie Carey | Administrator | 11/1/10

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 225 | Continued From page 1<br>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy and procedure, and staff interview, the facility staff failed to immediately notify administration and the state survey agency for 1 of 2 abuse/neglect allegations involving physical and/or verbal abuse and neglect. Failure to immediately report all allegations of abuse and/or neglect has the potential for the abuse and or neglect to continue and failed to protect residents from harm.<br><br>Findings include:<br><br>Review of the facility policy titled "Abuse Policy and Procedure"occurred on 10/05/10. This policy, dated July 2010, stated.". . . IV. IDENTIFICATION: 1. Any staff witnessing or possessing reliable knowledge of any act, or suspected act of abuse, . . . must immediately notify their department supervisor. The resident must be safeguarded immediately. . . . 2. The incident must be reported to the Administrator or person in charge, in the absence of the Administrator immediately. . . . 4. Outside agencies as required by State law, including the State Survey and Certification Agency, will be notified of all alleged violations and/or substantiated incidents." | F 225 | 4. The QA Coordinator will be responsible for completion and review of all QA. DON will be responsible for enforcing mandatory attendance of in-service.<br>5. Completion Date 11/10/10. | |

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| F 225 | Continued From page 2<br><br>Review of the facility's investigation of the prior twelve months abuse/neglect allegations occurred on 10/05/10 at 2:30 p.m. One of the alleged abuse investigations showed the following:<br>- Verbal abuse allegation, dated 12/12/09 @ (at) 1:00 p.m., was reported to the Director of Nursing at 9:00 a.m. on 12/14/09, the Administrator received notification at 10:00 a.m. on 12/14/09, and the North Dakota State Survey Certification Agency (NDSSCA) received notification on 12/14/09.<br><br>Review of this allegation identified the facility staff failed to immediately (within 24 hours) report the allegation on 12/12/09 to the administrator and the State survey agency.<br><br>During an interview on 10/06/10 at 10:15 a.m., an administrative staff member (#1) confirmed the facility staff did not follow facility policy/procedure in reporting an allegation of abuse to administration or State agency when it occurred. | F 225 | | |
| F 248 SS=D | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, facility policy/procedure review, and staff interview, the facility failed to provide an ongoing, meaningful activity program to meet the physical, mental, and | F 248 | F248<br>1. Corrective action for resident #3, #4, #9: A) 1:1 visits will be increased to 5X a week and be delegated specifically to the Activity Dept. for completion. B) Care plans will be updated to include current cognitive status, preference for activity, and individualized.<br>2. All residents have the ability to be affected.<br>3. A) A planned daily activity schedule will be posted in both units of the facility. B) SSD, Activity Director, and CNA will attend educational seminar regarding activities for memory impaired residents on | 11/10/10 |

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| F 248 | Continued From page 3<br>psychosocial needs for 3 of 3 sampled residents (Resident #3, #4, and #9) dependent on staff for activities. Failure to provide meaningful activities has the potential to negatively impact a resident's overall well-being.<br><br>Findings include:<br><br>Review of the facility policy titled "SPECIAL CARE UNIT - THERAPEUTIC PROGRAMS" occurred on 10/06/10. This undated policy stated, "Purpose 1. Residents have the opportunity to maintain and enhance their sense of dignity and self-esteem by engaging in meaningful social interactions throughout the day, every day. Both formal and informal activities provide the resident and the caregiver a sense of security and enjoyment . . . 4. In addition to meeting the special medical and nursing needs of each resident in the Special Care Unit, the nursing facility shall provide social services and activity programs specially designed to avoid programmatic isolation and to meet each resident's individual needs. These can be done by CNAs [certified nursing assistants], Activity Staff and other employees of the nursing facility . . . 6. Activities and social service programs shall provide the opportunity for interaction with non-dementia residents of the nursing facility to respond to individual resident needs and capabilities without disruption to other residents. . . ."<br><br>Review of the facility policy titled "PROGRAM AND ACTIVITIES" occurred on 10/06/10. This undated policy stated, "The goal of the program and activities department is to maintain the individual dignity and independence of each resident. The program encompasses group and individual activities and includes social, spiritual, | F 248 | 10/28/10. C) CNA activity documentation will be changed to include invitations and refusals and simplified to ensure compliance of documentation. D) The Activity Director will write a monthly summary in the ID notes on each resident based on this documentation. E) Staff will be educated on the new documentation system at a mandatory in-service on 11/3/10 given by DON and AD. F) QA will be completed weekly X4 and monthly X6. G) Care plans will be updated to indicated current cognitive status, preference for activity, and be individualized per MDS schedule. H) QA will be conducted monthly X6.<br>4. QA coordinator will be responsible for completion and review of all QA, along with the AD and DON.<br>5. Completion Date of 11/10/10. | |

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| F 248 | Continued From page 4<br>intellectual, creative and community components. This will be accomplished through a coordinated interdisciplinary team approach.<br>The basic objectives of the activity program are to:<br>1) Instill in the resident a feeling of usefulness and independence;<br>2) Encourage self-confidence and self-respect;<br>3) Provide socialization and individual attention as needed;<br>4) Provide mental activities to stimulate the individual's thinking process;<br>5) Provide physical activities as tolerated to maintain strength, endurance and circulation;<br>6) Provide opportunity for the individual to participate in spiritual programs of his/her choice; and<br>7) Encourage continued family and community involvement with the individual resident."<br><br>- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia, depressive disorder, major recurrent psychotic behavior, and anxiety. The resident resided on the special care unit. Resident #3's most recent quarterly Minimum Data Set (MDS), dated 08/05/10, identified short and long term memory problems, severe impairment with daily decisions, sometimes able to understand others, and is sometimes understood. The current MDS indicated the resident required total assistance of one staff member for locomotion on and off the unit. The "Activities" portion of the MDS showed Resident #3's preferred activities included cards/other games, exercise/sports, music, reading/writing, spiritual/religious activities, walking/wheeling outdoors, and watching TV; and Resident #3 spent 1/3 to 2/3 of his time involved | F 248 | | |

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| F 248 | Continued From page 5<br>in activities.<br><br>Resident #3's current care plan stated, " . . . Problem . . . Resident needs respectful encouragement to retain social involvement and activity . . . Goal . . . Will accept 1-1 [one to one] visitation or minivisits 2-3x week with staff in room or out of room, respond verbally, head movement or eye contact and attend 2-3 group weekly and will sit and observe persons in dayroom or watch TV . . . Approach . . . Offer animal or fishing magazine to look at PRN [as needed]. Allow to make choices. Try horse races . . . Sensory stimuli . . . Invite to outdoors for w/c [wheelchair] rides weather permit, story hour, special parties and entertainment, church, current events and horse races . . . Show pets PRN. Reminisce about fishing, the woods and wildlife, birds . . . Visit in and out of room for short periods. Use short simple sentences. Offer resident to come and sit in area not crowded or back of group activity PRN. Give TLC and respect resdient [sic] wishes . . . Assist to sit in day room PRN. Take for w/c rides and activities PRN . . . Offer hallmark and animal channels on TV, westerns and videos PRN . . . Give special treats. . . ."<br><br>Observations of Resident #3 occurred throughout the survey and revealed the following:<br>* 10/04/10 at 2:25 p.m.: In bed asleep<br>* 10/04/10 at 4:05 p.m.: Up from bed and toileted, taken to the unit living room and placed in front of the tv, sat with eyes closed and head down<br>* 10/05/10 at 7:30 a.m.: Sitting at the dining room table (nothing on table) with eyes closed and head down<br>* 10/05/10 at 8:30 a.m.: Fed breakfast at the dining room table<br>* 10/05/10 at 9:20 a.m.: In living room area sitting | F 248 | | |

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| F 248 | Continued From page 6 | F 248 | | |

in his wheelchair, eyes closed and head down
* 10/05/10 at 9:30 a.m.: Transferred to bed
* 10/05/10 at 10:50 a.m.: Toileted and taken to dining room table
* 10/05/10 at 11:30 a.m.: Fed noon meal
* 10/05/10 at 12:45 p.m.: Sitting in a recliner in the family room with his eyes closed, radio on
* 10/05/10 at 3:40 p.m.: Sitting in his room after being toileted, no radio or tv on
* 10/05/10 at 3:50 p.m.: Taken out to living room, tv on, eyes closed and head down (remained like this until 5:00 p.m.)
* 10/05/10 at 5:00 p.m.: Pushed to the dining room table in his wheelchair
* 10/06/10 at 8:10 a.m.: Fed breakfast at the dining room table
* 10/06/10 at 8:45 a.m.: Sitting in wheelchair at the dining room table (nothing on table), eyes closed and head down
* 10/06/10 at 9:15 a.m.: In bed asleep (still sleeping at 10:20 a.m.)

Review of Resident #3's "Resident Activities Participation Record" from July 2010 - September 2010 occurred on 10/05/10. The records showed the majority of the activities the resident participated in included observing, television, wheelchair rides, and group and one to one activities (specific activity not consistently identified).

During an interview on 10/06/10 at 9:15 a.m., an activity staff member (#5) stated staff are to read to Resident #3, apply lotion, play music, reminisce about fishing and cats, and assist to special music. Staff do one to one activities with Resident #3 a couple times a week for an average of 10 minutes and visit with him daily. She stated an activity aid goes to the special care unit three

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| F 248 | Continued From page 7<br>times a week for two hours in the afternoon. The staff member (#5) stated she goes to the special care unit herself at 1:00 p.m. during the week and does some one to one and group activities during this time (approximately an hour). On the weekends, an activity aid assists the residents to worship and Bingo. The staff member (#5) stated the CNAs in the special care unit are responsible for engaging residents in activities when they are not assisting with cares. The staff member (#5) stated she has a list of activities posted in the special care unit for the CNAs to reference when they need ideas for activities. The staff member (#5) stated she expected the CNAs to do more with Resident #3 and said "it doesn't look good when he is sitting there with his head down."<br><br>- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included depression, history of breast and brain cancer, epilepsy, schizophrenia, psychosis, organic brain syndrome, and dementia. The resident resided on the special care unit and is on hospice. Resident #4's most recent quarterly MDS, dated 07/26/10, identified short and long term memory problems, severe impairment with daily decisions, sometimes able to understand others, and is rarely/never understood. The MDS showed Resident #4 exhibited persistent anger with self or others, had a sad/pained/worried facial expression, was verbally and physically abusive, socially inappropriate, and resisted care. The current MDS indicated the resident required total assistance of one staff member for locomotion on and off the unit. The "Activities" portion of the MDS showed Resident #4's preferred activities included cards/other games, exercise/sports, music, reading/writing, spiritual/religious activities, walking/wheeling | F 248 | | |

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| F 248 | Continued From page 8<br>outdoors, watching TV, and talking or conversing; and Resident #4 spent 1/3 to 2/3 of her time involved in activities.<br><br>Resident #4's current care plan stated. " . . . Problem . . . Needs reminders and invite to group activity and assist at times . . . Goal . . . will attend 2-3 activities weekly and will respond to visits with staff and residents . . . Approach . . . Provide monthly activity calendar. Invite and assist as needed to music, special entertainment and parties, bingo, card games, outdoors, manicures, current and special events, Sunday church and communion, quizzes, devotions, fold towels, exercises, pets and singalongs. Respect resident rest times. Visit with resident. . . ."<br><br>Observations of Resident #4 occurred throughout the survey and revealed the following:<br>* 10/04/10 at 2:35 p.m.: In wheelchair, pushed into living room area in front of the tv, resident not looking at the tv<br>* 10/04/10 at 2:50 p.m.: Self-propelling wheelchair around living room area in wheelchair<br>* 10/04/10 at 3:05 p.m.: Called husband with staff assistance<br>* 10/04/10 at 3:15 p.m.: A CNA flipped through an Avon book with the resident. The resident did not appear interested and attempted to get out of her wheelchair multiple times.<br>* 10/04/10 at 4:40 p.m.: After toileting, staff pushed her in her wheelchair to the dining room table (nothing on table)<br>* 10/05/10 at 7:30 a.m.: In bed asleep<br>* 10/05/10 at 7:50 a.m.: Toileted and morning cares, taken to dining room table for breakfast<br>* 10/05/10 at 8:15 a.m.: Eating breakfast with staff assistance<br>* 10/05/10 at 9:45 a.m.: Self-propelling wheelchair | F 248 | | |

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| F 248 | Continued From page 9<br>around living room area<br>* 10/05/10 at 10:00 a.m.: Sitting at table eating a cookie<br>* 10/05/10 at 10:30 a.m.: Sitting in her wheelchair in the chapel/activity room off the special care unit, eyes closed and head down while staff played the piano and people sang along<br>* 10/05/10 at 11:30 a.m.: Toileted by a hospice CNA, pushed to dining room table<br>* 10/05/10 at 11:40 a.m.: Eating noon meal with staff assistance<br>* 10/05/10 at 12:45 p.m.: Self-propelling wheelchair around living room area<br>* 10/05/10 at 1:10 p.m.: Activity staff asked her if she wanted to go outside. Resident #4 shook her head "no". Transferred into a recliner in the family area, looking out the window<br>* 10/05/10 at 2:00 p.m.: Restless, trying to get out of recliner, toileted and transferred back into wheelchair<br>* 10/05/10 at 2:15 p.m.: Self-propelling wheelchair around living room area<br>* 10/05/10 at 3:00 p.m.: Sitting in wheelchair in front of tv, eyes closed and head down<br>* 10/05/10 at 3:20 p.m.: Staff member reading to the resident from the newspaper<br>* 10/05/10 at 3:30 p.m.: Resident sitting in her wheelchair in the living room, tv on, but resident not looking at tv, kicking her legs back and forth and leaning out of wheelchair (until 5:00 p.m. when taken to dining room table for supper)<br>* 10/06/10 at 8:10 a.m.: Eating breakfast with staff assistance<br>* 10/06/10 at 8:45 a.m.: Finished eating, table cleared, resident sitting in wheelchair at the dining room table, eyes closed<br>* 10/06/10 at 9:00 a.m.: Sitting in her wheelchair in the living room area, eyes closed and head down, no tv or music on | F 248 | | |

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| F 248 | Continued From page 10<br>* 10/06/10 at 9:15 a.m.: Taken to activity room off the special care unit for exercises, not participating in exercises, periods of time when head down and eyes closed, along with periods of restlessness and attempting to exit wheelchair<br><br>Review of Resident #4's "Resident Activities Participation Record" from July 2010 - September 2010 occurred on 10/05/10. The records showed the majority of the activities the resident participated in included observing, mail/newspaper, wheelchair rides, visits with other residents, visitors, worship services, music, radio/tv, story/current events, group and one to one activities (specific activity not consistently identified).<br><br>During an interview on 10/06/10 at 9:15 a.m., an activity staff member (#5) stated staff take Resident #4 on walks/wheelchair rides, visit with her, take her to activities off the special care unit, reminisce with her, look at magazines, read to her, and take her outside. The staff member (#5) stated her one to one visits are a couple of times a week and last about 10-15 minutes. She stated her family comes to visit often and that the resident likes to keep moving and sometimes she gets upset if the staff move her. The staff member (#5) stated hospice comes in and will also do some activities with the resident. She agreed staff could do more to provide engaging/stimulating activities specific to Resident #4's condition, and attempt different approaches when initiating activities with her.<br><br>During an interview on 10/06/10 at 10:10 a.m., an administrative nursing staff member (#1) agreed staff should provide more engaging/stimulating activities with the residents in the special care | F 248 | | |

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| F 248 | Continued From page 11<br>unit.<br><br>The facility failed to develop an ongoing, meaningful, and individualized activity program designed to meet the current physical, mental, and psychosocial needs of Resident #3 and #4. The facility failed to consistently provide stimulating and engaging activities to these residents residing on the special care unit and failed to adapt their activity program to their changing needs and health conditions. A well-developed and individualized activity program could potentially decrease behaviors and improve the residents' quality of life.<br><br>- Review of Resident #9's medical record occurred on 10/05/10. Diagnoses included dementia with psychosis, chronic paranoid, mental disorder, schizophrenia, and cataracts. Resident #9's most current MDS, dated 07/14/10 indicated short and long term memory problems and time awake as none of the above, average time involved in activities, some - from one third to two thirds, preferred activity settings as own room and outside facility, and general activity preferences are walking, watching TV, and talking or conversing.<br><br>Review of Resident #9's current care plan, dated 07/27/10, stated; "Problem: Alteration in thought process, is an observe [sic] and has independent activity of choice R/T [related to] dx [diagnosis]. Dementia, chronic Paranoid schizophrenia M/B [manifested by] needs 1-1 visits, Naps more than 1 hour in all periods. Prefers to spend time in solarium watching others or lays on bed sleeping. Refuses most group activity. Needs invite to activity prn [as needed]/ Makes own selective decision of activity passive at times. Moods vary. | F 248 | | |

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| F 248 | Continued From page 12<br>Vents to person of choice. Goal: Will respond to staff on mini visits or 1-1 visits 2 x weekly verbal, eye contact or whisper, have independent activity of choice and will attend 1-2 group activity monthly TNR. Approach: . . . Invite to group lunches, van outings, outdoors weather permits, special parties as desired prn. Allow independent activity of choice in and out of room such as observing. Offer sensory treats. reminisce about cooking, carpenter, car races, family, hunting and fishing. . . ."<br><br>Observations on 10/05/10 showed Resident #9 in his room lying on the bed from 2:00 p.m. to 4:55 p.m. with no activity provided.<br>Observation on 10/06/10 at 8:15 a..m. showed Resident #9 sitting in a chair by the nurses station with head down and eyes closed. From 8:45 a.m. to 11:00 a.m., Resident #9 laid in his bed with eyes closed; no activities observed.<br><br>Review of Resident #9's "Resident Activities Participation Record" for July 1st.- October 5th. 2010, (97 days total) indicated one to one visits occurred 15 times, devotions once, radio/tv 6 times, discussion 12 times, sensory stimulation 2 times, walk 6 times, and lunch group 28 times and no refusals charted. CNA charting for activities indicated the CNA's did 1-1 visits daily with Resident #9 on the morning and afternoon shift, had the resident walk or "observe", and the TV offered 12 of 97 days.<br><br>A quarterly activity summary, dated 07/16/10, stated, ". . . Respond to staff on mini visits or 1-1 visits 2 x [times] wkly.[weekly] Verbal, eye contact, independent activity of choice and will attend 1-2 group act. [activity] monthly. Goal being met. Prefers to spend time in dining room. | F 248 | | |

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| F 248 | Continued From page 13<br>Visits with kitchen staff requesting different foods. Sits in solarium and sunny room, reclines. Will ask for assistance to room, needs invites and assist to act., has been to special music, candle light supper, lunch group. Reminisce and sensory group with pets, treats, mood very, good imagination, visits with staff and residents. . . ."<br><br>During an interview on 10/06/10 at 9:15 a.m., an activity staff member (#5) stated; "1-1 visits for Resident #9 last about 10 minutes but are usually less because he doesn't respond. He has gone to some activities. Staff are not good about documenting when a resident refuses an activity."<br><br>The facility's staff failed to provide a meaningful activity program responsive to Resident #9's individual needs and failed to accurately document Resident #9's refusals. Failure to provide accurate documentation may contribute to the facility providing Resident #9 with an ineffective activity program. | F 248 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug | F 329 | F329<br>1. Resident #5 had a physician orders for a dose reduction of Zyprexa 10/21/10. Physician will further consider a dose reduction of Depakote upon evaluation on 10/28/10. Resident #5 will be seen yearly by a physician or psychiatrist for annual evaluation and medication reduction as long as remains on psychotropic medications per CMS guidelines. Documentation will be completed by staff and physician per CMS guidelines.<br>2. Any resident receiving psychotropic or mood stabilizing medications has the potential to be affected. | 11/10/10 |

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| F 329 | Continued From page 14<br>therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of professional reference, and staff interview, the facility failed to ensure the drug regimen remained free from unnecessary drugs for 1 of 1 sampled resident (Resident #5) receiving an anticonvulsant as well as other antipsychotic medications to treat mood/behavior symptoms. Failure to provide adequate monitoring or attempt a gradual dose reduction (GDR) may increase the risk of adverse consequences, including tardive dyskinesia.<br><br>Findings include:<br><br>The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of a medication dose/GDR which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains | F 329 | 3. A) All residents will be seen annually by a physician or psychiatrist regardless of status if on psychotropic or mood stabilizing medications. B) Psychotropic and/or mood stabilizing medications will be assessed for reduction annually per physician and orders/documentation obtained. C) QA will be conducted monthly X6.<br>4. The QA Coordinator will be responsible responsible for completion and review of all QA.<br>5. Completion Date of 11/10/10. | |

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| F 329 | Continued From page 15 | F 329 | | |

appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For antipsychotic medications, after the first year, a GDR must be attempted annually, unless clinically contraindicated.

Review of Resident #5's medical record occurred on October 4-6, 2010. The resident's diagnoses included vascular dementia, bipolar disorder and depression. Physician's orders identify Resident #5's current medications include Depakote (an anticonvulsant medication) 250 milligrams (mg) twice a day and Zyprexa (an antipsychotic medication) 3.75 mg every night. Resident #5 has received both Depakote and Zyprexa at these current doses since 06/23/07.

Review of Resident #5's Minimum Data Set (MDS) Assessments for the past year, identified the following:
- Quarterly MDS, dated 12/20/09, identified no mood or behaviors present/exhibited.
- Quarterly MDS, dated 03/20/10, identified no mood or behaviors present/exhibited.
- Annual MDS, dated 06/26/10, identified no mood or behaviors present/exhibited.
- Quarterly MDS, dated 09/26/10, identified no mood or behaviors present/exhibited.

Review of Physician's Orders identified no changes to the Depakote or Zyprexa dosages since 06/23/07. Review of Physician's Progress Notes failed to identify the continued use of/need for Zyprexa or Depakote. One recertification visit on 06/16/10 indicated, "Follows [with] [name of psychiatrist].

An interview occurred with an administrative

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| F 329 | Continued From page 16<br>nursing staff member (#2) on 09/22/10 at 4:15 p.m. This staff member confirmed Resident #5 has received the same doses of Depakote and Zyprexa since 2007, with no attempts at a gradual dose reduction. This staff member also indicated the psychiatrist has not seen Resident #5 since 2008 because the resident has remained so stable. When asked for a policy regarding the use of medications for mood/behavior, this staff member said the facility does not have a policy, they follow CMS guidelines. | F 329 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of professional reference, and staff interview, the facility's consultant pharmacist failed to identify and report irregularities to the attending physician and director of nursing for 1 of 9 sampled residents (Resident #5). Failure to attempt a GDR may result in adverse consequences for all residents.<br><br>Findings include:<br><br>The Centers for Medicare and Medicaid Services | F 428 | F428<br>1. A) Resident #5 will have pharmacy review completed on 11/4/10 by consultant pharmacist. B) Pharmacy review sheets will be completed monthly and be updated to include mood stabilizing medication with psychotropic medications for review. A new space will be added to the sheet for pharmacist suggestion of dose reduction on the review sheet as well. C) Any suggestions for dose reduction will be made in pharmacist's monthly letter and a copy given to DON and resident's physician. D) Updated CMS guidelines will be forwarded to the pharmacist to read and sign.<br>2. All residents on psychotropic or mood stabilizing medications have the potential to be affected.<br>3. A) Correction measures for resident #5 will be completed for all residents on psychotropic or mood stabilizing medications. B) QA will be completed monthly X6. C) Any dose reduction | 11/10/10 |

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| F 428 | Continued From page 17<br>(CMS) has outlined the the standards of practice regarding the drug regimen review which states the facility's intent should be to maintain the resident's highest practicable level of functioning and prevent or minimize adverse consequences related to medication therapy by providing a licensed pharmacist's review of each resident's regimen of medication. The pharmacist should identify and report irregularities to the attending physician and the director of nursing.<br><br>Review of Resident #5's medical record occurred on October 4-6, 2010. Physician's orders identify Resident #5's current medications include Depakote (an anticonvulsant medication) 250 milligrams (mg) twice a day and Zyprexa (an antipsychotic medication) 3.75 mg every night. Resident #5 has received both Depakote and Zyprexa at these current doses since 06/23/07.<br><br>Review of Resident #5's monthly pharmacy reviews occurred on 10/03/10. This review included pharmacy records from October, 2009 through September, 2010. These records lacked evidence to indicate the pharmacist recommended a GDR in regard to Resident #5's continued use of Depakote or Zyprexa. The records do not indicate the pharmacist addressed the resident's use of Depakote.<br><br>An interview occurred with an administrative nursing staff member (#2) on 09/22/10 at 4:15 p.m. This staff member confirmed Resident #5 has received the same doses of Depakote and Zyprexa since 2007, with no attempts at a gradual dose reduction. When asked for a policy regarding pharmacy review of medications, this staff member said the facility does not have a policy, they follow CMS guidelines. | F 428 | suggestions will be reviewed monthly by the DON and QA coordinator for follow through by physician.<br>4. The QA coordinator will be responsible for the completion and review of all QA.<br>5. Completion Date11/10/10. | |

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| F9999 | FINAL OBSERVATIONS<br><br>Based on observation, record review, resident and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated. | F9999 | | |