STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 06/23/14 and completed on 06/26/14, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	F-278 1.Resident #12's MDS from 6-12-14 was corrected 7-16-14 by removing the coding of hallucinations and delusions. 2. Most recent MDS of current residents will be reviewed by LSW for any coding of hallucinations/delusions. If any residents MDS found to have coding of delusions/ hallucinations, LSW will review for accurate supporting documentation. Need for corrections will be communicated to the MDS coordinator and be completed. 3. Nursing/MDS/LSW staff will be educated at all staff in-service on 7/29/14.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
J. Stone Jonathan Stone	Administrator	7/22/2014

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 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 1 of 1 sampled resident coded with delusions and hallucinations (Resident #12). Failure to accurately assess and code the MDS may affect the level of care provided to residents. Findings include: The Long-Term Care Facility RAI User's Manual, October 2013, pages E-1 and E-2, (Behavior), stated, "Definitions: Delusion: A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . . Steps for Assessment: . . . When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) . . . The resident's response to the offering of a potential alternative explanation is often helpful in determining whether the false belief is held strongly enough to be considered fixed."; and,". . . Hallucination: The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch . . . Steps for Assessment: . . . Observe the resident during conversations and the structured interviews in other assessment sections and listen for statements indicating an experience of hallucinations . . ." Review of Resident #12's medical record occurred on June 25-26, 2014. A significant	F 278	Definition of delusions and hallucinations as defined in RAI manual will be reviewed, and importance of accurate supporting documentation during the 7 day assessment period. The MDS coordinator and LSW will review RAI manual to determine accurate coding of MDS. 4. A focus audit will be completed by LSW or designee. The audit will focus on the correct coding of the MDS for section E including hallucinations/delusions, to review if any residents having MDS completed were coded for delusions and/or hallucinations, if yes, is there accurate and supporting documentation in the 7 day assessment period. Focus audit will be completed weekly times 4 weeks, then monthly times 2 months, then quarterly times 3 quarters. The findings will be reported to QA committee for further recommendations 5. July 31st, 2014	

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F 278	Continued From page 2 change MDS, dated 06/12/14, identified the resident experienced hallucinations and delusions during the seven day assessment period. A therapy progress note, dated 06/06/14, stated ". . . Still not orientated [sic] to person, place or time. Continues to talk about her ill father and thinks it is April fool's day." A progress note, dated 06/08/14, stated ". . . Insists she is living in the wrong apartment, that her stuff in [sic] in the room of another resident." A progress note, dated 06/10/14, stated ". . . spoke with resident and was able to redirect her that she was not in jail.", indicating Resident #12's false belief was not fixed and not delusional. Resident #12's medical record failed to identify the facility staff attempted to determine if her thoughts on 06/06/14 and 06/08/14 were delusional. Review of Resident #12's medical record within the seven day assessment period failed to identify any episodes of hallucinations. A psychiatric consultation, dated 06/16/14, failed to identify the resident experienced current or historical hallucinations or delusions.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	F-280 1. A) Resident #2's care plan was updated on 6/25/14 to include assistance needed during meal based on the outcome of the swallow evaluation. The Care plan and Kardex were revised 6/26/14 to include the use of the wanderguard and to inform staff of the location of the placement on the wheelchair.	

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F 280	Continued From page 3 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/26/13 Based on observation, policy review, record review, and staff interview, the facility failed to review and revise 3 of 13 sampled residents' (Resident #2, #3, and #13) care plans regarding therapy recommendations, equipment use, and transfer/ambulation assistance. Failure to review and revise each resident's care plan as the resident's status changed limited the staff's ability to provide care in a consistent coordinated manner. Findings include: Review of the facility policy titled "Care Plan" occurred on 06/26/14. This policy, revised April 2004, stated, "Policy: . . . Each resident will have an individualized comprehensive plan of care . . . Through the use of departmental assessments,	F 280	B) Resident #3's care plan was updated to include the staff assistance needed for toileting on 7-16-14. The toileting schedule is now check, change and reposition every 2-3 hours with assist of 2 staff; apply barrier cream after each incontinent episode. C) Resident #13's Care plan was updated on 7-16-14 regarding the need for assistance for mobility and transfers clarifying that this resident only ambulated with restorative staff. 2. All residents that require the use of a wanderguard have the potential to be affected in this area. All residents who receive assistance with meals, transfers, or ambulation have the potential to affected in this area. All care plans will be reviewed to ensure there is a current nursing recommendation for the use of a wanderguard. The review will include the number of staff required to assistance residents with toileting and transfer/ambulation is accurate. 3. All staff will be educated on 7/29/14 on the use of the Kardex for care planning interventions for wanderguards, transferring, and ambulation.	

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F 280	Continued From page 4 the Resident Assessment Instrument and review of the physician's orders, any problems, needs and concerns identified will be addressed. . . ." - Review of Resident #2's medical record occurred on all days of survey. Physician orders, dated 05/29/14, included "swallow evaluation completed: change diet to mechanical soft with thin liquides [sic], cueing to take smaller bites, drink after bites and slow down . . ." and dated 06/19/14, included "Wanderguard check daily." The chart contained a prior order for a wanderguard, dated 02/05/14. Observations throughout the survey showed Resident #2 seated at a table with staff assistance during meals and a wanderguard attached to her wheelchair. Resident #2's care plan included "Focus: The resident has impaired cognitive function and impaired thought processes R/T [related to] Alzheimer's Disease, Dementia, E/B [evidenced by] history of making unsafe decisions . . . Goals . . . Resident will be safe in their own environment as evidenced by not eloping, . . . Focus: The resident has an ADL [activity of daily living] self care performance deficit R/T . . . HX [history] CVA [cerebral vascular accident] . . . Interventions: . . . Eating: Resident requires supervision and assistance of 1 as needed to eat. . . . " Resident #2's care plan failed to include the interventions ordered after her swallow evaluation or the intervention of a wanderguard. During an interview on 06/26/14 at 8:10 a.m., a dietary manager (#6) stated the diet recommendations from the swallow evaluation	F 280	Licensed staff will receive education on the need to update and place therapy recommendations on the plan of care. Necessary revisions to care plans will be communicated to staff in a timely manner and communicated to appropriate staff. 4. A focus audit will be completed by DNS or designee. The audit will review 5 random residents checking for any new therapy orders, nursing recommendation for a wanderguard, the amount of staff assistance needed for eating, toileting, and ambulation is included on the care plan. Focus audit will be completed weekly times 4 weeks, then monthly times 2 months, then quarterly times 3 quarters. Findings will be reported to the QA committee for further recommendations. 5. July 31st, 2014	

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F 280	Continued From page 5 should be on the care plan. During an interview on 06/26/14 at 10:15 a.m., a licensed nurse (#7) stated a wanderguard was implemented several months ago and agreed it should be on the care plan. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia. Resident #3's current care plan stated, "TOILET USE: Resident requires assistance of 2 staff and total hoyer [full body mechanical lift] with split leg sling to use toilet . . ." Observations on all days of survey showed facility staff checked and changed Resident #3's brief and did not transfer her to a toilet. During an interview on 06/26/14 at 9:25 a.m., a certified nursing assistant (CNA) (#1) stated Resident #3 has been a check and change ever since her mode of transfer became a hoyer lift a few months ago. The facility failed to review and revise Resident #3's plan of care related to toileting assistance. - Review of Resident #13's medical record occurred on June 25-26, 2014. Diagnoses included Meniere's disease (symptoms include dizziness). The current care plan stated, ". . . MOBILITY: Ambulates with FWW [front wheeled walker], assist of 1 and 1 to follow with w/c [wheelchair]. Be watchfull [sic] for dizziness. . . . AMBULATION: Resident requires weight bearing support to ambulate: walker and 1-2 assist. . . ." During an interview on 06/26/14 at 9:50 a.m., a CNA (#1) stated Resident #13 only ambulates	F 280		

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F 280	Continued From page 6 with restorative therapy.	F 280		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: TRANSFERS AND ASSISTIVE DEVICES 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure appropriate use of devices to prevent accidents for 4 of 12 sampled residents (Resident #3, #7, #8, and #10) who required extensive assistance for transfers. Failure to clearly identify how staff are expected to transfer residents (Resident #3), failure to ensure the proper use of a gait belt (Resident #7), and failure to remove wheelchair footrests for residents who self propel (Resident #8 and #10) increased the risk for falls, pain, and injury to residents. Findings include: Review of the facility policy titled "NURSING DEPARTMENT SAFETY RULES" occurred on 06/26/14. This policy, revised in 2012, stated, ". . . Before transferring a resident, review the care plan for appropriate safe resident handling techniques. Be sure to request assistance when	F 323	F 323 Part 1 TRANSFERS AND ASSISTIVE DEVICES 1. A) Resident # 3's care plan was revised 6-26-14 regarding transfers. B) Resident #7's care plan was revised 7-03-14 regarding mobility and transfers. CNA was reeducated on proper transfer technique and gait belt use. C) Residents # 8 and #10's foot rests were removed 6-25-14 during survey. Care plan were revised to include removal of foot rests when residents self-propel with feet in a wheelchair. 2. All residents that need assistance with transfers or ambulation have the potential to be affected in this area. All current residents care plans will be reviewed and revised as needed for the amount of staff assistance needed currently for transfer and ambulation, and when to remove or place the wheel chair foot rests.	

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F 323	Continued From page 7 necessary. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia and a history of a fall on 04/22/14. The quarterly Minimum Data Sets (MDSs), dated 02/22/14 and 05/23/14, identified extensive assistance of two or more staff required for transfers. A progress note, dated 11/03/13, stated, "CNA [certified nursing assistant] reports res [Resident #3] more difficult to transfer, not bearing wt [weight] as well or participating all the time. More sleepy. Note left for PT [physical therapy] re [regarding]: lift PRN [as needed]." A progress note, dated 11/04/13, identified the facility changed Resident #3's care plan to a sit to stand lift for transfers. A progress note, dated 04/22/14 at 4:25 p.m., stated, "Resident bent knees while CNAs were transferring her from bed to chair." The incident report, dated 04/22/14, stated, "Resident was lowered to the floor, as she bent her knees during the pivot transfer. Was 2 assist with gait belt." At the time of Resident #3's fall on 04/22/14, her care plan stated, "TRANSFER: *Resident uses sit/stand lift with assist [of] 2, PRN *stand pivot transfer with assist [of] 2-3 . . ." Her current care plan stated, "TRANSFER: *Resident uses total hoyer with assist [of] 2, PRN *stand pivot transfer wit assist [of] 2-3 . . ." Observation on all days of survey showed facility staff utilized a hoyer lift for all transfers. During an interview on 06/26/14 at 9:25 a.m., a CNA (#1) stated Resident #3 has been a hoyer	F 323	3. All staff will be educated at an in-service meeting on 7-29-14 on the procedure titled Nursing Department safety rule and the need to accurately care plan the amount of staff assistance needed with transfers and ambulation with appropriate use of a gait belt. Education to inform staff that residents who self-propel a wheel chair with their feet should have foot rests removed. Staff will be instructed to inform appropriate member of care plan team or unit supervisor as soon as possible if care plan needs to be revised. Members of the care plan team or unit supervisors will be informed to update the care plan as soon as possible when informed of a needed change. 4. A focus audit will be completed by the DNS or designee by doing direct observations of at least 2 CNAs, selected randomly, monitoring for the following: A) Residents' transfer matches the care plan. B) Proper transfer technique. C) Gait belt used appropriately when needed. D) Foot rests removed if resident self-propels with feet when in wheelchair. 4. A focus audit will be completed 5 days per week for 2 weeks, then weekly for 2 weeks, monthly for 2 months, then quarterly for 3 quarters. Findings will be reported to the QA committee for further recommendations.	

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F 323	Continued From page 8 transfer for several months. The facility failed to clearly identify how the CNAs were expected to transfer Resident #3 at the time of her fall on 04/22/14 and failed to identify how they are expected to transfer her now. This failure may have contributed to her fall on 04/22/14 and may result in future falls or injury. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included history of a stroke. The quarterly MDS, dated 03/22/14, identified extensive assistance of one staff member for transfers. The current care plan stated, "MOBILITY: Resident uses assistive device wheeled walker or PFW [platform walker] for ambulation with assist [of] 1-2 . . . TRANSFERS: STRENGTH: Resident is able to pivot with assist [of] 1. PRN sit/stand lift and assist [of] 2." Observation on 06/24/14 at 4:15 p.m. showed Resident #7 seated in a wheelchair in his room. The CNA (#3) placed a gait belt around the resident's waist and a platform walker in front of him. The CNA then placed her hand under the resident's left armpit, but the resident stopped her and stated that was his sore arm (related to a fall from bed on 06/15/14). The CNA then only used the gait belt, but the resident failed to stand. The CNA (#3) placed her hand on the back of Resident #7's pants to assist him to stand and the resident stated, "Don't do that . . . get [CNA #2's name] in here." The CNA (#2) entered the room and, with the use of the gait belt, both CNAs assisted Resident #7 to an upright position. The facility failed to clearly identify how staff members are expected to transfer Resident #7.	F 323	5. July 31st, 2014 F 323 Part 2 HAZARDOUS CHEMICALS 1. The north bathing room cabinet was locked on 6/25/14. The bath aides on North wing were educated on 6/25/14 regarding the need to keep chemicals locked in the cabinet when staff members are not present in the room. 2. All residents have the potential to be effected in the area. 3. Staff will be educated at an in-service meeting on 7/29/14 regarding proper storage and locking of hazardous chemicals. 4. A focus audit will be completed by the Environmental Service Director or designee on proper storage of hazardous chemicals. An audit will be completed weekly times four weeks, monthly times 2 months, and then quarterly times 3 quarters. Findings will be reported to the QA committee for further recommendations. 5. July 31st, 2014	

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F 323	Continued From page 9 This failure may result in a fall, injury, or pain to the resident. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included pressure ulcer on the ankle and history of falls. The care plan, dated 05/05/14, stated, "Focus: The resident has limited physical mobility R/T [related to] Hx [history] of CVA [cerebral vascular accident] with right sided weakness . . . Interventions: Mobility: Resident uses wheelchair for independent locomotion; assist prn [as needed] when fatigued." On 06/24/14 at 9:30 a.m., observation showed Resident #8 seated in her wheelchair in her room, with footrests in place. Observation showed the resident moved her feet on the floor between the footrests in the down position to propel the wheelchair. On 06/24/14 at 1:15 p.m., observation showed Resident #8 seated in her wheelchair propelling herself out of the dining room, with her feet on the floor. The footrests remained in the down position, with the resident moving her feet between and behind the footrests. Resident #8's nursing progress notes, dated 06/13/14, noted, ". . . pressure ulcer found on each ankle. . . ." The wound data collection sheets, dated 06/13/14, identified a "0.2 cm [centimeter] x [by] 0.3 cm reddened intact area to the right outer ankle" and a "0.4 cm x 0.3 cm dry scab to the left outer ankle." On 06/25/14 at 10:58 a.m., observation with a licensed nurse (#9) identified an approximately 0.5 cm whitish scab on Resident #8's left outer	F 323		

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F 323	Continued From page 10 malleolus (ankle bone) and a healed right outer malleolus. This nurse (#9) agreed Resident #8 could possibly bump her ankles on the footrests when she moves her feet off the footrests to self propel the wheelchair. - Review of Resident #10's medical record occurred on June 25-26, 2014. The care plan, dated 05/28/2014, stated, "Focus: The resident has limited physical mobility R/T CVA with left hemiplegia . . . Interventions: . . . Mobility: Resident uses wheelchair for independent locomotion. . . ." On 06/25/14 at 5:15 p.m., observation showed Resident #10 propelling herself down the hall and into the dining room, using her hands to push the wheels and her feet pushing on the floor. The footrests remained in the down position on the wheelchair and Resident #10's feet were behind the footrests on the floor. Failure of staff to remove residents' footrests when they self propel in a wheelchair has the potential to cause lower leg/ankle injuries or contribute to falls. HAZARDOUS CHEMICALS 2. Based on observation and staff interview, the facility failed to maintain an environment free of accessible hazardous chemical supplies in 1 of 2 bathing rooms (North bathing room) on 2 of 4 days of survey. Accessible hazardous chemicals placed cognitively impaired and wandering residents at risk for accidents/injury. Findings include: Observations on 06/24/14 at 4:00 p.m. and on	F 323		

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	355093	A. BUILDING _____ B. WING _____	06/26/2014

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F 323	Continued From page 11 06/25/14 at 1:45 p.m. showed the door to the North bathing room to be open. Inside the room, an unlocked cabinet contained the following: Ecolab Disinfectant Cleaner 2.0, Lysol, and Asepticare Disinfectant Aerosol. The labels on these items identified them as "hazardous". During interview on 06/25/14 at 2:00 p.m., an administrative maintenance staff member (#8) identified the chemicals should be stored in a locked area.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F- 329 1. A) Resident #2's physician will be notified on 7/25/14 regarding Ativan use and the need for the clinical rationale to be documented if a dose reduction would be clinically contraindicated. B) Resident #9's physician will be notified on 7/25/14 regarding Olanzapine use, and the need for clinical rationale to be documented if a dose reduction would be clinically contraindicated. C) Resident #9's PRN Ativan orders were changed on 7/15/14 to a routine scheduled dose. The PRN	

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F 329	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review, policy/procedure review, and review of professional reference, the facility failed to ensure a medication regimen free from unnecessary medications for 3 of 8 sampled residents (Resident #2, #3, and #9) receiving a psychotropic medication. Failure to periodically attempt a gradual dose reduction (GDR) or document the clinical contraindication of a GDR, and failure to attempt non-pharmacological interventions prior to administration of an as needed (PRN) antianxiety medication and document the symptoms displayed requiring the need for the medication (Resident #9) placed residents at risk of receiving unnecessary psychotropic medications and experiencing adverse consequences related to their use. Findings include: Review of the facility procedure titled "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 06/26/14. This procedure, revised June 2014, stated, ". . . Procedure: Non-Emergency Administration: . . . 7. While the use of prn psychopharmacological medications and sedative/hypnotics is not encouraged, if a prn physician's order is received, ensure that the order has clear parameters, i.e., severe agitation that does not respond to other care plan interventions. It is important to initiate other care plan interventions prior to the use of prn psychopharmacological medications and sedative/hypnotics. . . . Gradual Dose Reductions: The purpose of tapering medication is to find an optimal dose or to determine if	F 329	was discontinued on 7/16/14 by the physician. D) Resident #3's physician will be notified 7/23/14 regarding Risperdal, Ativan and Benadryl use, and the need for clinical rational to be documented if a dose reduction would be clinically contraindicated. 2. All residents currently on psychoactive medications will be reviewed at the monthly reduction committee for scheduled gradual dose reductions and the physicians will be notified to document clinical rational if the attempted dose reduction would be clinically contraindicated. All residents currently receiving PRN psychoactive medications will have documentation in the eMAR on the need, reason, or behavior that the resident is displaying and to attempt non-pharmacological interventions prior to administering psychoactive medications. 3. System change: A facility form for gradual dose reduction was revised by the consultant pharmacist to include physician documentation as to the clinical rationale as to why the attempted dose reduction would be clinically contraindicated. AND-	

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F 329	Continued From page 13 continued use of the medication is benefiting the resident. . . . 1. Antipsychotics: . . . b. Within the first year a resident is admitted on an antipsychotic medication or after the center has initiated an antipsychotic medication, the center must attempt a gradual dose reduction (GDR) in two separate quarters with at least one month between attempts, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. . . . 3. Other Psychopharmacological Medications: a. During the first year in which a resident is admitted on a psychopharmacological medication, or after the center has initiated such medication, the center should attempt to taper the medication during at least two separate quarters (with at least one month between attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually unless clinically contraindicated. b. Tapering is considered clinically contraindicated if: 1) The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or 2) the resident's target symptoms returned or worsened after the most recent attempt at a gradual dose reduction within the center and the physician has documented the clinical rational for why any additional attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. . . . d. Non-pharmacological interventions are recommended before medication interventions. Attempts should be	F 329	The consultant pharmacist will start attending the reduction committee meetings; the next scheduled meeting is scheduled for 7/23/14. Appropriate staff will be educated at in-service meeting on 7/29/14 regarding the procedure titled, "Psychopharmacological Medications and Sedative/hypnotics" with a focus on the need to attempt non-pharmacological interventions prior to administration of an as needed antianxiety medication. 4. A focus Audit will be completed by the DNS or designee. The audit will focus on physician documentation for the clinical rationale or if clinically contraindicated for psychopharmacological medications. If a resident received a PRN antianxiety medication did staff document the attempt of a non-pharmacological intervention prior to administering PRN antianxiety medication. Audit will be done weekly times four weeks, monthly times 3 months, then quarterly times 3 quarters. Findings will be reported to the QA committee for further recommendations. 5. July 31st, 2014	

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F 329	Continued From page 14 documented in the resident care record. . . ." "Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams & Wilkins, Pennsylvania, page 844, states regarding Ativan (antianxiety medication), "Adverse Reactions: . . . drowsiness, sedation, . . . insomnia, . . . depression . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included anxiety and depression. Medications included Ativan 0.5 milligrams (mg) two times a day (BID), ordered 09/25/2009. Resident #2's annual Minimum Data Set (MDS), dated 05/03/13, and the current quarterly MDS, dated 05/30/14, indicated no mood symptoms or behaviors. The quarterly MDS, dated 08/03/13, indicated mood symptoms of trouble falling or staying asleep, or sleeping too much; feeling tired or having little energy; and no behaviors. The use of Ativan may have contributed to these symptoms. An untitled facility form for Resident #2, dated 09/20/13, stated, "Due for gradual dose reduction of Ativan 0.5 mg BID. Please address: . . ." The physician stated to continue medication the same but failed to address why the benefits of continuing the same dose of Ativan outweighed the risks of reduction. Psychiatric progress notes, dated 01/18/13, stated ". . . The staff is reporting that [resident's name] is doing quite well . . . Her mood is dysthymic [despondent]. Her affect is very flat but she does make some attempt to smile. . . . ;" and, dated 03/28/14, stated "She's presently on Ativan 0.5 mg and Lexapro 20 mg (antidepressant).	F 329		

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F 329	Continued From page 15 There's no concerns that the nurses have about [resident's name] behaviors. . . . I asked if she had concerns, she said no . . . " Each note stated "Continue Ativan 0.5 mg b.i.d." Review of Resident #2's record lacked evidence the consulting psychiatrist or the primary physician documented the clinical rationale why attempted dose reduction would be clinically contraindicated. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included anxiety and senile dementia with delusional features. Medications included olanzapine (antipsychotic) 2.5 mg every day (qd), ordered 01/24/12, and Ativan 0.5 mg every 4 hours PRN, ordered 06/20/14. An untitled facility form for Resident #9, dated 11/15/13, stated, "Due for gradual dose reduction of Olanzapine 2.5 mg qd. Please address: . . ." The physician stated to continue medication the same but failed to address why the benefits of continuing the same dose of olanzapine outweighed the risks of reduction. Psychiatric progress notes, dated 07/19/13, stated ". . . The nurses say she is doing extremely well . . . ," dated 01/17/14, stated ". . . The nurses are reporting that she's doing very well in general. . . . ," and dated 05/23/14, stated ". . . really has had no problems for a long time. . . ." Each note stated "Continue Olanzapine 2.5 mg po [orally] qd." Review of Resident #9's record lacked evidence the consulting psychiatrist or the primary physician documented the clinical rationale why attempted dose reduction would be clinically contraindicated.	F 329		

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F 329	Continued From page 16 Resident #9's care plan, dated 12/30/13, stated "Focus: The resident has a mood problem R/T [related to] Anxiety E/B [evidenced by] restless, h/o [history of] aggressive behaviors, resisting cares, h/o uncontroled [sic] laughing when mood unstable . . . Interventions: . . . Non-pharmacological: . . . offer snack, offer music, offer 1:1 [one to one] companionship . . . Focus: The resident has a behavior symptom R/T Profound intellectual disabilities, Anxiety, Dementia E/B h/o grabbing at staff, resisting cares . . . Interventions: Provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Resident prefers the following diversional activities: music, snack, watching birds and people . . . " Resident #9's June Medication Administration Record (MAR) stated to give Ativan for "behavioral issues related to senile dementia with delusional features." The MAR indicated staff administered Ativan PRN to the resident five times from June 20-26, 2014. Reasons included: 06/20/14 at 6:04 p.m. - "refusing her meds, laughing and very noisy" 06/22/14 at 7:45 p.m. - "behavior control" 06/23/14 at 4:30 a.m. - no reason given 06/25/14 at 4:57 a.m. - "a.m. behavior control" 06/26/14 at 5:00 a.m. - "behavior control" Staff failed to attempt non-pharmacological interventions prior to the use of PRN Ativan and failed to document the actual symptoms Resident #9 displayed that necessitated the use of an antianxiety medication on four of five occasions. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbances.	F 329		

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F 329	Continued From page 17 Daily medications included Risperdal (an antipsychotic) 0.5 mg at HS (hour of sleep) (dose present on admit, 08/23/13), Ativan (an antianxiety) 0.5 mg (BID) twice a day (initiated 11/21/13), and Benadryl (an antihistamine) 25 mg at HS (dose present on admit, 08/23/13). The physician's orders identify dementia with behavioral disturbances as the indication for use of these medications. The MDS assessments, dated 05/23/14 and 11/23/13, did not identify any behaviors (such as verbal/physical, rejection of cares, wandering, hallucinations or delusions). The facility's GDR form for Resident #3, dated 05/21/14, stated, "Due for gradual dose reduction of Risperdal 0.5 mg qd @ [at] hs. Please address: . . ." The physician stated to continue the medication the same but failed to address why the benefits of continuing the same dose of Risperdal outweighed the risks of reduction. Another facility GDR form for Resident #3, dated 05/21/14, stated, "Due for gradual dose reduction of Ativan 0.5 mg BID. Please address: . . ." The physician stated to continue the medication the same but failed to address why the benefits of continuing the same dose of Ativan out weighted the risks of reduction. Physician's progress notes since Resident #3's admission on 08/23/13 failed to identify a GDR attempt of Risperdal, Ativan, and Benadryl, and failed to identify specific contraindications for a GDR.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

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F 428	Continued From page 18 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and professional reference review, the facility's consulting pharmacist failed to report medication irregularities to the attending physician and the director of nursing for 1 of 1 sampled resident (Resident #3) receiving Benadryl (an antihistamine) for behaviors. Failure to question the use of Benadryl for behavioral disturbances has the potential for this resident to receive an unnecessary medication and suffer adverse reactions. Findings include: "Nursing 2013 Drug Handbook," 33rd ed., Lippincott, Williams, and Wilkins, Pennsylvania, page 435, stated, ". . . Benadryl . . . INDICATIONS [and] DOSAGES: Rhinitis [runny nose], allergy symptoms, motion sickness, Parkinson disease . . . Nightime sleep aid . . . Nonproductive cough . . . ADVERSE REACTIONS: CNS [central nervous system]: drowsiness, sedation, sleepiness, dizziness, incoordination, seizures, confusion, insomnia,	F 428	F 428 1. Resident #3's physician will be notified on 7-23-14 regarding the appropriate indication for use of Benadryl. A gradual dose reduction will be recommended and clinical rationale to be documented if dose reduction would be clinically contraindicated. 2. All residents on psycho-pharmacological medications have the potential to be affected in the area. The consultant pharmacist will review each of the listed residents' medication regimens for the appropriate indications for use. The consultant pharmacist will report medication irregularities to the DNS and the attending physician. 3. The consultant pharmacist and the DNS will be educated on 7-23-14. Medication Regimen review procedure will be reviewed with the pharmacist and the DNS. The consultant pharmacist will receive education by the Rehabilitation Skilled Care Consultant from the Good Samaritan National Campus on how to review medications using the electronic medical record system. 4. A focus audit will be developed to monitor if a drug regimen meets the criteria for a gradual dose reduction.	

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F 428	Continued From page 19 headache, vertigo, fatigue, restlessness, tremor, nervousness . . ." Dementia with behavioral disturbances was not listed as an indication for use. Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbances. Medications included Benadryl 25 milligrams (mg) at bedtime (dose present on admit, 08/23/13). The physician's orders identify dementia with behavioral disturbances as the indication for use of these medications. Upon request on 06/25/14, a nurse administrator (#10) provided Resident #3's consulting pharmacist's drug regimen reviews related to a GDR of Benadryl. The consulting pharmacist failed to recommend a GDR and failed to question the ongoing use of Benadryl for behavioral disturbances.	F 428	The diagnosis will be checked in order to ensure it is appropriate and accurate for the psychopharmacological medication usage. If the physician doesn't feel a reduction is appropriate did he/she document the clinical rationale. An Audit will be completed by the DNS or designee weekly for 4 weeks, monthly for 3 months, then quarterly for 3 quarters. Findings will be reported to the QA committee for further recommendations. 5. July 31st, 2014	