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	355111	A. BUILDING _____ B. WING _____	07/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on July 14, 2014 and completed on July 17, 2014, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review.	F 000		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, group interview, resident interview, review of a facility log, and staff interview, the facility failed to ensure a timely response to call lights during 3 of 3 months (04/15/14 through 07/15/14) reviewed. This has the potential to affect the quality of life, and the care and services provided for all residents within the facility. Findings include: During an individual interview on the morning of 07/15/14, Resident A stated/reported the staff do not answer "call lights fast enough." The resident stated/described experiencing incontinence of bowel movement on two occasions due to the delay.	F 246	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. F246: 1.) As concerns involving this tag stem from the resident council meeting held 7/15/2014 and Resident A is not identified, corrective action will be the systemic change and Policy update that will benefit the entire SNF population. 2.) All residents are included to be potentially affected by this same deficient practice. 3.) System change: If SNF census is >32 residents, facility shall staff an additional CNA on AM's, PM's, and NOC's for the specific purpose of answering call lights to assist residents with immediate needs. All nursing staff, including nurses, are to carry a pager with them during the duration of their shift. Policy update: Call light policy will be updated accordingly and all nursing staff will be required to review and sign acknowledgement of this change in our online education system "Healthstream". 4.) Completion Date: August 21, 2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	administrator	8/11/14

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 246	Continued From page 1 During a resident group interview of nine residents on the morning of 07/15/14, Resident A again reported staff do not answer call lights fast enough. Resident B stated/reported wait times up to an hour. Resident C stated it was rare to have a long wait time. Resident D stated she just "can't wait" for call lights to be answered. Observation during all days of survey did not identify visual or audible call lights from resident rooms. During interview on 07/16/14 at 2:40 p.m., an administrative staff (#3) stated the facility utilizes a "Silent Nurse Call System." The staff stated a review of call light responses that are greater than 15 minutes are reviewed in weekly meetings held by herself, the director of nursing, and a therapy staff member to review the patterns and trends including specific resident concerns/problems and and in relation to specific shifts. The staff agreed call light responses have been a problem. Review of a facility log "Event Activity Report" occurred on the morning of 07/17/14. The log showed monitoring of call lights by room number ("No Name"), location ("Patient" or "Lavatory"), date and time, and duration of the call light response. Review of the log between 04/15/14 through 07/15/14 identified the following response times as long as: * April: 77.8 minutes on 04/15/14 at 10:18 a.m.; 96 minutes on 04/26/14 at 1:09 p.m. * May: 60.4 minutes on 05/02/14 at 8:42 a.m.; 81.3 minutes on 05/08/14 at 8:47 a.m.; 90.5 minutes on 05/13/14 at 7:31 p.m. * June: 59.9 minutes on 06/01/14 at 6:01 p.m.; 46.2 minutes on 06/11/14 at 8:45 p.m.; 57.6	F 246	5.) Daily call light reports will be generated and reviewed by the Charge nurse or DON. All incidents of call lights > 15 minutes will be investigated by the DON with the use of a new form generated by the facility to document statements from staff that were working that shift. These reports will be filed in a binder and kept by the DON for further reference as needed. An audit will be completed by the DON and implemented 8/11/2014 to assess the frequency of lights > 15 minutes and the circumstances of those situation. This audit will be done monthly x 1 year and will be reviewed at monthly QA meetings. The review will be reflected in the monthly QA meeting minutes.	

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F 246	Continued From page 2 minutes on 06/13/14 at 5:43 p.m.; 136.6 minutes on 06/29/14 at 10:08 a.m. * July: 75 minutes on 07/04/14 at 5:33 p.m.; 79.7 minutes on 07/07/14 at 10:14 p.m. in the lavatory; 51.5 minutes on 07/13/14 at 12:48 a.m. During interview on 07/16/14 at 5:20 p.m., an administrative staff (#1) stated she would expect a maximum call light response of 10-15 minutes. The staff stated when residents put on their call light, staff receive notification through a pager, and if a certified nursing assistant (CNA) does not answer the call light from their assigned area, CNAs from other assigned areas are expected to answer the call light.	F 246		
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. 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.	F 280	F280: 1.) - Resident #2 care plan was currently updated to reflect the right foot/ankle brace, an above the wrist stretch glove to the right hand, a wheelchair equipped with a padded right arm rest, and that resident is not to be left unattended in wheelchair in her room. Resident #2 also had an update to her care plan to reflect fall risk. - Resident #4 care plan was currently updated to reflect the protective right elbow pad and a padded boot to the left foot. -Resident #9 care plan was currently updated to reflect interventions to attempt prior to catheterization. Resident #9 care plan also had updates to her anxiety and behavioral interventions. 2.) All residents are included to be potentially affected by this same deficient practice. 3.) System change: Care Plan Revision forms have been developed and will be used as an intra-departmental tool to keep care plans updated in a timely fashion and tailor them to be as resident specific as possible. These forms are available to all departments. A copy will go to a labeled binder in the main nurse's station for immediate reference and the originals are to be turned into the MDS Nurse/Care Plan Coordinator's mailbox upon completion for electronic revision.	

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F 280	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy/procedures, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' status for 3 of 9 sampled residents (Resident #2, #4 and #9). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Pressure Ulcer, Prevention of" occurred on 07/16/14. This undated policy stated, ". . . CARE PLAN DOCUMENTATION GUIDELINES . . . Problem: Identify the appropriate problem under which to list the pressure ulcer care as an approach . . . Goal: List measurable goal(s) to be accomplished . . . Approaches: . . . List instructions unique to this resident . . . List treatment as ordered if necessary. . . ." - Review of Resident #2's medical record occurred on all days of survey and included diagnoses of cerebral vascular accident (CVA) with right sided weakness, dementia, and a fall with injury on 06/02/14. Observation on 07/15/14 at 10:20 a.m., identified Resident #2 wore a right foot/ankle brace, an above the wrist stretch glove on the right hand, and used a wheelchair equipped with a padded right arm rest. Review of the current care plan showed no interventions regarding these care items.	F 280	4.) August 11,2014 5.) The MDS Nurse/Care Plan Coordinator will complete an audit of 5 random residents monthly x 1 year to ensure that the SNF care plan is current and resident specific. This audit will be implemented 8/11/2014 and the results of the audit will be discussed at the monthly QA meetings. The review will be reflected in the monthly QA meeting minutes.	

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Review of the "Investigation" form for Resident #2's fall on 06/02/14 stated, "Results of Investigation: Resident not to be left unattended in w/c [wheelchair] in room." Review of the current care plan verified no focus, goals, or interventions related to falls, specifically the one identified above.

During an interview on 07/16/14 at 4:45 p.m., a nursing supervisor (#1) verified staff had not updated the care plan to reflect the current care for Resident #2.

- Review of Resident #4's medical record occurred on all days of survey and included diagnoses of a Stage 1 left heel pressure ulcer, a Stage 2 right elbow pressure ulcer, and dementia. The quarterly Minimum Data Set (MDS), dated 05/14/14, identified extensive assist of 2 or more staff for bed mobility and transfer, and a risk for pressure ulcers.

Observation on 07/15/14 at 7:50 a.m., identified Resident #4 wore a protective right elbow pad and a padded boot on the left foot. Review of the current care plan verified no pressure ulcer interventions for the elbow pad or the left padded boot. The care plan stated, " . . . boots to feet. . . ."

During an interview on 07/16/14 at 4:45 p.m. a nursing supervisor (#1) verified staff had not updated the care plan to reflect the current care for Resident #4 and did not identify the padded boot to be worn on the left foot only.

- Review of Resident #9's record occurred on July 16-17, 2014 and identified problems with urinary

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F 280	Continued From page 5 retention, and the potential for urinary retention in relation to a specific medication used for depression/anxiety. An entry of the medication administration record, dated 01/30/14, included ". . . straight cath [catherize] as needed for no urine output" for eight hours or more. "Record residual." The care plan lacked interventions to attempt prior to catherization. The record identified nursing staff administered two medications (Amitriptyline - for depression and anxiety; and Oxazepam for anxiety) on an as needed basis between the months of December 2013 and June 2014 for anxiety. The care plan identified problems with behaviors, cognitive function, and moods. The care plan failed to make appropriate revisions to resident care since 11/18/13.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage behavioral symptoms for 3 of 3 sampled residents (Resident #6, #7, and #9) identified with behaviors including anxiety, agitation,	F 309	F 309: 1.) Resident #6 is currently participating in a Geriatric Inpatient Psychiatric Program at the Stadter Center in Grand Forks, ND recommended by facility Medical Director Dr. Mark Peterson and approved by family. Facility will implement their recommendations post discharge unless recommendations suggest placement to a Memory Care Unit and resident transfers to such a facility.	

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F 309	Continued From page 6 restlessness, wandering, and combativeness and on psychopharmacological medications. Failure to thoroughly assess the residents' behaviors, implement individualized interventions and establish on-going monitoring of the behaviors resulted in decreased physical, mental and psychosocial well-being and negatively impacted the residents' quality of life. Findings include: Review of the facility policy titled "BEHAVIOR MANAGEMENT COMMITTEE" occurred on 07/17/14. This undated policy stated, ". . . Mood and behavior symptoms as well as causes, interventions and outcomes will be documented. Possible interventions include: 1. Assist to area of choice 2. Offer a snack 3. Other 4. Provide diversionary activity 5. Provide reassurance 6. Redirect resident to an activity of interest 7. Take resident for a walk 8. Visit 1:1 [one-on-one] with the resident, individualized interventions will be added to the individual resident's care plan . . ." Review of the facility policy titled "Oral Medication Administration" occurred on 07/17/14. This undated policy stated, ". . . 5. Document PRN [as needed] medication administration; a. Document reason for giving PRN drugs and outcome (effects) . . ." - Review of Resident #9's record occurred on July 16-17, 2014. Diagnoses included dementia, anxiety, and hallucinations. Resident #9's Minimum Data Set (MDS), dated 04/10/14, identified moderate cognitive impairment, no delirium symptoms, no mood or behavior symptoms, no symptoms of psychosis	F 309	Resident #9 is followed by Trinity Riverside mental health practitioners in Minot, ND and has a follow up visit scheduled for 8/13/2014. Resident #7 is followed by facility's rounding Certified Nurse Specialist from Rural Mental Health Consortium out of Minot, ND and was seen 8/7/2014 with order changes to discontinue residents Seroquel. All three of these residents will be followed by the facility behavior management committee monthly x 1 year. 2.) All residents are included to be potentially affected by this same deficient practice especially those who are known to exhibit behaviors and may or may not be currently on a prn psychopharmacological medication. 3.) System change: Behavior and psychosocial progress note format in EMR has been modified from a narrative format to a SOAPIE format which will cue staff to be documenting the interventions specifically tried prior to prn psychopharmacological medication administration. Policy update: The Oral Medication Administration policy will be updated to include the requirement of a behavioral or psychosocial progress note prior to administering a prn psychopharmacological medication. - Nursing meeting 8/6/2014 discussed system change and prn medication administration policy update requiring a behavior/psychosocial progress note be documented prior to any administration of prn psychopharmacological medication. 4.) Completion date: August 21, 2014 5.) Director of Social Services will complete a monthly audit x 1 year of all residents with prn psychopharmacological medication orders to ensure that nursing staff is documenting interventions prior to any prn administration of the medications of concern. This audit will be implemented 8/11/2014 and the results of the audit will be discussed at the monthly QA meetings. The review will be reflected in the monthly QA meeting minutes.	

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F 309	Continued From page 7 including hallucinations or delusions, and verbal behavioral symptoms directed toward others one to three days per week in the seven day assessment period. A physician order, dated 10/29/13, included amitriptyline (an antidepressant) 100 mg (milligrams) prn for "depression/anxiety" at bedtime. Review of the Medication Administration Record (MAR) between the months of December 2013 and June 2014 showed nursing staff administered the prn amitriptyline 42 times. Resident #9's current care plan identified the following problems and interventions: * Behavior problem related to "Alzheimer's disease, anxiety . . . restlessness, resistance to care, paranoia, physical behaviors" with interventions including "Try validation therapy when resident is anxious and looking for her husband. Discuss feelings rather than explaining facts. . . . Medicate as ordered. Resident receives PRN [as needed] meds [medications] for anxiety. . . . Follow elopement precautions . . . Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television. Resident enjoys coffee, visiting, praying, church. . . . Try again later if resisting cares. . . ." * Impaired "cognitive function/impaired thought processes" related to Alzheimer's with interventions including medications as ordered, monitoring and documenting side effects, "Present just one thought, idea, questions or command at a time . . . Task segmentation . . . " * Mood problem related to "anxiety, depression, Alzheimer's disease" with interventions of "Administer medications as ordered. Monitor/document for side effects and	F 309		

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F 309	Continued From page 8 effectiveness; Behavioral health consults as needed . . . Educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. . . . The resident needs time to talk when anxious. Encourage the resident to express feelings. Validate feelings. . . . Provide limited choices when . . . anxious to assist her with decisions. . . Anxiety is typically worse as the day progresses. . ." Review of progress notes from January 1, 2014 through May 31, 2014 identified nursing administered the amitriptyline for anxiety and however failed to identify non-pharmacological interventions attempted prior. The progress notes included: * January and February: "increased anxiety," "for anxiety and depression," "Resident requests sleep at bedtime," "repeted [sic] attempts to stand per self, confused and restless" * 03/17/14 at 10:47 p.m.: "restless, delusion of son crying in hallway, anxious and unable to sleep" * 03/22/14 at 9:12 p.m.: "anxious, wanting to know how she is going to make it living here, repetitive questions." At 9:46 p.m.: "concerned that her husband is having an afair [sic] . . . said she is going to discuss situation with him tomorrow . . . support given. was medicated with Amitriptyline prn. calming down little now and is ready for bed. cooperative with staff." * 03/28/14 at 7:11 p.m.; on 03/20/14 at 8:22 p.m.: medicated with amitriptyline "for anxiety" with no evidence of interventions attempted prior * 04/15/14 at 9:05 p.m.: "Resident complaining of anxiety; is worried that there are men in her room even after multiple assurances that there isn't.	F 309		

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Resident unable to be redirected." The staff failed to utilize validation therapy to address the resident's concern.
* 05/23/14 at 6:54 p.m.: "At nurses stations with increased resp [respirations] and crying. 'I usually can eat but tonight I am nauseated.' Unable to visit with her . . very anxious. Prn [amitriptyline 100 mg] given."
* 05/31/14 at 5:31 p.m.: "Given for anxiety . . ."
The remainder of nursing' notes indicated amitriptyline administered for: ". . . anxiety and nervousness . . . anxiety at bedtime . . ."

The progress notes did not identify what type of support was given on 03/22/14, and what type of assurance and redirection occurred on 04/15/14.

A physician order, dated 06/27/14, changed the prn amitriptyline to a once daily dose at bedtime.

On 01/24/14, the provider ordered oxazepam 10 mg three times daily as needed for anxiety. Progress notes identified further entries of staff not providing non-pharmacological interventions before administering the oxazepam. The notes identified nursing staff administered 30 doses between 01/25/14 and 02/21/14 "for anxiety . . . crying, calling out . restless, crying . . . agitation . . . moaning . . . grunting . . . restlessness . . . very anxious, she did not have a brassiere on when she dressed herself . . . heard over the loud speaker that there was a meeting in 5 min. [minutes]. I told her it was for staff. She continued to say that she was so scared. . . ."

Failure to assess/identify causative factors contributing to Resident #9's anxiety and other behaviors, track the behavior for specific times of the day, implement appropriate

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non-pharmacological interventions, accurately/completely monitor the frequency of the behaviors, and establish goals to minimize the behavior and the use of behavior modifying/controlling medications, prevents Resident #9 from achieving/maintaining individuality and maximum allowable/appropriate control over her day-to-day life, routine, and goals.

- Review of Resident #6's medical record occurred July 14-17, 2014. Diagnoses included dementia with behavioral disturbances, anxiety, and depression. Resident #6's quarterly MDS, dated 05/22/14, identified the resident had both short and long term memory problems, little energy, trouble concentrating, restlessness, mild depression, and physical behavioral symptoms occurred one to three days. Medications included Lorazepam (Ativan, antianxiety medication) 0.5 mg every eight hours as needed for anxiety.

Resident #6's current care plan identified the following problems and interventions:
* Behavior problem related to "dementia m/b [manifested by] swearing, verbal and physical aggression, teasing others, hx [history] of sexual behaviors, elopement risk" with interventions including "Administer medications as ordered. Monitor/document for side effects and effectiveness; Anticipate and meet The resident's needs; Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by; Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed; Minimize potential for the resident's behaviors by offering tasks

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ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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which divert attention such as coffee, cards, social activities, devotions; Wanderguard in place due to hx of elopement; Monitor for increased restlessness, exit seeking and report to nurse. Follow elopement precautions; [Name of Resident #6] has made advances toward 3 female residents (kissing, hand-holding, touching). Remind him of inappropriateness of this behavior if it occurs and remove him from the situation; Lorazepam ordered for behaviors in afternoons. Monitor for side effects and effectiveness and report to nursing. . . . Door alarm placed on door. To be hooked up at HS [hour of sleep] to alert staff if he gets up at night and leaves his room; [Name of Resident #6 and name of another resident] do not get along and have had physical altercations. Monitor interactions and keep them apart as much as possible."

* Impaired cognitive function and thought process related to "Dementia" with interventions including "Administer medications as ordered. Monitor/document for side effects and effectiveness. . . . Cue, reorient and supervise as needed; Engage the resident in simple, structured activities that avoid overly demanding tasks. The resident prefers card matches, coffee, social events, devotions. . . . Use task segmentation to support short term memory deficits. Break tasks into one step at a time."

* Mood problem related to "anxiety, depression, dementia" with interventions of ". . . Administer medications as ordered. Monitor/document for side effects and effectiveness; Behavioral health consults as needed. . . . The resident needs time to express his thoughts. Encourage the resident to express feelings; Monitor for changes in mood: increased irritability, anxiousness, tearfulness and report to nursing. . . ."

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Review of Resident #6's progress notes from June 01, 2014 through July 16, 2014 identified the following:
* 06/23/14 at 1:38 p.m.: "combative towards staff."
* 07/02/14 at 8:55 a.m.: "Wandering into other rooms. PRN Ativan given at breakfast time."
* 07/08/14 at 9:12 p.m.: "Resident verbally aggressive to staff, wandering into room and ramming staff and objects with his walker. PRN ativan given with some difficulty. . . ."
* 07/08/14 at 9:13 p.m.: "res. [resident] combative and resistant to cares"
* 07/09/14 at 8:27 a.m.: Lorazepam administered with no indication for use.
Review of progress notes from June 01, 2014 through July 16, 2014 showed nursing staff administered Lorazepam and failed to identify indication for use one of five times and failed to identify non-pharmacological interventions attempted prior to administration four of five times.

Failure to assess causative factors and time patterns contributing to Resident #6's wandering and combativeness and implement appropriate non-pharmacological interventions, and monitor the frequency of the behaviors, does not allow staff to evaluate what interventions were most effective for Resident #6's behavior.

- Review of Resident #7's medical record occurred July 16-17, 2014. Diagnoses included dementia with behavioral disturbances and anxiety. Resident #7's quarterly MDS, dated 04/21/14, identified the resident had both short and long term memory problems, little interest in doing things, moderately severe depression, little

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F 309	Continued From page 13 energy, poor appetite, trouble concentrating, and restlessness. Medications included Lorazepam 0.5 mg twice a day as needed for agitation. Resident #7's current care plan identified the following problems and interventions: * Behavior problem "(repetitive verbalizations, repetitive movements, running into others with w/c [wheelchair]) r/t [related to] Dementia" with interventions including "Administer medications as ordered. Monitor/document for side effects and effectiveness; Anticipate and meet The resident's needs; Intervene as necessary to protect the rights and safety of others. Remove from situation and take to alternate location as needed when restless; Minimize potential for the resident's disruptive behaviors (restlessness, running into others with w/c) by offering tasks which divert attention such as 1:1 visits, twiddle muff [activity], coffee, prayers, music." * Impaired cognitive function and thought process related to "Dementia" with interventions including "Administer medications as ordered. Monitor/document for side effects and effectiveness. . . . Cue, reorient and supervise as needed; Engage the resident in simple, structured activities that avoid overly demanding tasks. The resident prefers 1:1 visits, music. . . ." * Mood problem related to "Dementia, anxiety" with interventions including "Report mood changes (tearfulness, irritability, increased restlessness) to nursing; Administer medications as ordered. Monitor/document for side effects and effectiveness; Behavioral health consults as needed . . ." Review of Resident #7's progress notes from April 01, 2014 through July 16, 2014 identified the following:	F 309		

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F 309	Continued From page 14 * 04/06/14 at 6:01 p.m.: "anxious and yelling" * 04/12/14 at 11:36 p.m.: "resident restless, and anxious..." * 04/18/14 at 5:31 p.m.: "very anxious" * 04/18/14 at 5:43 p.m.: "PRN Administration was: Unknown [unknown if prn effective]" * 06/13/14 at 6:14 a.m.: "resident very anxious rolling around in w/c saying the same thing over and over..running into to [sic] other residents" * 06/14/14 at 1:15 a.m.: "resident anxious hitting the wall and yelling out" * 06/24/14 at 5:22 p.m.: "Resident agitated. . . ." * 06/30/14 at 4:31 p.m.: "c/o [complaining of] heart racing, & [and] being nervous about "something" Review of progress notes from April 01, 2014 through July 16, 2014 showed nursing administered Lorazepam and failed to identify the effectiveness one of seven times and failed to identify non-pharmacological interventions attempted prior to administration seven of seven times. During an interview on 07/17/14 at 4:25 p.m., an administrative nurse (#1) confirmed she expected staff to document causative factors, non-pharmacological interventions attempted, and the effectiveness of prn medications. Failure to assess causative factors and time patterns contributing to Resident #7's anxiety and agitation and implement appropriate non-pharmacological interventions, and monitor the effectiveness of those interventions, does not allow staff to evaluate what interventions were most effective for Resident #7's behavior.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 15 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: Based on observation, review of policy/procedure, and staff interview, the facility failed to ensure 4 of 4 resident care areas (Wings 200, 300, 400, and 500) maintained acceptable ranges for hot water temperatures. Failure to maintain acceptable ranges creates the potential for burn injuries to residents and staff. Findings include: Review of the facility policy titled "Water Supply" occurred on 07/16/14. This undated policy stated, ". . . 4. Keep water temperature at 120 degrees (by code for showers and sinks). . . ." Observation of water temperatures occurred on 07/15/14 from 4:30 p.m. to 5:30 p.m. In resident bathrooms on wings 200, 300, 400, and 500 temperatures were as follows: Room 203 at 125.7 degrees Fahrenheit (F) Room 302 at 140.3 F Room 401 at 125.7 F Wing 500 had three resident bathrooms located in the hallway at 137.4 F, 136.6 F, and 136.8 F. Observation of water temperatures occurred on 07/15/14 at 5:30 p.m. with a maintenance staff	F 323	F 323: 1.) At the time of immediate findings, Maintenance was called back to the facility to adjust water heater and monitor temperatures to a safe range. 2.) All residents are included to be potentially affected by this same deficient practice. 3.) A new thermometer has been purchased for the water temperature testing. (See attached Manufacturing Instructions.) - System Change: Prior to Maintenance completing their weekly water temperatures testing, thermometer probe will be calibrated by testing as per manufacturer's instructions. (See attached.) The calibration process will be initialed upon completion and water temperatures logged on the newly modified internal log. (See attached.) Abnormal readings will require immediate adjustments and monitoring to reach normal ranges. When temperatures are running > 110 degrees, nursing staff will be notified via Maintenance with a *Elevated Water Temperature* notification sheet. So that resident safety can be immediately addressed. (example – hold on showers, ect.) - Policy Change: Please note the change in max water temperature on our internal policy. 4.) Completion Date: August 21, 2014. 5.) The facility plans to monitor this process by the temperature logs being reviewed weekly beginning 8/11/2014 by the Environmental Services Manager and logs being present to review at each monthly QA meeting. This will be reflected in the monthly QA meeting minutes.	

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F 323	Continued From page 16 member (#2). His infrared thermometer registered approximately 16 degrees less than the surveyor's digital thermometer. He obtained a digital thermometer from the kitchen which then confirmed the high water temperatures. Review of the "Water Temperature Checklist" occurred on 07/15/14. This form, dated 05/30/14 to 07/16/14, verified weekly temperature testing ranging from 96 F to 129 F.	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	F329: 1.) Dr. Brian Sullivan reviewed consulting pharmacist recommendation for a dosage reduction of Resident #9 Amitriptyline on 7/29/2014. Both Dr. Sullivan and Jackie Lindsey, FNP were recommending a reduction order as follows: Decrease Amitiriptyline to 75mg PO Q HS x 10 days then 50mg PO Q HS. Discussion with Dr. Brian Sullivan also included the recent deficient citing F329. Family refused the recommended changes.	

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F 329	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review and professional reference review, the facility failed to assess and monitor the use of psychotropic medications for 1 of 1 sampled resident (Resident #9) who experienced adverse consequences. Administering psychotropic medications in the presence of adverse effects resulted in Resident #9's receiving unnecessary medications. Findings include: The Nursing 2015 Drug Handbook identified amitriptyline (an antidepressant)dosages as daily and not an as needed medication. Indications for usage included depression (anxiety not as a listed indication). Adverse reactions included central nervous system of peripheral neuropathy, anxiety, restlessness, and hallucinations; gastrointestinal side effects of nausea, vomiting, constipation, paralytic ileus (also known as bowel obstruction); and genitourinary symptoms included urine retention. The Nursing 2015 Drug Handbook identified oxazepam as a (benzodiazepine anxiolytic) medication with effects including sedation, and antianxiety properties. Indication and usage on a scheduled basis. Adverse reactions included nausea. An internet reference "http://kidney.niddk.nih.gov" from the "National Kidney and Urologic Diseases" identified a complication of urinary retention as a urinary tract infection. The reference states, "Urine is normally sterile, and the normal flow of urine usually prevents bacteria from growing in	F 329	Family requests to leave Amitriptyline as is at 100mg PO Q HS. Both the orders for Oxazepam and Amitriptyline originated from Trinity Riverside. Family wishes to only have this medication potentially changed as recommended per Geriatric Psych Specialists at Trinity Riverside in Minot, ND where they have specifically chosen to have their mother followed for her mental health concerns. Resident #9 does have a follow up appointment at Trinity Riverside on 8/13/2014 at 11am. 2.) All residents are included to be potentially affected by this same deficient practice. 3.) System change: Facility will monitor PRN usage with psychopharmacological medications on a monthly basis. Any excessive use will be immediately reported to our Medical Director and resident will be scheduled to be seen by the next rounding MD. 4.) Completion date: August 21, 2014. 5.) Designated RN will complete a monthly audit of all residents with a prescribed psychopharmacological medication that will monitor the usage or non-usage of those prn's. This audit will be implemented 8/11/2014 and the results will be discussed at monthly QA meetings. The review will be reflected in the monthly QA meeting minutes.	

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the urinary tract. When urine stays in the bladder, however, bacteria have a chance to grow and infect the urinary tract."

Review of Resident #9's record occurred on July 16-17, 2014. Diagnoses included dementia, anxiety, peripheral neuropathy, and hallucinations. The record did not identify the resident with depression.

A physician order, dated 10/29/13 and renewed on 01/04/14, included amitriptyline 100 mg (milligrams) as needed (prn) for "depression/anxiety" at bedtime. Review of the Medication Administration Record (MAR) showed nursing staff administered prn amitriptyline on 40 occasions between December 2013 and May 2014.

An order by the provider, dated 06/27/14, changed the prn amitriptyline to a once daily dose at bedtime.

The progress notes identified the provider ordered oxazepam 10 mg three times a day as needed for anxiety on 01/24/14. The notes identified nursing staff administered 30 doses between 01/25/14 and 02/21/14. This included five doses in January and 25 does in February.

The progress notes identified adverse side effects from the medication use:
* 01/30/14 at 3:54 a.m.: ". . . used call light stated she needs to pee, resident sat on toilet for approximately [sic] 25 minutes this nurse at side, resident unable to urinate at this time. all efforts where [sic] ineffective, resident states 'it feels like I really have to go bad, but I cant get it to start? Resident asks over and over what can I do to

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F 329	Continued From page 19 make it start, tried everything running, water, hand in warm water, relaxation techniques, giving her a drink, nothing worked. . . . will fax the clinic." * 02/01/14 at 1:17 a.m.: ". . . confused and says she cant [can't] pee . . . resident void moderate amount of urine at this time. . . . At 1:20 a.m. "resident is having bladder spasms and muscle spasms per resident" At 2:50 a.m.: ". . . went to do a safety check and found resident sitting on the toilet in her room, grunting and saying she is trying to pee . . . resident is not reasoning at this time with reality, she still believes she did not void when in fact she did. . . ." At 3:59 a.m.: "resident up and anxious at this time wanting to go to bathroom again saying she can't go 'pee' when she in fact urinates a small amount." * 02/10/14 at 2:05 p.m.: "[1:45 p.m.] to [hospital] per facility van and driver hs been c/o [complaining of] nausea today and had a large projectile emesis at [1:00 p.m.] abd [abdomen] is rounded sl [slightly] tender and firm bowel sounds decreased [sic] . . . " At 4:56 p.m.: "Resident returned from [hospital] [emergency room]. UA [urinary analysis] [positive] for UTI [urinary tract infection], ABD [abdominal] x-ray done and no changes noted since the one completed in 1-2-14. Resident will be on clear liquids for 24 hours then diet as tolerated. Cipro [antibiotic] . . . for 7 days. Zofran [an antiemetic - to divert nausea and vomiting] 4 mg po [orally] [as needed three times a day] for nausea . . ." * 02/13/14 at 4:05 a.m.: ". . . having difficulty voiding, after sitting approximately 20 minutes resident was able to void moderate amount of urine. * 02/13/14 at 9:14 a.m.: "Received phone call from . . . [nurse practitioner] . . . @ [at] hospital. . . . stated that he was reviewing xray results and noted that [residents] abdomen xray showed	F 329		

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F 329	Continued From page 20 some air fluid pockets, which can indicate the start of a bowel obstruction. He wanted to know how she was doing. Informed him that to my knowledge she has had no further emesis since 2/10/14. According to POC [plan of care] look back BM [bowel movements] report she has had a total of 3 stools since 2/11/14. [provider] requests that we keep a close eye on [resident] and call the provider on call immediately if she shows further signs of bowel obstruction. . . ." * 02/13/14 at 2:15 p.m.: ". . . stated at dinner that she felt nauseous . . ." * 03/09/14 at 9:06 a.m.: complaining of nausea at breakfast; Zofran given * 03/17/14 at 5:02 p.m.: complaining of nausea; Zofran given * 04/01/14 at 3:04 p.m.: complaining of tingling to hands and fingers * 04/06/14 at 8:19 p.m.: complaining of nausea and Zofran given * 05/23/14 at 6:54 p.m.: "At nurses stations with increased resp [respirations] and crying. 'I usually can eat but tonight I am nauseated.' . . very anxious. Prn [amitriptyline 100 mg] given." At 8:45 p.m. . . . was: Ineffective." Failure to monitor the effects of the psychotropic medications with the emergence of adverse consequences resulted in Resident #9 experiencing urinary retention, nausea, vomiting, and identified a potential for a bowel obstruction.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333	F333: 1.) The medication for this specific tag was changed from a prn status to a scheduled status on 6/27/2014.	

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F 333	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards for medication administration for 1 of 1 sampled resident (Resident #9) who received medications before or after the scheduled time for administration. Failure to administer medications at the scheduled time limits the determination of the use of, the effectiveness, and monitoring for adverse effects of the medication prescribed for Resident #9. This practice has the potential to affect all residents within the facility. Findings include: Review of the policy "Oral Medication Administration" occurred on 07/17/14. The policy, undated, stated, "Policy Statement. To appropriately administer oral medications. Procedure . . . Administer medication only when you are sure the six rights are being carried out . . . Right Resident, dose, drug, time, route . . ." Review of the policy "Administering Medications" occurred on 07/17/14. The policy, undated, stated, " . . . Medications must be administered in accordance with the orders, including any required time frame. . . . The individual administering medications must check THREE (3) times to verify the right . . . time . . . Medications . . . must be administered within one (1) hour of their prescribed time . . ." Review of information provided on the afternoon of 07/14/17 identified the last medication pass scheduled for 8:00 p.m. The Nursing 2015 Drug Handbook identified	F 333	Resident #9 will have no further medication administration outside of scheduling window unless a doctors order has been received indicating to do so. 2.) All residents are included to be potentially affected by this same deficient practice. 3.) Resident # 9 has a follow up appointment at Trinity Riverside on 8/13/2014. Family wishes to only have this medication potentially changed as recommended per Geriatric Psych Specialists from Trinity Riverside in Minot, ND as they have specifically chosen to have their mother followed for her mental health concerns there. Nursing staff will be re-educated and medication administration policy will be reviewed at the scheduled mandatory all staff meeting 8/13/2014. Nurses and CMA II will be required to read and acknowledge medication administration policy in our online education system "Healthstream." 4.) Completion date: August 21, 2014 5.) Designated RN will complete an audit of 5 resident medication administration records per month x 1 year that will monitor medication administration times. This audit will be implemented 8/11/2014 and the results will be discussed at monthly QA meetings.	

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F 333	Continued From page 22 amitriptyline (an antidepressant) scheduled on a regular basis. Review of Resident #9's record occurred on July 16-17, 2014. A physician order, dated 10/29/13, included amitriptyline 100 mg (milligrams) as needed (prn) for "depression/anxiety" at bedtime. Review of the Medication Administration Record (MAR) showed nursing staff administered prn amitriptyline as follows: * December 2013: 13 times; administered as early as 4:32 p.m. and administered seven times outside the one hour range of 8 p.m. * January 2014: 10 times; administered at 2:30 a.m. once; as early as 3:06 p.m.; and five other times outside the one hour range of 8 p.m. * February 2014: four times; administered as early as 5:36 p.m. one time * March 2014: 10 times; administered as early as 5:26 p.m. once; administered four other times outside the one hour range of 8 p.m. * April 2014: one time; administered at 9:05 p.m., outside the one hour range of 8 p.m. * May 2014: two times; administered at 5:31 p.m. one time * June 2014: three times: administered as late a 9:26 p.m. During interview on 07/16/14 at 5:20 p.m., an administrative staff (#1) confirmed bedtime h.s. medications are scheduled for 8 p.m.	F 333		
F 385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a	F 385		

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F 385	Continued From page 23 recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review, review of policy/procedures, and staff interview, the facility failed to ensure a physician's written approval and orders for admission were obtained for 1 of 1 sampled resident (Resident #2) admitted since the last recertification survey (07/24/13). Failure to have a physician involved in the admission process may prevent the resident from achieving his/her highest quality of life and care. Findings include: Review of the facility policy titled "Admissions" occurred on 07/17/14. This undated policy stated, ". . . At the time of admission, the center will have the physician's orders for the resident's immediate care, consistent with the resident's present physical and mental status. . . ." Review of Resident #2's medical record occurred on all days of survey diagnoses included of cerebral vascular accident, aphasia, dysphagia, hypertension, dementia, and recurrent urinary tract infections. Admission orders, dated 04/29/14, identified a nurse practitioner's signature on the following: "Criteria for Admission	F 385	F 385: 1.) Resident #2 will have their admission paperwork, 30 day, and 60 day visit reviewed and co-signed by our facility Medical Director Dr. Mark Peterson. Resident #2 was seen by Dr. Brian Sullivan for 90 day review on 7/29/2014. 2.) All new admits are included to be potentially affected by this same deficient practice. 3.) Policy update: Physician Visit policy will be updated representing expectations from locum physicians participating in resident care. (See policy.) This policy will be discussed at the Medical Staff meeting at St. Luke's Clinic on 8/13/2014. 4.) Completion Date: August 21, 2014. 5.) The designated Dr. Day nurse will complete an audit of admitted residents to ensure that admission orders are signed by a MD. This audit will be completed monthly x 1 year and will be implemented 8/11/2014. This audit will be reviewed at monthly QA meetings and the review will be reflected in the monthly meeting minutes.	

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F 385	Continued From page 24 to St. Luke's Sunrise Care Center," The "Medication Reconciliation Report," and the 30 and 60 day visit review forms. During an interview on 07/17/14 at 8:15 a.m., a nursing manager (#1) verified a physician did not sign admission paperwork for Resident #2.	F 385		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON 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: ADVERSE EFFECTS TO RESIDENT 1. Based on record review, policy review, professional reference review, and staff interview, the facility failed to ensure the pharmacist completed a thorough evaluation of 1 of 9 sampled residents medication regimen (Resident #9) for irregularities, reported those irregularities to the attending physician and the director of nursing and acted upon these irregularities. Failure to complete this review resulted in Resident #9 receiving psychotropic medications in the presence of adverse consequences. Findings include:	F 428	F428 1.) All residents affected will have their monthly pharmacy review minutes signed or co-signed by MD within 10 days. 2.) All residents are included to be potentially affected by this same deficient practice.	

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F 428	Continued From page 25 Review of the "Pharmacy Services - Role of the Consultant Pharmacist" policy occurred on 07/17/14. The policy, undated, stated: ". . . Roles of the Consultant Pharmacist . . . Report any irregularities to the attending physician or the director of nursing or both (These reports must be acted upon and follow-up documentation maintained. . . ." The Nursing 2015 Drug Handbook identified amitriptyline dosages as daily and not an as needed medication. Indications for usage included depression (anxiety not as a listed indication). Adverse reactions included central nervous system of peripheral neuropathy, anxiety, insomnia, restlessness, drowsiness, hallucinations, delusions, and disorientation; gastrointestinal side effects of nausea, vomiting, diarrhea, constipation, paralytic ileus (also known as bowel obstruction); and genitourinary symptoms included urine retention. Contraindications and cautions include the elderly; and "Warn patient not to stop drug abruptly." The Nursing 2015 Drug Handbook identified oxazepam as a benzodiazepine anxiolytic (medication with effects including sedation, hypnosis, muscle relaxation, and antianxiety properties). Indication and dosages included anxiety on a scheduled basis. Adverse reactions included drowsiness, dizziness, and nausea. Contraindications and cautions include the elderly; and "Warn patient not to stop drug abruptly." Review of Resident #9's record occurred on July 16-17, 2014. Diagnoses included dementia,	F 428	3.) System Change: Dr. Day Nurse will have pharmacy review with medical provider and co-signed by MD within 10 days. Director of Nursing will ensure MD has co-signed all pharmacy review sheets. Policy Change: Medication Regimen Review policy will be updated accordingly. Pharmacist and Director of Nursing will review at next meeting. 4.) Completion Date: August 21, 2014. 5.) The Director of Nursing will complete an audit of 5 residents to monthly x 1 year to ensure that the medical record review has been signed or co-signed by an MD within 10 days. This audit will be implemented 8/11/2014 and the results will be discussed at monthly QA meetings. The review will be reflected in the monthly QA meeting minutes.	

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F 428	Continued From page 26 anxiety, peripheral neuropathy, and hallucinations. The record identified a provider order, initiated on 10/29/13 which included amitriptyline 100 mg (milligrams) as needed (prn) for "depression/anxiety" at bedtime. Review of the Medication Administration Record (MAR) showed nursing staff administered prn Amitriptyline on 40 occasions between December 2013 and May 2014. The MAR showed nursing staff administered the bedtime dose as early as 3:06 p.m. and as late as 2:30 a.m. An order by the provider, dated 06/27/14, changed the prn Amitriptyline to a once daily dose at bedtime. The progress notes identified the provider ordered Oxazepam 10 mg three times as needed for anxiety on 01/24/14. The notes identified nursing staff administered five doses in January and 25 doses in February between 01/25/14 and 02/21/14. The record showed, on 03/29/14, the provider changed the oxazepam to a scheduled dose three times a day. The progress notes identified adverse side effects including urinary retention, nausea and vomiting; abdominal symptoms including "abdomen xray showed some air fluid pockets, which can indicate the start of a bowel obstruction. . . ." Refer to F 329. A pharmacy reviews completed on 02/28/14, (the month nursing staff administered four doses of amitriptyline and 25 doses of oxazepam), "Findings . . . Oxazepam 10 mg . . . [three times a day] prn for anxiety was started - later changed to	F 428		

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F 428	Continued From page 27 scheduled. Had some urinary retention at first requiring straight cath [catherization] but has resolved. Behaviors are improved on oxazepam vs. [versus] clonazepam [also used for anxiety]. . . . Patient gets high dose amitriptyline 100 mg prn for depression/anxiety at bedtime - requires occasionally. Recommendations to Nursing Staff: Monitor for daytime sedation or urinary retention, as amitriptyline should be used cautiously in elderly patients with this condition. Recommendations to Prescriber: Is [medical doctor] comfortable with the prn amitriptyline 100 mg for her?" A mid-level practitioner signed the review on 03/11/14; the review included a notation of "Please d/w [discuss with] [physician]." There was no evidence this occurred. Pharmacy reviews completed the following months did not identify nor address the continued use of the Amitriptyline, or indicate if the prn use of the amitriptyline had been discussed with the physician. Those reviews included: *03/27/14, ". . . Anxiety is still improved on oxazepam . . ." The review failed to address the amitriptyline administered on an as needed basis 10 times in March. The progress notes for the month of March identified nursing staff did not administer Resident #9 any as needed oxazepam between 03/01/14 and 03/27/14. The progress notes showed the provider changed the oxazepam to a scheduled dose three times a day on 03/29/14. * 04/30/14, ". . . Anxiety is improved." The MAR showed nursing staff administered one dose of amitriptyline in the month of April. * 05/28/14, "Her anxiety is much improved compared to several months ago." The MAR showed nursing staff administered two doses of amitriptyline in May.	F 428		

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F 428	Continued From page 28	F 428		

Record review showed nursing staff administered three doses of amitriptyline the month of June. On 06/27/14, the provider changed the prn Amitriptyline 100 mg to a once daily dose at bedtime even though the pharmacist reported Resident #9's anxiety improved in the months of March, April and May. A pharmacy review, due for the month of June, was not available/provided for review.

PHARMACY RECOMMENDATIONS
2. Based on record review, the facility failed to ensure the attending physician reviewed and acted upon the consulting pharmacist's report of irregularities identified on monthly medication regimen reviews for 8 of 9 sampled residents (Resident #1, #2, #3, #4, #5, #7, #8, and #9) and one resident in a closed record (#10) reviewed. Failure to ensure the physician reviewed the consulting pharmacist recommendations has the potential to affect all resident's highest practicable level of functioning.

Findings include:

- Review of Resident #1's medical record occurred on all days of survey. Pharmacy reviews with recommendations, completed on 09/24/13, 10/29/13, and 03/11/14 lacked evidence of physician review/recognition of the pharmacist's findings.

- Review of Resident #2's medical record occurred on all days of survey. Pharmacy reviews with recommendations, completed on 05/06/14 and 05/30/14 lacked evidence of physician review/recognition of the pharmacist's findings.

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F 428	Continued From page 29 - Review of Resident #3's medical record occurred on all days of survey. Pharmacy reviews with recommendations, completed on 02/28/14 and 03/27/14 lacked evidence of physician review/recognition of the pharmacist's findings. - Review of Resident #4's medical record occurred on all days of survey. Pharmacy reviews with recommendations, completed on 09/24/13, 01/10/14, and 05/06/14 lacked evidence of physician review/recognition of the pharmacist's findings. - Review of Resident #5's medical record occurred on all days of survey. Pharmacy reviews with recommendations, completed on 02/28/14 and 05/28/14 lacked evidence of physician review/recognition of the pharmacist's findings. - Review of Resident #7's medical record occurred on July 16-17, 2014. Pharmacy review with recommendations, completed on 03/11/14 lacked evidence of physician review/recognition of the pharmacist's findings. - Review of Resident #8's medical record occurred on all days of survey. Pharmacy review with recommendations, completed on 01/10/14 lacked evidence of physician review/recognition of the pharmacist's findings. - Review of Resident #9's medical record occurred on July 16-17, 2014. Pharmacy reviews with recommendations, completed on 01/20/14, 02/28/14, and 03/27/14, lacked evidence of physician reviewed/ responded to the pharmacist's findings. The recommendations included: * 01/20/14: ". . . Clarify oxezapam order . . ."	F 428		

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F 428	Continued From page 30 * 02/28/14: ". . . Is [medical doctor] comfortable with the [as needed] amitriptyline [antidepressant] 100 mg [milligrams] for her? * 03/27/14: ". . . Do you think she might benefit from a dose increase of Advair [inhaler]? Please advise." - Review of Resident #10's medical record occurred on all days of survey. Pharmacy review with recommendations, completed on 01/24/14 lacked evidence of physician review/recognition of the pharmacist's findings.	F 428		