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

PRINTED: 07/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on June 17, 2013 and completed on June 20, 2013 the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review.	F 000		
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 and psychological symptoms of dementia (BPSD) for 2 of 4 sampled residents (Resident #3, and #4) with dementia who receive antipsychotic medications. Failure to thoroughly assess the residents' behaviors, implement individualized interventions, and establish on-going monitoring of the behaviors may result in decreased physical, mental, and psychosocial well-being and may negatively impact residents' quality of life. Findings include: Review of the facility policy titled "Behavior	F 309	1) After thorough review of resident behaviors by the Interdisciplinary Team, Care Plans for resident #'s 3 and 4 were updated to reflect more individualized interventions for behavior management. Changes made were based on current resident status' and interventions that were attempted previously but hadn't been clearly documented. Staff will be educated on these care plan changes at a department meeting held July 16th, 2013 at 2:30pm. Medication dose reduction of Seroquel was done for Resident #4 on 6-27-13. The Psychiatrist that ordered the increase of Resident #3's dose of Seroquel was sent communication via fax on 7-9-13 to update her on the survey findings. More information was requested to provide clinical rationale for increasing the dose of Seroquel on 6/17/13. Received communication back on 7/11/13 that the Psychiatrist was not in the office the rest of the week. Resident was scheduled to be seen by same Psychiatrist via Tele-Medicine on 7/15/13 to have face to face discussion regarding dosaging and behavior management.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7-12-13

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

Administrator 7-12-13

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F 309	Continued From page 1 Management" occurred on 06/20/13. This policy, dated 04/22/09, stated, ". . . The CNA [certified nursing assistant] charting form titled MDS [Minimum Data Set] Log is completed each shift for every resident at CMC [Cooperstown Medical Center]. 2. Monthly, or sooner if indicated, these forms will be reviewed by the MDS Coordinator. After review, the MDS Coordinator will initiate the process of having staff document on Behavior Observation Forms for each behavior that tracking is deemed necessary for. The forms indicate what the behavior was, events pre- and post behavior, interventions, etc. 3. After a period of monitoring has been completed, the Behavior Management Committee will discuss behaviors and make suggestions for plan of care. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included delusional disorder, dementia with behaviors, unspecified psychosis, lumbago (low back pain), spondylolisthesis (a displacement of the vertebrae), a history of urinary tract infections (UTIs), and a history of falls. The current MDS, dated 05/20/13, identified severe cognitive impairment; verbal behavior symptoms and rejection of care on 4 to 6 days; physical and other behavioral symptoms, and wandering on 1 to 3 days. The MDS also identified Resident #3 required extensive assistance from one person for dressing, toilet use, personal hygiene, and bathing. Current medications included Seroquel (an antipsychotic) 100 milligrams (mg) three times per day (tid) (increased from 75 mg tid on 06/17/13), Zoloft (an antidepressant) 100 mg every day (qd) (decreased from 150 mg qd on	F 309	2) All residents with dementia who receive antipsychotic medications have the potential to be affected. Interdisciplinary team reviewed the resident directory and diagnosis/medication lists to help identify residents who may be affected. This was done 7/9/13. 3) The process for documenting resident behaviors and interventions attempted has been reviewed and revised. See changes reflected in the policy titled Behavior Management for Residents with Diagnosis of Dementia. (attachment F309 A).The Behavior Observation Form was updated to include an area to document interventions attempted. (Attachment F309A1) Nursing staff will be educated on the changes at a department meeting on July 16th at 230pm. All nursing staff will also receive education at the meeting regarding types of interventions that may be attempted prior to administering antipsychotic medications. Social Services staff will be part of the meeting to assist with training of staff.	

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F 309	Continued From page 2 05/01/13), and Tylenol 650 mg tid. The current care plan stated, ". . . Occ [occasional] episodes of aggression, will hit out, kick, pinch, throw things at anyone around, episodes come and go quickly . . . Plan and Approach: 1. Ensure Resident's safety 2. Attempt to redirect as able 3. If safe may need to leave and reapproach later 4. Limit number of staff responding to situation 5. If incont [incontinent]- encourage to allow help [with] care if unable reapproach later 6. May need to change staff 7. May need to separate [sic] from other resident- if affects them 8. Attempt diversional activities- does not always work et [and] may escalate behavior. . . ." Review of the Behavior Observation Forms since 12/01/12 showed the following: *05/29/13 at 8:30 a.m.: ". . . Behavior (describe what you saw): We went to get [Resident #3] ready for bed, we went in and everything was fine. She snapped called us every name and so forth. I was holding her so we could get a brief on her, her hand got away and she pulled my glasses off my face and also left fingernail marks on my arm . . . What helped stop the behavior: nothing, other than being done with what we were doing . . . Interventions Recommended: Cont. [continue] to follow CP [care plan]. . . ." *05/03/13 at 8:15 p.m.: ". . . Behavior (describe what you saw): 2 cnas . . . and myself were trying to put [Resident #3] to bed, she was angry and reached up and scratched my top lip. . . . What happened before the incident: undressing, was upset over that idea . . . What made the behavior worse: asking her to stop and get clothes on . . . Interventions Recommended: Cont. to follow CP.	F 309	Activities Director was educated on the importance of attempting programming for dementia residents on 7/9/13 by the D.O.N. and agreed to initiate getting a program/policy in place. This will be implemented by 7/25/13. Activities staff will also participate in daily Interdisciplinary Team "Stand Up" meetings (where Behavior Management discussions take place) , as available, to provide input on behavioral interventions/resident activity preferences. All residents identified by the Interdisciplinary Team in #2 above will have behaviors and interventions/care plans reviewed by 7-25-13 and updates will be made as needed. Staff will be advised of changes via the Resident Care Sheets currently in place and verbal education, on an ongoing basis. 4)	7/25/13

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F 309	Continued From page 3 . . ." *04/28/13 at 12:08 p.m.: ". . . Behavior (describe what you saw): Resident exiting building out south door [with] walker, 'you [expletive] get away from me,' trying to redirect back into facility. Resident hit nurse et pinched, unable to redirect back into facility, CNA used W/C [wheelchair] to escort resident to room, resident in room 'you [expletive]' . . . What helped stop the behavior: brought her to her room . . . What made the behavior worse: trying to redirect back into the facility . . . Interventions recommended: Cont. to follow CP . . ." *04/13/13 (untimed): ". . . Behavior (describe what you saw): resident was sleeping with no brief on and her bed was soiled so resident needed to be helped with cares and when CNAs tried to help the resident the resident was hitting biting and yelling at the CNAs . . . What helped stop the behavior: CNAs completed cares and left . . . What made the behavior worse: trying to talk to the resident calmly . . . Interventions recommended: . . . Cont. to follow CP . . ." *02/09/13 at 4:38 p.m.: ". . . Behavior (describe what you saw): Resident sitting in TVL [TV lounge] taking shirt off et another nurse [nurse's name] approached her to ask to put shirt back on, resident got upset et started yelling et hitting at nurses. I approached resident et asked if I could help et take her to the room. Resident proceeded to put shirt back on et she was struggling to find the arm hole et I stated to resident it's right here . . . Resident hit nurse across left side of face et eye . . . What helped stop the behavior: I left resident alone . . . Interventions recommended: Cont. to follow CP . . ." *02/03/13 at 2:00 p.m.: ". . . Behavior (describe what you saw): [Resident #3] struck out, was	F 309	5) Facility Quality Assurance Coordinator, who is also part of the Interdisciplinary "Stand Up" Team meeting will review Stand-Up Meeting Notes (attachment F-309 B) on a weekly basis and check Resident Care Sheets and Care Plans to see if all recommended individualized interventions were care-planned and carried out. This will occur weekly x8 and then monthly x2. Problems identified will be reported immediately to the D.O.N. for corrective actions, if needed. All results will be reported to the facility QA Committee at scheduled meetings and recommendations for further monitoring will be made by the Committee.	

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F 309	Continued From page 4 kicking at and pulling hair of CNA's. 2nd CNA present [and] necessary to assist. . . . What happened before the incident: resident was inc [incontinent] of urine [and] BM [bowel movement]. Needed to be changed . . . What helped stop the behavior: leaving room . . . What made the behavior worse: attempting to discuss what we were trying to do. How we need to help her. . . . Interventions recommended: Reviewed @ [at] standup 2/4/13 . . . Resident has hx [history] of this type of behavior at times when approached. Staff completed necessary care and left resident in a safe environment . . ." *12/15/13 (all a.m. shift): ". . . Behavior (describe what you saw): Resident through [sic] all drinks @ CNA, hollaring [sic], swearing while she was doing it. Swing out @ staff when approached. . . . What happened before the incident: Sitting on couch, whispering to her teddy bear . . . What helped stop the behavior: leaving resident room . . . Interventions recommended: Cont. to follow CP . . ." *The record failed to show evidence of updates/new approaches in response to the behaviors described above, determination of causative/contributing factors, and interventions attempted by staff. A facility form titled "Psychoactive Medication Monitoring Record" contained blank spaces for staff to make check marks if certain behaviors occurred. These forms, completed on all three shifts for each month, listed the following behaviors: *Physical Aggression (Hit, kick, bite, scratch, throw objects, destruction of property) *Verbal Aggression (Threaten, name call, swear) *Psychotic Symptoms (Paranoia, hallucinations,	F 309		

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F 309	Continued From page 5 delusions) These forms lacked times as well as specific behaviors (i.e. Resident #3's frequent resistance to cares) unique to each resident to enable staff to track and trend the behaviors, determine patterns, and identify possible causative factors. The monitoring record failed to identify approaches/interventions attempted by staff, and failed to include possible causes for physical/verbal aggression (i.e. with cares, due to pain, hunger, etc). Resident #3's "Psychoactive Medication Monitoring Record" showed the following: *June 2013: 6 episodes of physical aggression, 6 episodes of verbal aggression, 9 episodes of psychotic symptoms *May 2013: 15 episodes of physical aggression, 7 episodes of verbal aggression, and 1 episode of psychotic symptoms *April 2013: 28 episodes of physical aggression, 27 episodes of verbal aggression, and 4 episodes of psychotic symptoms. (The April 2013 form showed 43 of the 59 documented behaviors occurred between April 21-26. The record lacked evidence of further investigation into possible causes for the increased behaviors.) *March 2013: 10 episodes of physical aggression, 14 episodes of verbal aggression, 4 episodes of psychotic symptoms *February 2013: 20 episodes of physical aggression, 15 episodes of verbal aggression, 6 episodes of psychotic symptoms *January 2013: 3 episodes of physical aggression, 2 episodes of verbal aggression, 4 episodes of psychotic symptoms *December 2013: 5 episodes of physical	F 309		

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F 309	Continued From page 6 aggression, 7 episodes of verbal aggression, 5 episodes of psychotic symptoms Review of nurses' notes since 12/17/12 identified multiple incidents of Resident #3 resisting cares with resulting physical/verbal aggression. The nurses' notes lacked consistent documentation as to the circumstances of the behaviors, possible precipitating factors, approaches used by staff, resident responses to these approaches, etc. Nurses' notes also showed Resident #3 experienced urinary frequency, burning, and foul-smelling urine on 05/09/13. A urine culture obtained on 05/15/13 was positive for Escherichia coli (i.e. E. coli, a bacteria commonly found in the digestive tract) and Resident #3 started antibiotics for a UTI on 05/16/13. The record lacked evidence that facility staff considered other possible causes for Resident #3's behaviors such as recent wrist injury with pain, recent UTI, etc. prior to increasing her antipsychotic medication in June 2013. Psychiatric progress notes stated the following: *06/17/13: ". . . Patient seen via tele-med [a health consultation done via electronic communications] health . . . Nursing staff says that [Resident #3] has a 'lot of flip-flop with her behavior,' but indicates she is in a good mood today. She did have some agitation last week. . . . [Resident #3] says that she has been doing pretty well, without any 'major bouts.' She then leans back and doesn't answer any more questions today . . . Staff reports she has been doing ok on current medications. . . . talks out of turn quite a	F 309		

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F 309	Continued From page 7 bit pointing out things in the room. Highly distractable [sic]. . . . Could try to increase Seroquel to 100 mg tid to see if controls moodiness any better. . . . Time: 10 minutes of medication management with >50% of time spent in counseling and coordination of care. . . ." *04/22/13: ". . . [Resident #3] says that she has been doing pretty well, without any 'major bouts.' . . . Staff reports she has been doing ok on current medications. . . . behaviors have been doing better with the increase in Seroquel. Will continue medications the same. . . ." *11/29/12: ". . . [Resident #3] was last seen on 10/23/12, at which time Seroquel was increased to 75 mg three times a day. Staff reports that she hasn't hit anybody since the increase. She is a little more sleepy, but they don't feel she is oversedated. She did fall on the floor this morning. She also is getting cold symptoms. . . . behaviors have been doing better with the increase in Seroquel. Will continue medications the same. . . ." Psychiatric progress notes identified Resident #3 as stable on 04/22/13 with no medication changes recommended. On 06/17/13, Resident #3's Seroquel was increased from 75 mg tid to 100 mg tid to help control moodiness. However, nurses' notes and behavior monitoring logs showed no increase in behaviors between 04/22/13 and 06/17/13 when compared to the months prior to the 04/22/13 psychiatric visit. The record also failed to identify an appropriate clinical rationale warranting the increase of an antipsychotic medication. During an interview on 06/20/13 at 9:55 a.m., a nursing staff member (#2) stated the physician	F 309		

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F 309	Continued From page 8 felt Resident #3 was disoriented and disorganized during her tele-med appointment on 06/17/13, and felt the resident might benefit from an increase of Seroquel. The nursing staff member (#2) agreed there was a lack of documentation regarding worsening behaviors or other indications that would warrant an increased dose of Seroquel. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia with behaviors, Alzheimer's disease, a history of falls, and a history of UTIs. The current MDS, dated 05/09/13, identified severe cognitive impairment; physical, verbal, and other behavioral symptoms on 1 to 3 days; rejection of care on 4 to 6 days; and wandering on 1 to 3 days. The MDS also identified Resident #4 required extensive assistance from one person for dressing, toilet use, personal hygiene, and bathing. Current medications included Seroquel 50 mg tid (increased from 25 mg tid on 06/17/13) and Seroquel 25 mg twice a day (bid) as needed (prn). The current care plan stated, ". . . Resident occ. hits, kick [sic], pinches, yells out, resists cares . . . Plan and Approach . . . 1. Try to minimize staff doing cares 2. Approach slowly et try to talk quietly 3. If safe, leave et reapproach later 4. Try to follow Resident routine et have thing [sic] in room in same place . . ." Psychiatric progress notes showed the following: *04/22/13: ". . . He is still having a lot of agitation, especially with cares. . . . [Resident #4] is still	F 309		

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F 309	Continued From page 9 having a lot of agitation and appears very grumpy and irritable. Will try increasing the Seroquel to better control this. . . . Increase Seroquel to 25 mg tid . . ." *06/17/13: ". . . Nursing home staff reports [Resident #4] has been having more agitation, with hitting out at staff. Resident shoved nursing home staff into chair several times; another time, hit, kick, several times he has bit when staff was trying to do cares and get him ready for bed; another times [sic] punched and hit at staff when they were trying to put him in bed; another few times with trying to change resident's wet brief. . . . [Resident #4] is still having a lot of agitation and appears very grumpy and irritable. Will try increasing the Seroquel to better control this. . . . Increase Seroquel to 50 mg tid and start Seroquel 25 mg bid PRN agitation, give prior to cares . . ." The facility's "Psychoactive Medication Monitoring Record" showed the following: *June 2013: 3 episodes of physical aggression, 1 episode of verbal aggression, and no episodes of psychotic symptoms *May 2013: 19 episodes of physical aggression, 8 episodes of verbal aggression, and no episodes of psychotic symptoms *April 2013: 7 episodes of physical aggression, 7 episodes of verbal aggression, and no episodes of psychotic symptoms *March 2013: 3 episodes of physical aggression, no episodes of verbal aggression, and no episodes of psychotic symptoms These forms lacked times as well as specific behaviors (i.e. Resident #4's frequent resistance to cares) unique to each resident to enable staff to track and trend the behaviors, determine patterns, and identify possible causative factors.	F 309		

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	355039	A. BUILDING _____ B. WING _____	06/20/2013

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 309	Continued From page 10 The monitoring record failed to identify approaches/interventions attempted by staff, and failed to include possible causes for physical/verbal aggression (i.e. with cares, due to pain, hunger, etc). Review of nurses' notes since 12/17/12 showed a pattern of resisting cares, medications, and baths beginning 03/29/13. The nurses' notes lacked consistent documentation as to the circumstances of the behaviors, possible precipitating factors, approaches used by staff, resident responses to these approaches, etc. Review of the Behavior Observation Forms since 04/01/13 showed the following: *06/11/13 at 6:30 p.m.: ". . . I [CNA name] went into resident's room to ask to get ready for bed then resident shoved me into his chair. I stood up and tried to calm resident down but resident shoved me again. I stood back up and put resident in his chair. . . ." *06/07/13 at 7:30 p.m.: ". . . [Resident #4] was biting, kicking, screaming, and hitting at staff when trying to do HS [bedtime] cares . . ." *06/05/13 at 7:30 p.m.: ". . . Resident kicked, pinched, and tried to bite both CNAs when putting him to bed . . ." *06/04/13 at 6:30 p.m.: ". . . Resident was swearing and hitting at me. Wouldn't let me out of the bathroom. Wouldn't let me put the brief on him. Kicking, almost got me in the face . . ." *05/31/13 at 2:15 a.m.: ". . . Resident was talking gibberish (loudly), CNA was trying to change his wet brief, and he was trying to hit and kick at staff. . . ." *05/28/13 at 9:00 a.m.: ". . . Resident was hitting, kicking, trying to bite CNAs. Yelling at CNAs. . . ."	F 309		

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F 309	Continued From page 11 *05/24/13 at 8:55 a.m.: ". . . Resident very aggitated [sic] in tub room. Tried to calm [without] results. Refused to leave tub room so cont'd [continued] [with] bath. Resident hitting, kicking, [and] attempting to bite staff . . ." *05/21/13 at 12:00 p.m.: ". . . I was trying to feed the resident when he shouted at me and called me 'dumb.' Got up from the table twice and was mad. . . ." *05/21/13 at 7:19 a.m.: ". . . While giving Res. his a.m. insulin he pulled away trying to hit @ this nurse. He then took his walker [and] tried to hit this nurse [with] it . . ." *05/21/13 at 7:00 a.m.: ". . . Enter resident room to get him up for the day. Told him what I was doing, when started to dress him he started kicking, swearing, hitting out @ CNA . . ." *05/13/13 at 6:30 p.m.: ". . . [Resident #4] was very upset getting ready for bed. He tried to grab my arm when undressing and getting him in bed, covering him up he kicked me several times . . ." *04/14/13 at 8:00 p.m.: ". . . CNA was doing HS cares and resident was sitting his [sic] chair stated, 'I'm going to bit [sic] you.' I asked the resident why are you going to bit [sic] me? and he lunged at the CNA and when the CNA backed away resident started laughing. . . ." *04/13/13 at 9:10 p.m.: ". . . Resident was getting help from the CNA for his evening cares and was getting his brief put on and he started yelling and kicking at the CNA. . . ." *04/13/13 at 2:45 p.m.: ". . . Resident came down the hall and crashed his walker into the water cart, making noise. . . ." *04/13/13 at 7:20 a.m.: ". . . Tried to get him up out of bed [and] he pushed me into the wall, started ramming his walker into me . . ." *The notes identify that 7 of the 15 behaviors	F 309		

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F 309	Continued From page 12 documented above occurred with HS cares. The record lacked evidence that staff attempted to determine patterns/causative factors or modify interventions in response to the behaviors. During an interview on the morning of 06/20/13, a nursing staff member (#2) stated 6:30 p.m. was too early to go to bed, and staff should not be attempting evening cares that early. During an interview on 06/20/13 at 9:05 a.m., an activity staff member (#5) stated they do not currently have a program for residents with dementia, but do one to one visits and room visits as needed.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility standing orders, and staff interview, the facility failed to provide services to treat urinary tract infections (UTIs) for 1 of 5 sampled residents (Resident #3) with a history of UTIs. Failure to provide prompt treatment of UTIs may result in	F 315	1) N/A 2) All residents who have ordered labs, urinalyses, etc have the potential to be affected. 3)A Lab Requests/Results received log (attachment F-315 A) was initiated 6/27/13 to provide a better mechanism for tracking when labs are requested and how long it takes to get results back. It provides at a glance information to nursing staff on what lab results have not been received back yet.	

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F 315	Continued From page 13 unresolved pain and discomfort, increased behaviors, and kidney infections. Findings include: The facility's standing orders, revised 01/18/12, stated, ". . . 4. Suspected UTI: As evidenced by: Difficulty with urination, burning with urination, cloudy urine, foul smelling urine or significant changes in resident behavior - obtain a midstream clean catch urine specimen. If unable to obtain a clean catch specimen, use mini-cath/Foley [urinary catheter]. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia with behaviors, bladder hypertonicity, and a history of UTIs. The current Minimum Data Set (MDS), dated 05/20/13, identified extensive assistance from one person for personal hygiene and frequent urinary and bowel incontinence. A laboratory report identified Resident #3 experienced urinary frequency and increased irritability on 11/28/12, and staff sent a urine sample for a culture/susceptibility. The final report, dated 12/01/12 at 9:40 a.m., showed a positive culture for E. coli. The report indicated laboratory staff faxed the results to the facility on 12/04/12. A health care provider (HCP) progress note, dated 12/06/12, stated, ". . . [Resident #3] culture returned with E-Coli (i.e. Escherichia coli, a bacteria commonly found in the digestive tract). . . . Urinary tract infection secondary of [sic] frequency and complaints. . . . She will be placed on Ciprofloxacin [an antibiotic] 250 mg	F 315	All lab requests get recorded on the log. Nursing Home Standing Orders (attachement F-315 B) were also updated to indicate a time frame of 8 hours to wait for a clean catch specimen. After 8 hours, nursing staff is to collect per catheter to help ensure timely treatment if a UTI is present. Nursing staff were provided education on the updated standing orders on 6/27/13 when they were signed into place via a posting at the Nurse's Station. Education was also provided at the department meeting 7/16/13. Nursing staff were also informed of the importance of writing standing orders for U/A collection for symptoms listed on the Standing Orders immediately rather than just passing the information on to the next shift. It was stressed that with the new 8 hour time frame this will speed collection and treatment times up significantly. This education was done at the meeting noted above. A facility fax form to the clinic (attachment F-315 C) was also initiated to help speed up communication/notification to HealthCare Providers in the clinic. The form is used to inform HCPs of any resident concerns and lab results and includes an area that they can write orders and fax the form back to the Nursing Home. This was started 6/27/13	

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F 315	Continued From page 14 [milligrams] twice a day for the next 5 days. . . ." Record review identified the initiation of antibiotics on 12/06/12 (eight days after the onset of symptoms). During an interview on the morning of 06/20/13, a supervisory nurse (#3) stated it is nursing staff's responsibility to follow up with a urine culture. Further review of HCP orders and nurses' notes showed the following: *05/09/13 at 5:44 p.m.: ". . . Resident incontinent of urine several times today with foul odor noted. Resident states to this nurse "I just can't stop pee peeing." Resident states it sometimes burns during urination. Peri [perineal] cares completed with resident and very cooperative at this time. Will notify oncoming nurse of resident's status. . . ." *05/13/13 at 2:10 p.m.: An HCP order stated, ". . . obtain cath UA per protocol. Dx: [diagnosis] frequency. . . ." *05/16/13 at 4:23 a.m.: ". . . Obtained UA and urine very cloudy, and foul. Resident was also verbally abusive saying 'you [expletive], you dirty [expletive]' and tried to hit and kick staff. . . ." The UA was obtained on 05/15/13 at 11:30 p.m. and documented on 05/16/13. *05/16/13 at 10:45 a.m.: An HCP order stated, ". . . Cipro 250 mg PO [by mouth] BID [twice per day] x 5 days. Culture urine UTI. . . ." Record review showed the initiation of antibiotics on 05/16/13 (seven days after the onset of symptoms). A laboratory report identified staff sent a urine sample for a culture/susceptibility on 05/15/13 at 11:30 p.m. The final report, dated 05/18/13 at 1:16 p.m., showed a positive culture for E. coli.	F 315	4) 5) The facility QA Coordinator will review the lab log daily (M-F) x4 to ensure that all requested labs and U/As are reported in a timely manner. Problems during daily checks in the first 4 weeks will be reported immediately to a staff nurse so follow-up can be done with the lab to see where results are at. This monitoring will also include whether U/As were collected in a timely manner from symptom onset. Facility fax forms will be monitored to see if HCPs are responding within a reasonable time frame from when faxes were sent. This monitoring will be done by the facility QA Coordinator, or designee daily (M-F) x4 weeks and then weekly x2 weeks as well. Problems will again be reported to staff nurses immediately so HCPs can be contacted as needed. D.O.N. will be notified of any noted problems with process immediately so corrective action can be taken, if needed. Results of QA monitoring will be reported to the facility QA Committee at scheduled meetings and recommendations for further monitoring will be made by the Committee.	7/25/13

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F 315	Continued From page 15 During an interview on 06/20/13 at 9:55 a.m., a nursing staff member (#2) stated she was unsure if staff reported on Resident #3's symptoms on the evening of 05/09/13, or why staff did not obtain a urine sample until two days after the HCP ordered the UA. Failure to ensure timely follow-up and provide prompt treatment of Resident #3's urinary tract infections on 05/16/13 (seven days after the onset of symptoms) and 12/06/13 (eight days after the onset of symptoms) may result in unresolved pain/discomfort, increased behaviors, and kidney infections.	F 315		
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	F 329	1) See Plan of Correction for F-309 for corrections that were made regarding monitoring/recording of behaviors for resident #3. The Psychiatrist that ordered the dose increase for resident #3 was sent communication via fax 7/9/13 from the facility regarding surveyor concerns noted in this report and a request was made for more documentation including clinical rationale for why the increase was made. On 7/11/13 facility received communication back that the Psychiatrist was out of the office the rest of the week. Resident was scheduled to be seen by same Psychiatrist via Tele-Medicine on 7/15/13 to have face to face discussion regarding dosaging and behavior management. Interdisciplinary Team members will attend the Tele-Medicine visit with resident #3.	

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F 329	Continued From page 16 drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a drug regimen free from unnecessary medications for 1 of 5 sampled residents (Resident #3) receiving an antipsychotic. Failure to thoroughly assess Resident #3's behaviors resulted in an increase in antipsychotic medications without adequate indications and placed this resident at risk for adverse drug reactions. Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included delusional disorder, dementia with behaviors, unspecified psychosis, lumbago, spondylolisthesis (a displacement of the vertebrae), a history of UTI's, and a history of falls. The current MDS, dated 05/20/13, identified severe cognitive impairment; verbal behavior symptoms and rejection of care on 4 to 6 days; physical and other behavioral symptoms, and wandering on 1 to 3 days. The MDS also identified Resident #3 required extensive assistance from one person for dressing, toilet use, personal hygiene, and bathing. Current medications included Seroquel (an antipsychotic) 100 milligrams (mg) three times per day (tid) (increased from 75 mg tid on	F 329	2) All residents with behaviors and who are on antipsychotic medications have the ability to be affected. 3) See Plan of Correction for F-309 for process changes made regarding better documentation of behaviors to justify increasing resident's antipsychotic medications. Discussion will be held with Psychiatrist at Tele-Medicine visit 7/15/13 on regulations and requirements set forth related to antipsychotic use in residents diagnosed with dementia. Psychiatrist will be provided with a copy of the regulations, if needed. 4) 5) See Plan of Correction for F309 regarding QA monitoring of documentation of behaviors and implementation of individualized behavior interventions.	7/25/13

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F 329	Continued From page 17 06/17/13), Zoloft (an antidepressant) 100 mg every day (qd) (decreased from 150 mg qd on 05/01/13), and Tylenol 650 mg tid. Resident #3's "Psychoactive Medication Monitoring Record" showed the following: *June 2013: 21 behavioral episodes *May 2013: 23 behavioral episodes *April 2013: 59 behavioral episodes *The April 2013 form showed 43 of the 59 documented behaviors occurred between April 21-26. The record lacked evidence of further investigation into possible causes for the increased behaviors. *March 2013: 28 behavioral episodes *February 2013: 41 behavioral episodes *January 2013: 9 behavioral episodes *December 2013: 17 behavioral episodes Psychiatric progress notes stated the following: *11/29/12: ". . . [Resident #3] was last seen on 10/23/12, at which time Seroquel was increased to 75 mg three times a day. Staff reports that she hasn't hit anybody since the increase. She is a little more sleepy, but they don't feel she is oversedated. She did fall on the floor this morning. She also is getting cold symptoms. . . . behaviors have been doing better with the increase in Seroquel. Will continue medications the same. . . ." *04/22/13: ". . . [Resident #3] says that she has been doing pretty well, without any 'major bouts.' . . . Staff reports she has been doing ok on current medications. . . . behaviors have been doing better with the increase in Seroquel. Will continue medications the same. . . ." *06/17/13: ". . . Patient seen via tele-med health . . . Nursing staff says that [Resident #3] has a 'lot	F 329		

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F 329	Continued From page 18 of flip-flop with her behavior,' but indicates she is in a good mood today. She did have some agitation last week. . . . [Resident #3] says that she has been doing pretty well, without any 'major bouts.' She then leans back and doesn't answer any more questions today . . . Staff reports she has been doing ok on current medications. . . . talks out of turn quite a bit pointing out things in the room. Highly distractable [sic]. . . . Could try to increase Seroquel to 100 mg tid to see if controls moodiness any better. . . . Time [time spent with resident via tele-med]: 10 minutes of medication management with >50% of time spent in counseling and coordination of care. . . ." Psychiatric progress notes identified Resident #3 as stable on 04/22/13 with no medication changed recommended. On 06/17/13, Resident #3's Seroquel was increased from 75 mg tid to 100 mg tid to help control moodiness. However, nurses' notes and behavior monitoring logs showed a decrease in the number of documented behaviors between 04/22/13 to 06/17/13. The record also failed to identify an appropriate clinical rationale warranting the increase of the antipsychotic medication. During an interview on 06/20/13 at 9:55 a.m., a nursing staff member (#2) agreed there was a lack of documentation regarding worsening behaviors or other indications that would warrant the increased dose of Seroquel. Refer to F309	F 329		