STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355051	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTON PRAIRIE VILLAGE	950 DAKOTA AVE HATTON, ND 58240

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on March 10, 2014 and completed on March 13, 2014 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 and staff interview, the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms of dementia (BPSD) for 3 of 3 sampled residents (Resident #1, #2, and #7) with a diagnosis of dementia and receiving psychopharmacological medications. The failure to identify BPSD, assess the reason/causative factor(s) for behaviors, implement appropriate individualized interventions (including non-pharmacological interventions), and establish accurate on-going monitoring of the behaviors has the potential for unnecessary use of medications, failure to manage pain, and may add to avoidable agitation/anxiety. Findings include:	F 309	**Plan of Correction F309** 1. The residents found to be affected by the deficient practice will be assessed for individual non-pharmacological interventions and these individual interventions will be addressed in each resident's care plan. A minimum of 2 non-pharmacological interventions will be implemented prior to the administration of either pain medications or psychoactive medications. The interventions and resident's response to the interventions will be documented in the resident's long term care record or Pain Flow Sheet.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cynthia Tredwell	Administrator	4/7/14

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 309	Continued From page 1 Review of Resident #1's medical record occurred on all days of survey. Diagnoses include dementia, anxiety, confusion, congestive heart failure, and osteoarthritis. The resident's significant change Minimum Data Set (MDS), dated 02/07/14, identified the resident as having severely impaired cognition, exhibiting other behavioral symptoms occurring daily and interfering with the resident's activities or social interactions, and physical behaviors occurred one to three days. This MDS also identified the resident with frequent pain, affecting sleep and activities, and rated a seven on a pain scale of 0-10. A Care Area Assessment (CAA) for Pain, dated 02/11/14, stated, ". . . She frequently complains of right knee pain. She takes Lorcet [Hydrocodone-acetaminophen] on a daily basis for this. She describes it as aching. the time that pain occurs varies throughout the day. She often moans when she is having pain. She becomes restless and anxious, she has a diagnosis of anxiety. She sleeps poorly at night. . . ." A CAA for Behaviors, dated 02/11/14, stated, ". . . She has Dementia and impaired decision making. She has pain, very poor memory recall. She hollers out, asking for her daughter . . . She moans or groans loudly . . . She is not taken to various activities because she hollers out and other residents complain . . . " Review of Resident #1's "Pain Evaluation," dated 11/12/13 and 02/04/14, stated, "Does the resident have any diagnosis(es) which would give a reason to believe he/she would be in pain No . . . 'Have you had pain or hurting at any time in the last 5 days?' No . . . CONCLUSION Pain	F 309	2. Facility will identify other residents having the potential to be affected by the same deficient practice by reviewing residents' MDS, Section I (Dementia); Section E (Behaviors); Section N (Medications); and Section J (Pain). Those residents showing dementia and behaviors and psychoactive medications and those residents showing pain will be assessed for non-pharmacological interventions and these individual interventions will be addressed in each resident's care plan. A minimum of 2 non-pharmacological interventions will be implemented prior to the administration of medications. The interventions and resident's response to the interventions will be documented in the resident's long term care record or Pain Flow Sheet.	4/10/14

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F 309	Continued From page 2 management intervention is necessary, refer to resident plan of care, potential for pain . . ." The assessment failed to identify nonverbal/non-cognitive signs of pain or list any non-pharmacological interventions. Resident #1's current care plan stated the following: "PROBLEM Resident has potential for pain R/T [related to] several medical problems . . . APPROACH acetaminophen as ordered, handle gently, Monitor and record any complaints of pain: location, frequency, effect on function, intensity, alleviating factors, aggravating factors. Position for comfort with physical supports as necessary. . ." Resident #1's care plan failed to list non-pharmacological interventions related to pain, other than postioning. "PROBLEM Antianxiety medication R/t anxiety. APPROACH 1. ativan as ordered 2. Monitor side effects most common are insomnia, irritability, dizziness, depression, suicide. 3. Monitor mood and response to medication record all mood & [and] behavior indicators 4. Keep family & MD [medical doctor] informed . . ." Resident #1's care plan failed to list non-pharmacological interventions related to anxiety. "PROBLEM Behavioral Symptoms Hollers out and moans loudly, has anxiety and [sic] . . . discontentment. agitated at night hollars [sic] - anxious sleep poorly. GOAL Minimize moaning & disruptive behaviors. Decrease anxiety. APPROACH Daughter [name] visit [sic] often. Interact 1:1, talk to her loudly & to her face so she is aware of interaction. Medications as ordered . . . see that her physical needs are met . . may refer to psych . . . " Resident #1's medication regimen for December	F 309	3. Facility will put these measures into place to help prevent the deficient practice from recurring: (a) Interdisciplinary Team and nurses will be retrained on how to identify behavioral and psychological symptoms of dementia, assess the reasons for behaviors and how to implement appropriate individual interventions (including non-pharmacological interventions); (b) Interdisciplinary Team and nurses will be retrained on how to develop and implement a non-pharmacological, resident-focused approach to pain, how to identify nonverbal/non-cognitive signs of pain and how to accurately monitor the pain; (c) Identified residents will be reviewed by the Interdisciplinary Team weekly for one month, then every other week for 3 months to insure proper assessment and appropriate individual interventions are being followed prior to the administration of pain medications or psychoactive medications; and (d) Interdisciplinary Team and nurses will be trained on effective and defensive long term care charting.	4/10/14 4/10/14 ~~07/29/14~~ delete per adm 4/10/14 dd ee 4/3/14

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F 309	Continued From page 3 2013 to March 2014 included: *Scheduled Tramadol (a pain medication) 50 milligrams (mg) twice a day (BID), initiated on 08/08/13 and discontinued on 02/19/14 *Acetaminophen 325 mg two tabs as needed (PRN) every 4 hours, initiated on 08/08/13 to current *Hydrocodone-acetaminophen PRN initiated 12/02/13, and doses changed on 12/21/13, 01/01/14, and 02/21/14. Current dose one to two tabs three times a day (TID) *Scheduled Hydrocodone-acetaminophen initiated on 12/04/13, and doses changed on 12/21/13, 01/05/14, 02/12/14, and discontinued on 02/21/14 *MS Contin (morphine) 15 mg initiated on 02/19/14 to current *Ativan (an antianxiety medication) 0.5 mg TID PRN, initiated on 12/25/13, increased to 1 mg every 8 hours on 01/05/14, and discontinued on 02/12/14 *Scheduled Ativan 1 mg BID, initiated on 02/12/14 to current *Scheduled Seroquel (an antipsychotic medication) 12.5 mg daily, initiated on 01/08/14, increased to 12.5 mg BID on 01/22/14, and discontinued on 02/12/14 *Scheduled Trazadone (an antidepressant medication) 100 mg at hour of sleep (HS) initiated on 02/19/14, and increased to 150 mg on 02/28/14 to current Review of Resident #1's "Long Term Record" notes from 12/25/13 to 02/21/14 stated the following: * 12/25/13 10:00 a.m., "noted to be anxious, sitting in w/c [wheelchair] repeating in loud voice 'can you help me, I can't sit here' has been assisted into bed several times, but each time,	F 309	4. Facility will monitor its performance through weekly x 4 and bi-weekly x 6 audits reviewed by Interdisciplinary Team and Quality Assurance Committee. Facily ~~secevring~~ monitoring residents with dementia + behaviors + psychoactive medications or PRN pain medication for use of non-pharmacological interventions. Per administrator on 4/10/14 - telephone call dl.	~~07/31/14~~ delete per adm 4/10/14 dl

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F 309	Continued From page 4 she gets up out of bed, brought out to parlor for staff to keep an eye on her stated 'I can't stand this' denies pain on call FNP [family nurse practitioner] informed [and] order received for ativan 0.5 mg po tid prn . . . " * 01/01/14 5:00 a.m., "Up numerous times tonoc [tonight] Freq [frequently] to bathroom. Sometimes just walking in room. Had Ativan 0.5 mg at 10:15 p.m. [with] little effect. Lorcet [Hydrocodone-acetaminophen] 5-500 [2 tabs] at 2:30 a.m. Up less after given." * 01/05/14 11:25 p.m. [sic], "noted to be anxious at 8:30 a [a.m.] was calling out 'can you help me, I want to lay down' was laid down 5 times between 8:30-8:45, and each time, was getting out of bed, repeatedly, then sat in w/c and repeatedly called out 'can I lay down' also moaning & saying 'I feel terrible' given ativan 0.5 mg no improvement by 9:30 a.m., given lorcet 5/500 [2 tabs] no improvement by 11 a.m., [physician's name] contacted & order received for [arrow up] [increase] ativan to 1 mg po [by mouth] Q [every] 8 hrs [hours] PRN, [arrow up] lorcet to 5/325 mg [3 tabs] po bid & 2 tabs BID PRN given 0.5 mg ativan at 10:30 a . . . " *01/08/14 11:00 a.m., "Seen by [physician's name] for wt. [weight] gain, pedal edema and anxiety/agitation . . . [physician's name] reviewed meds, labs, vitals order received for Seraquel [sic] 12.5 mg po QD [once a day] [arrow up] Lasix [a diuretic medication] to 80 mg po BID, . . . resident c/o [complained of] 'pain all over' during exam. . . ." * 01/21/14 3:15 a.m., " Continues to be restless Ativan 1 mg po given at 2:40 a.m., c/o neck & shoulder pain, lorcet 5/325 [2 tabs] po given 2:45 a.m. . . ." * 01/22/14 2:30 p.m., "order received to d/c [discontinue] lorcet (scheduled) and [arrow up]	F 309		

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F 309	Continued From page 5 seraquel [sic] to 12.5 mg po BID." * 01/25/14 4:00 a.m., ". . . Ativan given for restlessness and Lorcet given shortly after as res [resident] moaning and c/o hurting 'all over' . . . " * 02/01/14 5:00 a.m., ". . . Res [Resident] refused to stay in bed. Up in w/c & out to N.S. [nurses' station] Ativan 1 mg po given 9:30. Dozed on & off constantly moving. In recliner in TV parlor, back in w/c & on couch by N.S. for awhile. Slept quietly from 4a-4:30am then sitting up & lying down on couch c/o R [right] knee pain Lortab 5-325 mg [2 tabs] po given . . ." * 02/01/14 8:30 a.m., "Slept until this time, now is anxious & restless, c/o R knee pain given [2 tabs] lorcet 5/325 and [1 tab] ativan 1 mg. . . ." * 02/02/14 12:00 a.m., Ativan given 10:15 p.m., Restless & calling out Transferred onto couch by N.S. Almost continuous talking until about 11 p.m. then res fell asleep. . . . " * 02/02/14 5:00 a.m., " Slept til [sic] about 3:30 am [2 tabs] lorcet given 4:15 AM as moaning loudly restless." * 02/07/14 6:00 a.m., "Sitting up in w/c yelling at 12M [12:00a.m.] Ativan given. c/o R knee pain at 12:30 am. lorcet 2 given . . . " * 02/09/14 6:50 a.m., "c/o R knee pain, noted to be anxious and restless, given [2 tabs] norco [Hydrocodone-acetaminophen] and 1 mg ativan . . ." * 02/09/14 7:30 p.m., "Resident very anxious and calling out. Also c/o knee discomfort. Resident given PRN Norco [2 tabs] and 1 mg Ativan at this time." * 02/10/14 10:30 p.m., "Moaning & calling out loudly Ativan & lortab 2 tabs given for restlessness & R leg pain." * 02/12/14 11:30 a.m., " discussed agitation and anxiety [with] [physician's name] as well as chronic c/o R knee pain. order received to D/C	F 309		

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F 309	Continued From page 6 prn ativan & schedule BID, schedule lorcet 5/325 mg 2 tabs po BID, cont [continue] prn . . . " * 02/21/14 12:15 p.m., " . . . Updated daughter on medication change. Daughter stated her Mom's sleep had always been poor at night." Review of Resident #1's PRN Medication Administration Record (MAR) showed the following: *December 25-31, 2013 - 14 doses of PRN Ativan and 6 doses of PRN pain medication. *January 2014 - 40 doses of PRN Ativan and 34 doses of PRN pain medication. Only 2 doses staff recorded non-pharmacological interventions. *Feburay 2014 - 14 doses of PRN Ativan and 30 doses of PRN pain medication. Only 2 doses staff recorded non-pharmacological interventions. During the month of January 2014, on six occasions the facility staff administered an antianxiety medication and a pain medication at the same time. This practice does not allow staff to adequately assess the effectiveness of one medication before administration of another medication. The facility failed to develop and implement a non-pharmacological resident focused approach to Resident #1's pain and behaviors. Failure to track and trend signs and symptoms, in order to implement an individualized specific approach that benefited the well being of the resident, does not allow for a true assessment of the effectiveness of the medication and/or the non-pharmacological interventions. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimers disease and agitation. The	F 309		

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F 309	Continued From page 7 quarterly MDS, dated 01/05/14, identified severe cognitive impairment. Resident #2's current care plan identified the following: ". . . Problem: Behavior Symptoms Potential for physical harm. Slaps at nursing assistants during care. . . . Approach: Inform staff of the potential for [resident's name] to slap at them. Invite to activities. Try to keep her active and involve. Leave and approach later if she is too agitated or having a lot of anxiety. Problem: Behavior Symptoms Wandering. . . . Have her sister, [name] visit. Re-direct, attempt to lessen anxiety. Take time to interact and reassure her when she is asking for her loved ones. . . . Problem: Behavior Symptoms . . . Believes resident [number] and resident [number] are her sister. . . . Approach: Alprazolam (Xanax) [antianxiety medication] as ordered scheduled and prn [as needed]. Remeron [antidepressant] daily as ordered. APAP [tylenol] as ordered. Listen to [resident name] and offer support for time she has anxiety or frustration. She sometimes reverts back to yesteryears when she cared for [name] as a child. Give redirection and allow to vent feelings. . . . Problem: Psychotropic Drug Use Resident receives antianxiety medication R/T [related to] generalized anxiety disorder. . . Approach : Alprazolam (Xanax) as ordered, scheduled and prn. . . ." Resident #2's drug regimen included: * Xanax 0.5 mg three times a day, initiated on 11/20/13 and discontinued on 03/06/14 * Xanax 0.5 mg one tablet twice a day as needed * Risperidone (antipsychotic medication) 0.25 mg twice a day and 0.5 mg at bedtime Resident #2's MARs and long term record notes	F 309		

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F 309	Continued From page 8 identified the staff administered Xanax .05 mg for anxiety without identifying specific non-pharmacological interventions attempted prior to the administration of Xanax as follows: * December 2013, 15 times * January 2014, 11 times * February 2014, 6 times * March 01-09 2014, 5 times - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia and anxiety with depression. The quarterly MDS dated 01/24/14, identified Resident #7 as cognitively intact. Resident #7's care plan stated, ". . . Problem: Resident has anxious complaints/concerns (non-health related) . . . Approach: During acute phase, do not make demands, remove from public areas as she wishes and take back to room. Encourage to verbalize feelings, concerns and fears. Clarify misconceptions. Follow familiar routines. Keep daughter informed of changes prn. Maintain a calm environment and approach to the resident. . . . Remove from dining room or other rooms when meal/activity is finished per her request. . . . Lorazepam prn as ordered. . . . Problem:` . . . Resident receives antianxiety medication, Lorazepam, R/T anxiety with depression. . . . Approach: . . . Monitor resident's mood and response to medication. . . . Supportive listening and acceptance . . ." Resident #7's drug regimen included: * Ativan 0.5 mg every four hours as needed for anxiety, initiated on 01/02/13 and decreased to 0.25 mg as needed on 02/19/14. Resident #7's MARs and long term record notes	F 309		

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F 309	Continued From page 9 identified the staff administered Ativan for anxiety without identifying specific non-pharmacological interventions attempted prior to the administration of Ativan as follows: * January 2014, 6 times * February 2014, 6 times * March 01-12 2014, 13 times During an interview on the morning of 03/11/14 and on 03/12/14 at 10:00 a.m., a supervisory nurse (#1) stated the non-pharmacological interventions used before administration of an antianxiety medications are in the long term notes, the interventions are on the care plan, and staff follow the care plan. Failure to try non-pharmacological interventions prior to administering antianxiety medications and establish on-going monitoring of resident's behaviors may result in decreased physical, mental, and psychosocial well being.	F 309		