STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	10/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 58639

(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 10/25/10 and completed on 10/27/10 the sampled included two residents for complete review, seven residents for focused review, and one closed record for review. The sample included one additional resident to verify specific concerns during the survey.	F 000	The facility has prepared and submitted this Plan of correction because of the requirements Under state and federal law that mandate submission of a plan of correction to participate in the title 42 program. The submission of the plan of correction should in no way be considered or construed as an agreement with the allegations of non-compliance shall constitute this facility's credible allegation of compliance. This applies to tag's F250, F281, F309, F323, F327, & F329	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and resident interview, the facility failed to provide medically-related social services for 1 of 2 residents (Resident #2) who verbalized feelings of loneliness. Failure to address the psychosocial needs of Resident #2 and develop and implement interventions related to these needs may be detrimental to the resident's psychological and mental well-being and may negatively affect her overall level of functioning. Findings include: Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included depressive disorder and anxiety state. Current medications included Xanax (an anxiolytic with sedation, drowsiness, anxiety, and irritability as possible adverse reactions) 0.5 milligrams (mg)	F 250	1) Resident #2 will be evaluated by Dr. T. Johnson, Psychiatrist on 11-11-10. Dr. Johnson has been updated by Rose Bergquist, PA about the concerns of state surveyors having to do with the potential of unnecessary administration of Seroquel. 2) All residents have the potential to be affected. 3) The Licensed Social Worker will gain baseline assessment of all residents using the MDS 3.0 PHQ-9 or PHQ9-OV. The resident's physician will be notified of any increased levels in depression and/or thoughts of suicide that arise with the use of the PHQ-9 or PHQ9-OV. It will be reported to the physician by the charge nurse or unit manager. The LSW will report any concerns to the DON for investigation and follow up. If the resident is determined to be at high risk for increased thoughts of suicide, the LSW will complete a monthly PHQ9 or PHQ9-OV on those residents for continued follow-up and intervention. 4) Continued monitoring will be done through the use of the MDS 3.0 system. The LSW will also monitor residents who have an increased score and triggers for thoughts of harming themselves. The LSW will bring these findings to the weekly Mental Health Meeting and they will be discussed with the MD, FNP or PA. Any residents who	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11/19/10

nv deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ng 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 250	Continued From page 1 four times a day, Xanax 0.5 mg daily prn (as needed), Remeron (an antidepressant with somnolence, suicidal behavior, and dizziness as possible adverse reactions) 60 mg every night at bedtime, Celexa (an antidepressant with somnolence, anxiety, agitation, and dizziness as possible adverse reactions) 10 mg every day, and Seroquel (an antipsychotic with dizziness, somnolence, seizures, and orthostatic hypotension as possible adverse reactions) 100 mg at 6:00 a.m. and 11:00 a.m. and 200 mg every night at bedtime. The social service assessment, completed on admission in August 2009, identified Resident #2 as a widow with no children and no family in the area. Resident #2's current Minimum Data Set (MDS), dated 08/16/10, identified no long term or short term memory impairments, independence with decision making, and the ability to make herself understood and to understand others. Review of Resident #2's MDS regarding mood and behavior patterns revealed the following: * 08/16/10 (Annual): No mood or behavior patterns identified * 05/19/10 (Quarterly): No mood or behavior patterns identified * 02/24/10 (Quarterly): No mood or behavior patterns identified * 11/19/09 (Quarterly): No mood or behavior patterns identified * 10/05/09 (Quarterly): No mood or behavior patterns identified Observations of Resident #2 occurred throughout the survey and revealed the following: *10/25/10 at 1:25 p.m.: Asleep in bed *10/25/10 at 3:45 p.m.: Transferred self to recliner	F 250	trigger will be referred to the Behavior Program run by the Activity Director for 1:1 or small group intervention. Interventions will be provided by the LSW in conjunction with the behavior activity aide to provide a Positive Behavior Plan. Any findings by the behavior activity aide will be brought to the weekly Mental Health meeting for further discussion with the LSW, Rose Bergquist Psychiatric PA, and the interdisciplinary team. Any residents who trigger for increased levels of depression and/or thoughts of suicide will have updates to their care plan, which will include a reference to the Positive Behavior Plan. This will be an ongoing process. Education to nursing staff will be provided on adequate documentation related to mood and behavior. Education will be provided by the LSW and DON at next nursing staff meeting on 12/02/2010. 5) Completion date: December 24, 2010.	

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F 250	Continued From page 2 in TV area, dozed on and off until 4:27 p.m. when she took herself to the bathroom *10/26/10 at 6:52 a.m.: Asleep in recliner in TV area *10/26/10 at 8:15 a.m.: Transferred self to recliner after breakfast, fell asleep in recliner *10/26/10 at 9:55 a.m.: Asleep in bed *10/26/10 at 1:30 p.m.: Asleep in bed *10/26/10 at 4:30 p.m.: Asleep in recliner in TV area *10/27/10 at 6:50 a.m.: Asleep in recliner in TV area *10/27/10 at 8:30 a.m.: Asleep in recliner in TV area *10/27/10 at 10:00 a.m.: Asleep in bed *10/27/10 at 12:10 p.m.: Transferred self to recliner after lunch, fell asleep in recliner *10/27/10 at 1:30 p.m.: Asleep in recliner in TV area Review of Resident #2's provider progress notes revealed the following: * 10/27/09 (Provider #2): ". . . She feels that life is not worth living, and if she has to live with all this anxiety, she wishes that God would just take her. She states that she would not harm herself . . ." * 11/04/09 (Provider #2): ". . . [Resident name] is focused on that she just does not want to wake up. She wants to go to Heaven. . . . She has these thoughts that there is nothing to look forward to . . . she does not enjoy living. . . . She states that there is no reason. . . ." * 01/20/10 (Provider #2): ". . . Today she did express that she wishes she could just go to sleep in the evenings and not wake up in the morning but she realizes that this is part of life. . . . She is not suicidal where she would hurt herself. . . ." * 02/05/10 (Provider #1): ". . . Social history is	F 250		

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F 250	Continued From page 3	F 250		

pertinent to the fact that the patient is anxious, depressed, and continues to verbalize a lot of anxiety about not having any family nearby. . . ."
* 05/04/10 (Provider #2): ". . . She still has feelings where she wishes that she would not wake up in the morning. . . . She does not understand what her purpose in life is. Several of her friends have passed away. She feels quite lonely. She has no family in the area. . . . She has suicidal ideation as described above. . . ."
* 06/22/10 (Provider #2): ". . . She still makes statements that she does not know why she is alive and she wishes that she would wake up in heaven one day. . . . She does wish that she had more family. [Resident name] is a widow and she has never had any children and none of [Resident name] family live within the area. She has some close friends that do visit her on occasion. . . ."
* 08/26/10 (Provider #1): ". . . She says she just wants to die. I think she would commit suicide if she had the chance. . . ."
* 08/31/10 (Provider #2): ". . . She has no other complaints except that she does feel kind of anxious and wishes that she could just go to sleep and not wake up, but she has no suicidal plan. . . ."
* 09/21/10 (Provider #2): ". . . [Resident name] is quite anxious today. She expresses concern about just not wanting to live, not wanting to go on . . ."

Review of Resident #2's "Social Progress Notes" revealed the following:
* 11/20/09: "Quarterly Review: . . . No mood or behaviors indicated. . . . She has anxiety at times. [provider names] follow her care. . . ."
* 01/19/10: "Resident was discussed during Mental Health Mtg [meeting]. . . ."
* 02/09/10: "Resident was discussed during

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F 250	Continued From page 4 Mental Health Mtg. today. Resident continues being difficult with staff. . . ." * 02/23/10: "Quarterly Assessment: . . . No moods or behaviors were noted. . . . Resident did verbalize concerns about her medication and increased level of anxiety. Resident reported that her mind does wander to past events [and] this creates anxiety for her. . . . Resident said she doesn't have any family nearby [and] doesn't have many visitors. . . ." * 03/02/10: "Resident's status was discussed during Care Conference today. . . ." * 03/10/10: "Met with resident [and] discussed needing to change rooms. . . ." * 04/06/10: "Resident was discussed during Mental Health Meeting. . . . Resident is doing well. . . ." * 05/25/10: "Resident's status was discussed during care conference. . . . Resident still does have episodes of anxiousness and does well with 1:1 interventions. . . ." * 05/27/10: "Quarterly Assessment: . . . No moods or behaviors were noted. . . . She admitted to being depressed and said she's been on medication for a long time. . . ." * 07/06/10: "Resident was discussed during Mental Health Meeting. . . ." * 08/19/10: "Annual Review/Assessment: . . . No moods or behaviors were noted. . . . Resident doesn't have any family nearby but does get support from staff and family. . . ." * 08/24/10: "Resident's status was discussed during Care Conference. . . ." * 08/31/10 (most recent entry): "Resident was discussed in Mental Health Meeting. . . . She continues to do well behaviorally. . . ." The medical record lacked evidence the facility staff followed up on the provider's concern of	F 250		

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F 250	Continued From page 5 Resident #2 committing suicide. The medical record also lacked evidence of personal visits from social services other than those related to MDS assessments/care planning meetings. During an interview on 10/27/10 at 9:00 a.m., Resident #2 stated the following: * "I eat and sleep and that's about it." * She has no one to talk to, and she gets "lonely." * Health care provider visits "are kind of rushed." * "It hurts me to think I don't have any family." * She is concerned about the monthly cost of all her medications. * No one visits her. "I don't think we have one of those." (referring to a LSW) * She has a POA (power of attorney) but "She is busy too. She still has a job." Review of Resident #2's care plan occurred on 10/26/10. The care plan failed to identify problems, establish goals, and include interventions related to her loneliness, verbalizations of sadness regarding her lack of family and visitors, and suicidal ideations. During an interview on 10/27/10 at 1:45 p.m., a social services staff member (#13) stated she visits Resident #2 "prn and for MDS purposes." She stated Resident #2 "seems to have a decrease in anxiety", the resident's symptoms "seem to have stabilized over the past several months", and staff discuss Resident #2 at mental health meetings "as needed."	F 250		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	1) Resident #2's physician's orders and MAR both verified for accuracy. Correction was made to the physician orders sheet for the month of October 2010 on 11-10-10. Resident #7's discrepancy relating to the dose of Exelon Patch has been corrected on the MAR on 11-10-10.	

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F 281	Continued From page 6 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/08/10. Based on review of professional reference, medical record review, and staff interview, the facility failed to follow accepted standards of practice regarding medication administration for 2 of 10 medical records reviewed (Resident #2 and #7). Failure to reconcile the physician's orders with the medication administration record has the potential to result in a medication error. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, dated 2008, page 841, states, ". . . Communicating a Medication Order . . . CLINICAL ALERT . . . If your assigned client receives new medication orders, double-check the transcribed information with the primary care provider's order. This ensures client safety." Page 850 states, ". . . Check Three Times for Safe Medication Administration . . . Compare the label of the medication against the MAR. . . ." - Review of Resident #2's medical record occurred on all days of survey. Medications included Remeron (an antidepressant) 60 mg (milligrams) every night at bedtime. Resident #2's current physician's orders, dated October 2010, failed to include an order for Remeron (although the order for Remeron did appear on the physician's orders for September). Resident #2's October Medication Administration Record (MAR) listed Remeron as one of the resident's	F 281	2) All residents have the potential to be affected. 3) Two nurses will sign off every physician order in the chart as a double check system. Each nurse will complete a check list form for that order received. The check list form will have the resident's name, date of order, both nurses' initials, and a checklist containing the following: order signed off on physician order, old order yellowed out in physician order for that month, order placed on MAR/Treatment/Diagnostic book, new order placed on new MAR for next month (if applicable), cassette removed from med cart, family notified, pharmacy faxed, and documentation in nurses' notes. This check list will be sent to medical records for transcription into the computer. This order needs to be entered into the computer system within 24 hours or the next business day. All residents with orders will have a daily audit between physician's orders taken, physician's orders transcribed to the physician order, the MAR/Treatment/Diagnostic, and the medication cassettes. This will be done by the QA nurse, Unit Manager, and the MDS Coordinator. The Medical Records coordinator will be the only person entering orders into the computer system. Any and all discrepancies related to F 281 and will be reported to the DON. 4) The QA nurse, Unit Manager, and the MDS Coordinator will audit all orders monthly for 3 months, and then the QA nurse will audit 10% of all orders monthly for accuracy and completion of above stated process for compliance. Education will be provided at the next nurses meeting December 2, 2010. Education will be completed by the Education/QA nurse.	

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F 281	Continued From page 7 medications. Resident #2's medical record did not contain a physician's order to discontinue the Remeron, and interview with a nursing staff member (#12) on the morning of 10/27/10 confirmed Resident #2 still received Remeron nightly. - Review of Resident #7's medical record occurred on October 26-27, 2010. Medications included an Exelon patch (an medication used to treat dementia) 9.5 mg every day. Resident #7's physician wrote an order on 09/30/10 to increase the Exelon patch from 4.6 mg to 9.5 mg every day. Resident #7's MAR listed an Exelon patch 4.6 mg every day as one of the resident's medications. Nursing staff initialed the MAR every day (indicating they had administered the Exelon patch daily). Inspection of the medication cart showed Exelon patches for Resident #7 at the correct dose of 9.5 mg. On the morning of 10/27/10, when shown the discrepancy between the MAR and the actual medication, a nursing staff member (#12) stated the MAR was wrong.	F 281	5) Completion date: December 24, 2010	
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 observation, record review, review of facility policies/procedures, professional literature,	F 309	1) Education of all nursing staff regarding documentation of resident's bowel movements occurred on 11/02/2010 (resident #1, #5, and #7 and all other residents). Identification of residents at high risk for constipation will be determined by the accurate documentation of bowel record. Education will again be completed at the next Nursing meeting on December 2, 2010. Education will include proper documentation of the Vitals BM log and the bowel protocol. On-the-spot education will be provided by Charge Nurse, Unit Manager, QA nurse, and DON. Formal education will be provided by the Unit Manager, Education/QA nurse, and the DON. 2) All residents have the potential to be affected. 3) All nursing staff will be educated regarding	

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F 309	Continued From page 8 and staff interview, the facility failed to develop and implement an effective bowel management/elimination program for 3 of 3 residents (Resident #1, #5, and #7) who experienced no bowel movement for three to seven days. Failure of facility staff to implement interventions to prevent constipation has the potential for residents to experience pain, bowel obstruction, and hospitalization. Findings include: Berman, Snyder, Kozier, Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 8th edition, Pearson Education, Inc., New Jersey, pages 1328-29, stated, "Constipation may be defined as fewer than three bowel movements per week. This infers the passage of dry, hard stool or the passage of no stool. . . . Many causes and factors contribute to constipation. Among them are the following: . . . Poor motility or slow transit, emotional disturbances such as depression or mental confusion, and medications such as opioids, . . . and antidepressants. . . ." Review of the facility's protocol titled "BOWEL PROTOCOL" occurred 10/27/10. This protocol dated 12/23/09, stated, "This Bowel Protocol is being implemented to enhance and promote bowel movements for the residents of [name of facility]. 1. DAY ONE: Offer fluids and give regular prescribed medications on MAR [Medication Administration Record] to promote bowel movement of resident. 2. DAY TWO: Offer fluids and give regular prescribed medications on MAR to promote bowel movement of resident. 3. DAY THREE: Offer fluids and give regular prescribed medications on MAR to promote bowel movement. Give MOM [Milk of Magnesia] in the	F 309	proper documentation of resident's bowel movements and the bowel and dietary protocol. DON is consulting with Dietary Consultant and Medical Director for appropriate Dietary Protocol. On-the-spot education will be provided by Charge Nurse, Unit Manager, QA nurse, and DON. Formal education will be provided by the Unit Manager, Education/QA nurse, and the DON. Care plan updates will be completed for those residents who are at increased risk for constipation. 4) Charge Nurse will monitor the Vitals BM Log sheet daily to ensure that proper documentation is in place. The Unit Manager will also audit documentation on 10% of residents 3 times weekly until 100% compliance is achieved, then PRN. QA nurse will audit 10% of documentation bi-weekly until 100% compliance is achieved, then PRN. Communication will come through daily resident report on bowel/dietary protocols initiated. Unit manager will audit 10% of residents 3 times weekly until 100% compliance is achieved, then PRN of bowel/dietary protocols initiated. QA nurse will audit 10% of residents bi-weekly until 100% compliance is achieved, then PRN. DON will audit as needed. Unit manager and QA nurse will report documentation discrepancies to the DON for further investigation. The Dietary Manager will audit 10% of residents monthly until 100% compliance is achieved, then PRN for residents that are at high risk for constipation to ensure dietary protocol is being used. 5) Completion date: December 24, 2010.	

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evening as ordered on PRN [as needed] medication list for primary MD [Medical Doctor]. 4. DAY FOUR: Offer fluids and give regular prescribed medications on the MAR to promote bowel movement. Give Dulcolax Suppository in the morning as ordered on PRN medication list for primary MD. 5. DAY FOUR: Offer fluids and give regular prescribed medications on MAR to promote bowel movement with Fleets Enema if no results from Dulcolax Suppository as ordered on PRN medication list from primary MD. If no response to treatment, (bowel movement), CALL PRIMARY MD FOR FURTHER ORDERS."

Review of the facility policy titled "Hydration" occurred on 10/27/10. This policy, dated 2007, stated, "POLICY: Ensure adequate fluid intake of the resident. PROCEDURE: . . . 2. Encourage fluids with cares . . . 5. Assist dependent residents with fluids."

Review of the facility's "Physician Standing Orders" occurred on 10/27/10. The orders, dated 2010, stated, "MEDICATIONS: Bowel Management - MOM 30 ml [milliliters] PO [by mouth] Q [every] 12 hrs [hours] PRN - not to exceed 3 days. Dulcolax Suppository (R) [rectally] PRN. Fleets, or oil retention enema PRN. Kondremul 30 ml PO Daily PRN."

- Review of Resident #1's medical record occurred October 26-27, 2010. Diagnoses included bilateral lower extremity amputation, depression, anxiety, malnutrition, and pain. The Minimum Data Set (MDS), dated 07/26/10, stated Resident #1 required extensive assist of two for toileting.

Resident #1's Physician Orders included

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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 Oxycontin 60 milligrams (mg) twice a day (bid) for pain, Xanax 0.25 mg one half tablet every morning for anxiety, and Remeron 45 mg at bedtime for depression. These medications have the potential to cause constipation. The care plan stated, "PROBLEM/NEEDS: Risk for constipation, Contributing factors may be: 1. hx [history] of constipation, 2. medication, 3. immobility, 4. dementia, 5. inadequate intake. GOAL: Will have BM [bowel movement] at least every three days on ongoing basis. APPROACHES: . . . 2. Monitor BM's and give laxatives or enemas as ordered or needed . . . 3. Monitor diet and medications for cause of constipation as needed . . . 4. Encourage resident to drink fluids . . . 6. Notify MD as needed . . ." Resident #1's bowel records from May 2010 through October 2010 indicated the following dates without a bowel movement: * May 11, 12, 13, 14 * May 30, 31, June 1, 2 * June 12, 13, 14, 15 * June 23, 24, 25, 26, 27 * July 31, August 1, 2, 3 * August 14, 15, 16, 17, 18 * September 28, 29, 30, October 1, 2, 3, 4 The resident's medical record failed to indicate administration of any as needed laxatives for constipation from 05/11/10 through 10/4/10, nursing interventions attempted to alleviate constipation, dietary interventions, and failed to indicate physician notification. - Review of Resident #5's medical record occurred on all days of survey. Medical diagnoses included senile dementia and constipation.	F 309		

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F 309	Continued From page 11 Scheduled medications included Senokot S (an over the counter medication used to aid in bowel elimination) two tablets daily. Review of Resident #5's quarterly MDS, dated 09/14/10, identified the resident required total assistance for eating, drinking, and toileting needs. Review of Resident #5 "Nutrition Risk Assessment," dated 03/09/10, identified a diagnoses of chronic constipation and required 1850 cubic centimeters (cc) of fluids daily. Supplements/snacks offered daily included Plus 2 (a nutritional supplement) 120 cc three times a day (tid) and Arginaid (a nutritional supplement to aid wound healing) 120 cc tid. The assessment failed to identify the resident's daily fluid consumption. Resident #5's nutritional assessment identified a problem of constipation however, no nutritional interventions were planned and implemented to assist the resident with bowel elimination. Review of Resident #5's current care plan identified the following problems: "Risk for constipation. Contributing factors may be: hx of constipation . . . inadequate intake at times. Approaches: . . . Encourage resident to drink fluids . . ." "Potential for dehydration . . . unable to give self fluids - dependent on staff for all foods/fluids - may not open his mouth when offered fluids and fluids at times [sic] . . . Interventions: . . . Watch for s/s [signs and symptoms] dehydration . . . Offer fluids of his liking . . . Be patient when feeding resident and attempt to get his fluids to him at meals and in between meals as best as	F 309		

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F 309	Continued From page 12 possible . . ." Review of Resident #5's bowel records from June 2010 to October 26, 2010, identified the following dates without a bowel movement: * June 19, 20, and 21 - no PRN medications administered. * June 30, July 1, 2, 3, and 4 - no PRN medications administered. * July 16, 17, and 18 - the resident received two Dulcolax suppositories on the 19th at 4:00 a.m. and 2:00 p.m. resulting in a bowel movement. * July 22, 23, and 24 - no PRN medications administered. * August 23, 24, and 25 - no PRN medications administered. * September 18, 19, 20, and 21 - the resident received a Dulcolax suppository on the 22nd. Observation of personal cares provided to Resident #5 occurred at the following times: * 10/25/10 at 3:40 p.m. * 10/26/10 at 6:45 a.m., 9:15 a.m., 11:00 a.m., and 1:20 p.m. Observation showed an unopened Thick & Easy Hydrolyte (thickened water) on the night stand next to the bed and the CNAs (#4, #5, #6, #7, #8, and #9) failed to offer fluids. On 10/26/10 at 4:20 p.m., observation showed Resident #5 in bed and two unopened containers of Thick & Easy Hydrolyte on the night stand. During an interview on 10/27/10 at 12:30 p.m., an administrative nurse (#1) stated he expected facility staff to offer fluids to residents during cares. Facility staff failed to offer Resident #5 fluids during cares, failed to administer a less invasive	F 309		

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F 309	Continued From page 13	F 309		

intervention, such as MOM, before a suppository, and failed to implement dietary interventions to assist with bowel elimination.

- Review of Resident #7's medical record occurred on October 26-27, 2010. Diagnoses included intestinal obstruction and generalized abdominal pain. Medications included Miralax (a laxative) 17 gms (grams) daily, Exelon (which is used to treat dementia) 9.5 mg (milligrams) daily, Cymbalta (an antidepressant) 60 mg daily, and Xanax (an anxiolytic) 0.25 mg twice a day. A side effect of Exelon, Cymbalta, and Xanax is constipation.

Resident #7's current care plan identified the problem: "risk of constipation." This undated care plan stated, ". . . GOAL/DATE. . . Will have BM every three days on on-going basis . . . APPROACHES . . . 2. Monitor BM's and give laxatives or enemas as ordered or needed and special juices if ordered. . . . 8. See MAR for meds [medications] for constipation . . ."

Review of Resident #7's bowel records showed from June 29 through July 3, 2010, the resident did not have a bowel movement. Resident #7's PRN MAR for this time frame indicated facility staff failed to administer any medications for constipation during the five-day period. Documentation in the nurses' notes failed address the episode of constipation or any interventions attempted by staff.

Failure of facility staff to monitor bowel movements and implement interventions, including hydration and dietary, according to facility policy and protocol resulted in no bowel movements for three to seven days for Residents

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F 309	Continued From page 14 #1, #5, and #7.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 09/10/09 AND 04/08/10. Based on observation, record review, review of manufacturer instructions, and staff interview, the facility failed to provide safe transfers for 1 of 2 residents (Resident #8) requiring assistance with a mechanical lift (Vander-lift II lift). Failure of facility staff to utilize the mechanical in a safe and appropriate manner has the potential to result in injury to the resident. Findings include: - Review of the Vander-lift II Model B450 Operation Manual occurred on 10/27/10. The manual, dated 01/2000, stated, ". . . Patient Assessment Criteria for Vander-lift Transfers: . . . The Patient must have no injuries or medical conditions that might be aggravated by the Vander-lift transfer procedure . . . Criteria for the Two Methods of Connecting the Uni-fit sling to the Vander-lift II: Method One: Crossed Loop	F 323	1) On-the-spot education of nursing staff regarding proper application of sling for Vander-lift II for resident #8 was completed on October 28, 2010. Care plan updates were made to all residents who require the Vander-lift II for the facility's acceptance of the proper application of the full body lift slings on 11-17-10. It has been determined by this facility that application of the Vander II full body lift slings will be applied using the "between the legs" and "criss/cross" application method. 2) All residents who require the full body lift have the potential to be affected. 3) Education of all nursing staff regarding proper use of all mechanical lifts and slings used in this facility will be completed on December 2, 2010. All nursing staff will be required to complete a return competency evaluation with the Education/QA nurse by December 24, 2010. 4) Charge Nurse will monitor the proper application of slings used for transfer lifts daily. The Unit Manager will audit all residents requiring the Vander-lift sling 3 times weekly until 100% compliance is achieved, then PRN. QA nurse will audit all residents who require the Vander-lift sling bi-weekly until 100% compliance is achieved, then PRN. DON will audit as needed. Unit manager and QA nurse will report documentation discrepancies to the DON for further investigation. Completion date: December 24, 2010.	

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Connection . . . Method Two: Crossed Leg Support Connection - Cross one leg support under both of the patient's legs then cross the other leg support under both of the patient's legs. . . . To transfer the patient in a lying position, connect the farthest shoulder loop from the sling and the closest leg loop to the sling to the hanger bar hooks. . . ." The photographs of sling placement on an individual in the manual showed Method Two (Crossed Leg Support Connection) with the distal leg support straps behind the legs near the bend of the knees. The instructional video, "Vander-Lift II", provided by the facility, also showed Method Two with the distal leg support straps behind the individual's legs at the bend of the knee area.

Review of Resident #8's medical record occurred 10/27/10. The resident's diagnoses included Multiple Sclerosis (MS), paraplegia, muscle spasms, and pain. Current medications included Percocet, MS Contin, and Acetaminophen for pain and Baclofen, a muscle relaxant. The Minimum Data Set (MDS), dated 07/26/10, indicated short term memory problems, moderate independence with decision making and no problems making self understood or understanding others. The MDS also indicated the resident required total assistance of one to two staff for all activities of daily living.

Observation on 10/27/10 at 8:20 am, showed two Certified Nursing Assistants (CNAs) (#6 and #10) assisted Resident #8 with transfer from a wheelchair to the bed by use of a Vander-lift II total lift. The CNAs connected the sling loops to the lift and proceeded to transfer the resident into the bed. The lower sling straps were crossed behind the resident at the lower buttock level, not

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F 323	Continued From page 16 across the back of the resident's legs as stated in the instructions. Observation on 10/27/10 at 10:45 a.m. showed two CNAs (#6 and #10) transferred the resident from the bed to the wheelchair using the total lift. The CNAs crossed the lower sling straps beneath the resident below her buttocks and connected the sling to the lift at the most distal loops. Resident #8 remained rigid during the transfer and unable to bend at the hips and knees. Upon lowering the resident into the wheelchair, she began sliding down through the bottom opening in the sling. Observation showed the leg straps of the sling up around the resident's hips. The resident stated, "I'm slipping! I'm slipping!" The CNAs quickly raised the lift, encouraged Resident #8 to bend at the knees, manually assisted her to bend at the knees, and lowered her into the chair. The CNAs (#6 and #10) failed to cross the sling straps across the back of the resident's legs as stated in the instructions. Observation on 10/27/10 at 1:15 p.m. showed two CNAs (#6 and #8) transferred Resident #8 from the wheelchair into the bed using the Vander-lift II. The CNAs crossed the sling straps around the resident's lower buttock, attached the sling to the lift, and transferred the resident to bed. Again, the CNAs failed to cross the sling straps behind the resident's legs as stated in the instructions. An interview with two CNAs (#6 and #8) occurred at 1:22 p.m. following the 1:15 p.m. transfer with Resident #8. When asked how to position the distal leg straps for Resident #8, the CNAs explained and showed the crossing of the leg straps and placement immediately below the buttocks.	F 323		

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F 323	Continued From page 17 The facility staff failed to properly utilized the Vander-lift according the the manufacturer instructions and placed Resident #8 at risk for injury.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility staff failed to provide fluids to ensure sufficient intake for 2 of 2 sampled residents (Resident #5 and #8) dependent on staff for their hydration needs. Failure to offer fluids placed these residents at risk of dehydration and constipation. Findings include: Review of the facility policy titled "Hydration" occurred on 10/27/10. This policy, dated 2007, stated, "POLICY: Ensure adequate fluid intake of the resident. PROCEDURE: . . . 2. Encourage fluids with cares . . . 5. Assist dependent residents with fluids." - Review of Resident #5's medical record occurred on all days of survey. Medical diagnoses included senile dementia and chronic constipation. Scheduled medications included Senokot S (an over the counter medication used to aid in bowel elimination) - two tablets daily.	F 327	1) Education of nursing staff provided by DON regarding providing proper fluids (at least 8 ounces of free water per shift in addition to regular meals and snacks) for resident #5 and #8 was completed on 11-8-10. DON also informed nursing staff that fluids need to be encouraged to all residents with cares. Residents who need assistance for most or all meals have been indentified for increased risk for dehydration from the ADL charting, dining room monitoring, and MDS 2.0/3.0 system. Education will be provided to all nursing staff regarding providing increased fluid intake (8 oz. free water/shift) on those residents who have been indentified to be at increased risk for dehydration/hydration. Formal education will be provided on December 2, 2010. Education will be provided by the Education/QA nurse and the DON. The policy "Resident Hydration and Prevention of Dehydration" was reviewed and revised on 11-2-10 and education will be provided to staff on December 2, 2010. Resident #5 and #8 have been placed on Intake/Output for closer monitoring of resident's hydration status. 2) All residents have the potential to be affected. 3) Education will be provided to all nursing staff regarding providing proper fluids on December 2, 2010. Education will be provided by the Education/QA nurse and the DON. The policy "Resident Hydration and Prevention of Dehydration" was reviewed and revised on 11-2-10 and education will be provided to staff on December 2, 2010. 4) Charge Nurse will monitor adequate hydration of residents daily. The Unit Manager will audit 10%	

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F 327	Continued From page 18 Review of Resident #5's quarterly Minimum Data Set (MDS), dated 09/14/10, identified long and short term memory difficulties, severely impaired in making daily decisions, rarely understands others or makes himself understood, and required total assistance for eating/drinking. Review of the "Nutrition Risk Assessment," dated 03/09/10, identified Resident #5 required 1850 cubic centimeters (cc) of fluids daily and supplements/snacks offered daily included Plus 2 (a nutritional supplement) 120 cc three times a day (tid) and Arginaid (a nutritional supplement to aid wound healing) 120 cc tid. The assessment failed to identify the resident's daily fluid consumption. Review of Resident #5's current care plan identified the following problems: "Risk for constipation. Contributing factors may be: hx [history] of constipation . . . inadequate intake at times. Approaches: . . . Encourage resident to drink fluids . . ." "Potential for dehydration . . . unable to give self fluids - dependent on staff for all foods/fluids - may not open his mouth when offered fluids and fluids at times [sic] . . . Interventions: . . . Watch for s/s [signs and symptoms] dehydration . . . Offer fluids of his liking . . . Be patient when feeding resident and attempt to get his fluids to him at meals and in between meals as best as possible . . ." Observation of personal cares provided to Resident #5 occurred at the following times: * 10/25/10 at 3:40 p.m. * 10/26/10 at 6:45 a.m., 9:15 a.m., 11:00 a.m., and 1:20 p.m. Observation showed an unopened Thick & Easy	F 327	of residents for adequate hydration 3 times weekly until 100% compliance is achieved, then PRN. QA nurse will audit 10% of residents bi-weekly until 100% compliance is achieved, then PRN. DON will audit as needed. Unit manager and QA nurse will report documentation discrepancies to the DON for further investigation. 5) Completion date: December 24, 2010.	

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Hydrolyte (thickened water) on the night stand next to the bed and the CNAs (#4, #5, #6, #7, #8, and #9) failed to offer fluids. On 10/26/10 at 4:20 p.m., observation showed Resident #5 in bed and two unopened containers of Thick & Easy Hydrolyte on the night stand.

During an interview on 10/27/10 at 12:30 p.m., an administrative nurse (#1) stated he expected facility staff to offer fluids to residents during cares.

- Review of Resident #8's medical record occurred on 10/27/10. Medical diagnoses included Multiple Sclerosis, paraplegia, muscle spasms, and pain. Scheduled medications included MS Contin (for pain), Baclofen (for muscle spasms/pain), Senna S (an over the counter medication used to aid in bowel elimination), and Percocet (for pain) as needed.

Review of Resident #8's MDS, dated 07/19/10, identified the resident required total assistance for eating/drinking.

Review of Resident #8's current care plan identified the following problems: "Risk for constipation . . . risk for dehydration . . ." The care plan indicated total dependance upon staff for all fluid intake. Goals included maintenance of adequate hydration without signs of dehydration. Interventions included encouragement of fluid intake and offering of fluids by staff.

Observations of Resident #8 showed the following:
* 10/27/10 at 8:20 am - Two CNAs (#6 and #10) transferred the resident from her wheelchair to her bed. Observation showed a large cup

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F 327	Continued From page 20 containing water on the bedside table. The CNAs failed to offer Resident #8 fluids. * 10/27/10 at 9:42 am - A CNA (#11) entered the resident's room and assisted the resident with her audio tape. The CNA failed to offer the resident fluids. * 10/27/10 at 10:45 am - Two CNAs (#6 and #10) transferred Resident #8 from her bed to a wheelchair. The CNAs failed to offer the resident fluids. Facility staff failed to offer fluids to Resident #5 and #8 as identified in the facility's policy and procedure and in each resident's care plan. Failure to provide fluids to residents who cannot access fluids independently places the residents at risk for dehydration and constipation.	F 327		
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	F 329	1) Resident #2 will have review of medications noted in citation by Rose Bergquist, PA on 11-9-10. 2) All residents have the potential to be affected. 3) The Pharmacy Consultant will review all medical records for appropriate diagnosis of all medications. This will be done through the medication regimen review process. If discrepancies are noted, orders will be obtained by DON or designee for proper diagnosis to match medications. If there are discrepancies, the physician order sheet for that month will be updated in the computer system and a new updated physician order sheet will be printed. If there are discrepancies noted and a new physician order has to be printed, the diagnosis of medications will be re-reviewed for accuracy by the pharmacist consultant at the time of the next regimen review. Pharmacy consultant will also maintain recommendations for dose reduction of all federally mandated medications that require reductions. Education to nursing staff will be provided on adequate documentation related to mood and behavior and the use of antipsychotic	

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F 329	Continued From page 21 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 09/10/09 AND 04/08/10. Based on observation, record review, review of professional reference, and resident interview, the facility failed to ensure a drug regimen free from unnecessary drugs for 1 of 1 sampled residents (Resident #2) receiving an antipsychotic without an adequate indication for its use. The initiation and continuation of an antipsychotic medication without adequate indication and monitoring may result in residents receiving an unnecessary drug, experiencing adverse consequences related to its use, and failing to achieve their highest level of well-being. Findings include: The Nursing 2009 Drug Handbook, 29th Edition, pp. 669-670, identified indications for the use of Seroquel included schizophrenia, short-term treatment of acute manic episodes associated with bipolar I disorder, and depression associated with bipolar disorder. Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included depressive disorder and anxiety state. Current medications included scheduled and prn (as	F 329	medications. Education will be provided by Education/QA and DON at next nursing staff meeting on 12/02/2010. This will be done to help necessitate the use of the drug. 4) Audit will be completed by Pharmacy Consultant through dug regimen review monthly. 5) Completion date: December 24, 2010.	

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F 329	Continued From page 22 needed) Xanax (an anxiolytic), Remeron (an antidepressant), Celexa (an antidepressant), and Seroquel (an antipsychotic with dizziness, somnolence, seizures, and orthostatic hypotension as possible adverse reactions) 100 mg at 6:00 a.m. and 11:00 a.m. and 200 mg every night at bedtime. The current physician's orders identified Seroquel used for "anxiety." The health care provider ordered prn Xanax on 09/21/10. Review of Resident #2's medication administration record (MAR) identified no administration of prn Xanax. Resident #2's current Minimum Data Set (MDS), dated 08/16/10, identified no long term or short term memory impairments, independent with decision making, and able to make herself understood and understand others. Review of Resident #2's MDS regarding mood and behavior patterns revealed the following: * 08/16/10 (Annual): No mood or behavior patterns identified * 05/19/10 (Quarterly): No mood or behavior patterns identified * 02/24/10 (Quarterly): No mood or behavior patterns identified * 11/19/09 (Quarterly): No mood or behavior patterns identified * 10/05/09 (Quarterly): No mood or behavior patterns identified Resident #2's medical record contained documents completed by certified nursing assistants (CNAs) titled, "CNA Daily Documentation" on which CNAs chart (on each of the three shifts) any mood or behavior pattern exhibited by the resident. Review of the CNA documentation since initiation in February 2010 through October 26, 2010 revealed the following:	F 329		

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F 329	Continued From page 23 *February: One episode of verbally abusive and socially disruptive behavior on February 27th. *March: No mood or behavior patterns documented *April: One episode of persistent anger with self/others, repeated criticism of staff, and unpleasant mood in the morning documented on April 25th. * May: One episode of persistent anger with self/others, repeated criticism of staff, verbally abusive, and resisting cares identified on May 6th. *June: No mood or behavior patterns documented *July: One episode of repeated criticism of staff on July 1st, one episode of repeated criticism of staff and crying/tearfulness on July 2nd and July 3rd, and one episode of repeated anxious complaints and verbal abuse on July 11th. *August: No mood or behavior patterns documented. *September: No mood or behavior patterns documented. *October: No mood or behavior patterns documented. *According to the above charting, mood or behavior patterns occurred on only 7 days of the nearly nine months reviewed. Review of Resident #2's Interdisciplinary Notes (all written by nurses) from October 2009 through October 26, 2010 revealed the following: * 10/23/09: ". . . Earlier resident very impatient r/t [related to] anxiety. Asking for Xanax to be scheduled around the clock today. I am leaving a note for [provider name]." * 11/05/09: ". . . Resident reported to CN [charge nurse] that res. [resident] [not] sleeping well @ noc [night]. . . . Order to [increase] remeron to 60 mg @ HS [bedtime]. . . ."	F 329		

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F 329	Continued From page 24 * 11/29/09: ". . . Shows [decreased] anxiety since [provider name] started res. on clonazepam 11-12-09. . . ." * 12/15/09: ". . . Pleased [with] the use of prn Xanax on only 3 days in past 2 weeks - marked decrease in use of Xanax . . ." * 01/19/10: "L.E. [late entry] reviewed @ mental H. [health] mtg [meeting] - no prn Xanax in past 2 weeks - will D/C [discontinue] prn [and] routine Xanax . . ." * During this time frame, the use of Xanax (an anxiolytic) decreased with the increased use of Seroquel (an antipsychotic). The dose of Seroquel increased from 50 mg tid (three times a day) in September 2009, to 100 mg tid (exact date unknown), to a 400 mg total daily dose in October 2009. The dose remained at 400 mg total until a reduction attempt in June 2010. * 01/21/10: ". . . Resident requests a prn Xanax for c/o's [complaints of] being so anxious. Resident informed that prn meds [medications] was [sic] D/C'd. Became upset. Phone call made to [provider name] . . . message left on cell phone re: [regarding] resident wishes for it to be resummed [sic] . . ." * 01/22/10: ". . . Resident informed of [increased] dosage of Clonazepam . . . tells nurse that she has always been on Xanax and that [provider name] doesn't know what works for her." * 02/05/10: ". . . Res. very demanding this eve [evening]. Res. kept req. [requesting] 'a pill to calm me down'. Asked Res. to slow her breathing down. States people are always telling me to do that. . . ." * 02/13/10: ". . . Resident very upset [et] agitated. Wanting a bath now. . . . Says I am tired of waiting. . . ." * 03/09/10: ". . . [No] [increased] agitation or	F 329		

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F 329	Continued From page 25 anxiety noted. . . ." * 03/11/10: ". . . Is cheerful [and] cooperative [with] staff. [No] behaviors. . . ." * 04/08/10: ". . . periods of mild anxiety noted, redirection [and] activities decrease anxiety, cooperative [with] staff. . . ." * 05/06/10: ". . . Resident agitated. Wanted a specific aide to put her to bed right now. . . ." * 06/22/10: ". . . [Provider name] here . . . orders received to [decrease] Seroquel 75 mg [every] 6A [6:00 a.m.] [and] 11 a.m. Continue [with] Seroquel 200 mg po [by mouth] [every] HS [hours slept] . . ." * 08/08/10: ". . . Res shows [no] s/s [signs and symptoms] of anxiety . . ." * 08/11/10: ". . . [No] [increase] in anxiety noted. . . ." * 08/21/10 at 2:30 a.m.: ". . . Res. very anxious [and] wanted up [sic] and dressed. Could [not] explain why she was 'nervous' . . . Res. calmed down [and] rested for [one] hr. [hour] then got anxious again waiting for 0600 Xanax that she asked for by name. . . ." * 08/21/10 at 10:20 p.m.: ". . . [increased] anxiety noted, can't sit still, attempting to transfer self . . ." * 08/23/10: ". . . No s/s of anxiety today. . . ." * 08/26/10: ". . . appt. [appointment] [with] [provider name], return [with] n.o. [new order] for [different provider name] to eval [evaluate] for [decrease] Seroquel . . ." * 09/01/10: ". . . noted a little anxiety when spoken too [sic] . . . does voice she feels tired all the time . . ." * 09/21/10: ". . . [provider name] here; visited [and] assessed resident re: [increased] anxiety. . . ." * 10/08/10: ". . . can have [increased] anxiety at times if things or concerns aren't dealt [with] right away. Resident becomes agitated [and] verbally	F 329		

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F 329	Continued From page 26 abusive to staff . . ." * Of the above interdisciplinary notes reviewed, staff documented 12 occasions of resident anxiety/making demands of staff. These notes failed to identify other instances of resident mood or behavior patterns, and failed to show an increase in these mood or behavior patterns with the dose reductions in Seroquel. Review of Resident #2's Healthcare Provider Notes revealed the following: * 09/15/09 (Provider #2): ". . . [Resident name] anxiety has improved since she receives Xanax 0.5 mg every a.m. on a scheduled basis . . . She is also on . . . Seroquel 50 mg t.i.d. . . ." * 10/08/09 (Provider #1): ". . . I need to talk to [Provider #2] regarding whether she needs all these drugs and see if we can do a dose reduction on the Seroquel. . . ." * 10/27/09 (Provider #2): ". . . [Resident name] tells me today that her anxiety is just awful . . . She wants me to order Xanax around the clock . . . She says that is the only thing that helps. She is getting Xanax twice a day. [0.5 mg per dose]. She is also on Seroquel 100 mg t.i.d. She was started on the Seroquel when she was hospitalized at [hospital name] for her fractured right knee. . . . At this time she is not complaining of any pain. [Resident name] feels that it is more her anxiety that she is dealing with. . . . Continue . . . Xanax 0.5 mg b.i.d. [twice a day] and then the p.r.n. order. Increase Seroquel to 100 mg b.i.d. and then 200 mg q.h.s. [sic] . . ." It is unclear from the medical record when Resident #2's Seroquel dose increased from 50 mg t.i.d. to 100 mg t.i.d. and the indication for the increase. * 12/10/09 (Provider #1): ". . . I think she needs mostly all of these medicines. I am not sure about the two different antidepressants in addition to the	F 329		

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F 329	Continued From page 27 Seroquel. . . ." * 01/20/10 (Provider #2): ". . . [Resident name] states that she feels she is taking too many medications at this time. She is concerned about her medication bill. . . . Also, her anxiousness has improved since she has been on the clonazepam. . . . we could try discontinuing the scheduled Xanax and the p.r.n. Xanax, and then if she did have an increase in her anxiety, we could maybe increase her clonazepam. . . ." * 02/02/10 (Provider #2): ". . . [Resident name] is upset since the Xanax has been discontinued. . . . She feels the clonazepam is not working as well and she is requesting to be put back on Xanax. . . . She states that she feels that she does not need all of this medication. She did have more anxiety once the Xanax was discontinued but she really feels strongly that the Xanax helps her more than anything. . . . We will restart her Xanax 0.5 mg every 6 hours . . . No p.r.n. Xanax was ordered. . . ." * 04/08/10 (Provider #1): ". . . She does not really voice any depressive symptoms. She is not particularly anxious as she had been in the clinic when I saw her last time. . . ." * 06/22/10 (Provider #2): ". . . [Resident name] states that overall she is doing fairly well. . . . She states that she still has anxiety. The nursing staff reports that she appears to be comfortable that [sic] she is not restless or easily irritated. . . . Seroquel 200 mg at bedtime with a decrease her [sic] other two doses of Seroquel to 75 mg . . ." * 08/10/10 (Provider #2): ". . . I did change her Seroquel to 100 mg q.a.m. [sic] [every morning] and 200 mg q.h.s. [sic] [every night at bedtime] . . ." * 08/17/10 (Provider #2): ". . . She always feels that her anxiety is worse than it has ever been but then when I asked her directly if she thinks it was	F 329		

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worse than the last week, she said, no, it was not. . . . She is aware that she had a medication reduction a week ago and she feels that her anxiety is about the same as it was then. . . ."
* 08/26/10 (Provider #1): ". . . I am concerned about her being on all of these psychotropics and she is on a large dose of Seroquel, Remeron, and Celexa. I will consult [Provider #2] about trying to get her off some of these which does pose a risk for falling. . . ." The record showed Resident #2 experienced falls on 01/20/10, 08/09/10, 08/19/10, and 08/20/10.
* 08/31/10 (Provider #2): ". . . She did make her usual statements about not wanting to wake up and that she was experiencing some anxiety. . . . We will split her Seroquel 100 mg into 50 mg at 6:00 a.m. and 11:00 a.m. and continue with Seroquel 200 mg at bedtime . . ."
* 09/21/10 (Provider #2): ". . . We have been trying to cut back on . . . her Seroquel . . . and since we have done that she has just progressively been having an increase in anxiety. . . . We will increase the Seroquel to 100 mg every 6 a.m. and 11 a.m. along with 200 mg at bedtime. I have also left a p.r.n. order for Xanax 0.5 mg one tablet daily p.r.n. . . ."

Although a provider attempted dose reductions starting in June 2010, the interdisciplinary notes and CNA charting failed to indicate an increase in anxiety or depressive symptoms, as was stated in the September 2010 provider note and which resulted in an increased dose of Seroquel.

Resident #2's medical record contained a progress note from a psychiatrist dated November 12, 2009. The note stated, in part, ". . . She is extremely anxious. . . . I did not see any evidence of psychosis. . . . At this time I would

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F 329	Continued From page 29 continue her Seroquel 100 mg b.i.d. . . . I will try to be available to assist as needed. . . ." Although the note indicated a total dose of Seroquel at 200 mg/day, the record shows at this time the total dose was actually 400 mg/day. The medical record lacked evidence of facility contact with the psychiatrist regarding Resident #2's medications/mental state or of visits with the psychiatrist since November 2009. Observations of Resident #2 occurred throughout the survey and revealed the following: *10/25/10 at 1:25 p.m.: Asleep in bed *10/25/10 at 3:45 p.m.: Transferred self to recliner in TV area. Dozed on and off until 4:27 p.m. when she took herself to the bathroom. *10/26/10 at 6:52 a.m.: Asleep in recliner in TV area. *10/26/10 at 8:15 a.m.: Transferred self to recliner after breakfast. Fell asleep in recliner. *10/26/10 at 9:55 a.m.: Asleep in bed *10/26/10 at 1:30 p.m.: Asleep in bed *10/26/10 at 4:30 p.m.: Asleep in recliner in TV area *10/27/10 at 6:50 a.m.: Asleep in recliner in TV area *10/27/10 at 8:30 a.m.: Asleep in recliner in TV area *10/27/10 at 10:00 a.m.: Asleep in bed *10/27/10 at 12:10 p.m.: Transferred self to recliner after lunch. Fell asleep in recliner *10/27/10 at 1:30 p.m.: Asleep in recliner in TV area During an interview on 10/27/10 at 9:00 a.m., Resident #2 stated the following: * "I eat and sleep and that's about it." * "I feel like I'm taking so much medicine and I don't know what they're all for."	F 329		

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F 329	Continued From page 30 * "They change my medications all the time." * "I wonder if they can take some of it [the medication] away." * "Xanax used to help so much. I never feel like I get any relief from the other ones." * She has no one to talk to. * Health care provider visits "are kind of rushed." * She did not know she was taking Seroquel and didn't know what it was for. * She does not want to request the prn Xanax because "I'm already taking so many medications." * "I wonder if I can just have Xanax." * She is concerned about the monthly cost of all her medications. The use of Seroquel without an appropriate indication and without adequate justification for its continued use may have resulted in Resident #2 receiving an unnecessary medication.	F 329		