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 _____	10/29/2015

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 10/26/15 and completed on 10/29/15, the sample included 2 residents for complete review, 9 residents for focused review, and one closed record for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
F 226	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to implement policies regarding abuse/neglect and failed to report 3 of 3 abuse allegations to the State Agency (SA) within 24 hours and report the results of the investigation to the SA within 5 working days. Failure to implement the facility's written abuse/neglect policies and procedures may have contributed to the delay in reporting to the SA and placed all residents at risk without protective measures from abuse and neglect. Findings include: Review of the facility policy titled, "ACCIDENTS AND INCIDENTS INVESTIGATING & REPORTING" occurred on October 29, 2015. This policy, dated 09/01/11, stated, ". . .	F 226	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal Law. F226 1. Corrective action for Residents Found to Be affected by this Deficiency: All required reports of abuse/neglect to the State agency for the 10/06/2015, 02/23/2015, and 03/08/2015 incidents	12/7/15

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

Electronically Signed | 11/22/2015

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F 226	Continued From page 1 Reporting/Recording All Allegations of Abuse, Neglect, Misappropriation of Resident Property, Suspicion of Criminal Activity, and Unexplained Injuries . . . Policy Interpretation and Implementation . . . 2. . . . b. . . . if the event that cause reasonable suspicion does not result in serious bodily injury to a resident, , [sic] law enforcement is involved or not, the event needs to be reported within 24 hour after forming the suspicion to the ND Dept [department] of Health. c. Final report by the Administrator or Designee will be completed and submitted to the ND Dept of Health within 5 days of the incident being reported. . . ." Review of the facility's investigation file revealed the following: * Incident occurred on 10/06/14 and the facility reported the incident and results of the investigation to the SA on 10/09/15. * Incident occurred on 02/23/15 and the facility reported the incident to the SA on 02/25/15 and reported the results of the investigation to the SA on 03/03/15. * Incident occurred on 03/08/15 and the facility reported the incident and results of the investigation to the SA on 03/10/15. During an interview on 10/28/15 at 3:00 p.m. an administrative nurse (#2) stated all three investigations were not reported to the SA within 24 hours.	F 226	have been completed to the extent practicable. 2. Corrective Action for Residents that May be Affected by this Deficiency: All Residents have the potential to be affected by this deficiency. To ensure timely reporting of future abuse/neglect allegations, the Administrator has been designated as the abuse reporting coordinator and all abuse/neglect must be immediately reported to the Administrator. The Administrator or designee is then responsible to ensure all allegations of suspicion of abuse are reported to the State agency in the allotted time set for by the State agency. 3. Corrective Measures Put Into Place to Ensure this Deficiency will not Recur: All facility staff, including the Administrator, DON, the facility QA and the SSD were in-serviced on the facility policy and procedures to report abuse/neglect to the state agency, including the requirement to report all allegations and suspicion of abuse/neglect within 24 hours of each incident, and then filling a report of the results of any subsequent investigations to the state agency within 5 working days. The in-service for this deficiency will be	

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F 226	Continued From page 2	F 226	conducted on 11/23/2015. The Administrator or his designee will conduct weekly audits for alleged abuse/neglect M-F. The charge nurse will conduct the audits on the weekends and place the audit report to the Administrator in his mailbox. This will be done weekly for one month then quarterly for 1 year post survey. 4. Measures to be Implemented to Monitor the Plan of Correction All suspected abuse/neglect will be reviewed in the morning staff meeting to ensure timely reporting to the state agency and facility compliance with all facility policies and procedures. The Administrator or designee will report the results of the daily audits to the Quality Assurance Committee quarterly. QA weekly for one month and then quarterly for 1 year post survey conducted by the Administrator or his designee. 5. Expected Date of Compliance for this Deficiency The expected date of compliance for this deficiency is December 7th, 2015.	
F 250	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social	F 250		12/7/15

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F 250	Continued From page 3 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 record review, review of facility policy, and staff interview, the facility failed to assess specific socially inappropriate behaviors exhibited, develop and implement individulized approaches/interventions, and monitor the effectiveness for 1 of 6 sampled residents (Resident #7) who exhibited behaviors. Failure to adequately assess, specific socially inappropriate behaviors and respond appropriately placed Resident #7 and others in situations of potential harm. Findings include: Review of the facility policy titled "Behavior Assessment and Monitoring" occurred on 10/29/15. This policy, revised 09/09/15, stated, " . . . 1. Problematic behavior will be identified and managed appropriately. . . . Assessment: . . . 2. the nursing staff will identify, document, and inform the physician and/or PA [physician assistant] Psychiatric Clinical Nurse Specialist [CNS] about an individual's mental status, behavior, and cognition, including: a. Onset, duration and frequency of problematic behaviors or changes in behaviors, cognition, or mood . . . Monitoring: . . . 2. the staff will document (in nursing notes and/or on behavior/mood documentation forms) . . . "	F 250	F250 1. Corrective action for Residents Found to be Affected by this Deficiency: The care plan and social services documentation for Resident #7 has been revised to reflect the specific interventions and plan of care to address the resident's behavior issues, wandering tendencies, and inappropriate sexual interactions with other residents. Social services staff is to be notified immediately of all assessments and recommendations made by the resident's physician or physician assistant, as well as other mental health professionals, concerning the resident's behavioral issues and treatment. The social services staff will be included in all behavioral meetings concerning resident #7. The social worker reviewed and updated the social services progress notes and documentation to verify the accuracy of the resident's plan of care and to ensure the plan of care addresses the resident's specific behavioral issues.	

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F 250	Continued From page 4 Review of Resident #7's medical record occurred on all days of survey. Diagnoses included anxiety, major depressive disorder, dementia with behavioral disturbance, and Alzheimer's disease. Review of a quarterly Minimum Data Set (MDS), dated 10/10/15, identified severely impaired cognition, physical behaviors and wandering occurred one to three days in the assessment period, and independent with transfers, walking and bed mobility. Resident #7's medical record identified the following: * A progress note from the PA, CNS, dated 08/19/15, stated, "[Resident #7] is seen in follow-up to her Alzheimer's dementia with behaviors and depression. [Resident #7] has had a couple of incidences where she was sexually inappropriate. We discussed these situations. . . . it was decided to continue with interventions and she is easily distracted or redirected and just monitor the sexual inappropriateness at this time. . . . She is not aggressive. . . . I am not aware of any interactions with other residents. Her case was discussed at the behavioral meeting. . . ." * An Interdisciplinary Note, dated 10/21/15, stated, "Reviewed behaviors. Resident has been following male visitors [and] touches their faces. Staff has interceded each time and redirected resident each time. She is monitored [with] all visitors. This has been reported to her Dr. [doctor]. Reviewed careplan [and] updated." Review of Resident #7's current care plan failed to identify a problem area related to the above documentation. Review of the behavioral meeting notes failed to	F 250	2. Corrective Action for Residents that May be Affected by this Deficiency: The medical chart, behavioral assessments, intervention recommendations, and care plans for all residents with identified behavioral issues were reviewed to ensure that the documentation was complete and accurate. 3. Corrective Measures Put into place to ensure this deficiency will Not Recur: The social services designee and nursing staff were in-serviced on the facility Behavior Assessment and Monitoring Policy regarding the assessment, documentation and implementation of interventions to address identified resident behavioral issues. The Social Services staff will be informed of and included in all interdisciplinary meetings concerning resident behaviors. The in-service for this deficiency will be on 12/03/2015. The QA for this deficiency will start on 10/30/2015 and will occur for one month post survey and continue quarterly for one year post survey. 4. Measures to be implemented to Monitor the Plan of Correction The Social Services Director/Designee	

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F 250	Continued From page 5 identify any specifics or interventions regarding Resident #7's behavior. During an interview the morning of 10/29/15, a social services staff member (#3), stated, "[Resident #7] will ask if 'that person is married' and has randomly touched peoples shoulders or patted their face." The surveyor provided documentation written by the PA CNS and a staff nurse. The staff member (#3) lacked awareness these behaviors had been a problem or could be a problem. The facility failed to provide medically-related social services to address behaviors and determine a plan of care for Resident #7. Failure to document and/or track and trend the type of behaviors observed has the potential to effect Resident #7's psychosocial functioning/well-being.	F 250	will conduct weekly audit all medical charts for residents with identified behavioral issues to ensure that all documented assessments and interventions noted by the resident's physician and other health care professionals are accurately reflected in the plan of care and are being implemented and communicated to the nursing staff and other health care professionals involved in their care. The social services director/designee will report to the QA committee quarterly the results of the weekly chart audits for residents with identified behavioral issues. 5. Expected Date of Compliance for this Deficiency The expected date of compliance regarding this deficiency is December 7th, 2015.	
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278		12/7/15

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F 278	Continued From page 6 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.13), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 5 of 11 sampled residents (Resident #1, #3, #4, #6, and #8). Failure to accurately code the reason for an assessment (A0310A) as a significant change (Resident #1 and #4), and failure to accurately code verbal behaviors (E0200B) (Resident #3), turning/repositioning program (M1200C) (Resident #6), and wandering (E0900) (Resident #8) does not allow each resident's assessment to reflect the resident's current status/needs, and may affect the accuracy of the care plan and the level of care provided to the resident.	F 278	1. Corrective action for Residents Found TO Be Affected by this Deficiency: Resident #1 - The 09/12/2015 MDS for Resident #1 item A0310 was modified from admission to significant change. Resident #3 - The 09/19/2015 MDS for Resident #3 item E0200B verbal behaviors was modified from Behaviors occurring 4 - 6 days to 0 days as no documentation to back up any days for this behavior. Resident #4 - The 09/04/2015 MDS for Resident #4 item A0310A was modified from significant correction to significant change. Resident #6 - The MDS Assessment dated 07/18/2015 Resident #6 did not	

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F 278	Continued From page 7 Findings include: The Long-Term Care Facility RAI 3.0 User's Manual, dated October 2015, stated: * pages 2-18 to 2-19, "The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident . . . if: . . . the resident has been admitted to this facility and was discharged return not anticipated, OR the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. . . ." * page 2-20, "A 'significant change' is a decline or improvement in a resident's status . . . A significant change differs from a significant error because it reflects an actual significant change in the resident's status and NOT incorrect coding of the MDS. . . ." * page E-1, "Section E: BEHAVIOR Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident . . . may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. . . Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. . . ." * page M-38, "Definitions: Turning/Repositioning Program: Includes a consistent program for changing the resident's position and realigning the body. 'Program' is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs."	F 278	need to have any changes. Resident #8 - The MDS Assessment dated 07/14/15 for Resident #8 did not need to have any changes. 2. Corrective Action for Residents that May be Affected by this Deficiency: All residents are potentially affected. The MDS Coordinator and the DON or their designee reviewed the current MDS Assessments sections A, E, and M on Residents #1,#3, #4, #6, and #8, and the medical charts for these residents to identify incorrect assessments. None were identified. 3. Corrective Measures put into place to Ensure this Deficiency Will Not Recur: An MDS Coordinator will have an in-service 12/03/2015 for all staff who are involved in creating the MDS and documentation. The MDS Coordinator will use the current MDS Manual that is available on line and hard copy of the 2015 manual to make sure the MDS's are in compliance with state and federal regulations. The MDS Coordinator will attend the MDS training session provided by the state agency in January, 2016. 4. Measures to Implemented to Monitor the Plan of Correction	

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F 278	Continued From page 8 - Review of Resident #3's medical record occurred on all days of survey. The quarterly MDS, dated 09/19/15, identified verbal behavioral symptoms directed towards others occurred on four to six days, but less than daily. The seven-day lookback period from September 13-19, 2015 identified verbal behaviors on the following three days: 09/15/15 at 9:00 p.m., 09/16/15 at 12:30 p.m., and 09/17/15 (time not listed). Upon request on the afternoon of 10/27/15, an administrative nurse (#1) was unable to provide documentation of additional verbal behaviors. - Review of Resident #4's medical record occurred on all days of survey. Review of a significant change MDS, dated 06/08/15 identified extensive assist of one person for locomotion both on and off the unit and extensive assist of one person with eating. A significant correction to a prior comprehensive MDS, dated 09/04/15, and a quarterly MDS, dated 09/05/15, identified Resident #4 independent with locomotion on and off the unit and independent with setup help only for eating. The facility failed to code the 09/04/15 MDS as a significant change as a result of Resident #4's improvement in three areas. During an interview on the morning of 10/28/15, an administrative nurse (#1) verified the MDSs were coded inaccurately. - Review of Resident #6's medical record occurred on all days of survey. Review of a significant change MDS, dated 07/08/15, identified a turning and repositioning program.	F 278	The MDS Coordinator and the DON, or their designee, will audit the resident MDS , assessments and medical charts weekly for 3 months for coding inaccuracies in Sections A, E and M of the MDS. Will continue to monitor after the 3 months, 3 MDS per quarter for a year post survey. The results of the audits will be reported quarterly to the Quality Assurance Committee. 5. Expected Date of Compliance for this Deficiency The expected date of compliance for this deficiency is December 7, 2015.	

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F 278	Continued From page 9 During an interview on 10/29/15 at 11:30 a.m., an administrative nurse (#2), in regard to a turning and repositioning program, stated, "the schedule we have is every two hours." This does not meet the requirements for a "Turning/Repositioning Program." - Review of Resident #1's medical record occurred on all days of survey. Resident #1's record identified a hospital stay from August 25-31, 2015. The facility completed a "discharge return anticipated" MDS and upon return from the hospital, incorrectly completed an "admission" MDS, dated 09/12/15. During an interview on 10/28/15 at 7:45 a.m. an administrative nurse (#1) stated she coded the MDS, dated 09/12/15, incorrectly as an admission versus a significant change MDS. - Review of Resident #8's medical record occurred on 10/29/15. The quarterly MDS, dated 07/14/15, identified the resident wandered four to six days, but less than daily during the assessment period, and intruded on the privacy or activities of others. Review of the progress notes identified the following: *07/11/15: ". . . Resident does wander about facility. Staff puts resident up to table [with] various activities for her to do which she remains busy with. . . ." *07/12/15: ". . . She was wandering about when in her w/c [wheelchair] today. We gave her a magazine to look at and items to feel et [and] play [with] @ [at] the table which redirected her	F 278		

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F 278	Continued From page 10 wandering. . . ." The medical record lacked evidence Resident #8 wandered four to six days and intruded on the privacy or activities of others.	F 278		
F 323	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: Based on record review, review of facility policy, and staff interview, the facility failed to consistently implement interventions to reduce the risk of elopement for 1 of 2 sampled residents (Resident #7) who wear a wanderguard. Failure to ensure staff implemented interventions correctly and consistently, evaluated the effectiveness of the interventions, and modified the interventions as needed, placed Resident #7 at risk of elopement and possible injury. Findings include: Review of the facility policy titled "Elopements" occurred on 10/29/15. This policy, dated 09/01/2015, stated, ". . . 1. It is the responsibility of all personnel to report any resident attempting to leave the premises . . . 3. Upon return of the resident to the facility . . . a. . . . evaluate for	F 323	F323 1. Corrective action for Residents Found to be Affected by this Deficiency: The care plan and documentation for Resident #7 has been revised to reflect the Resident #7's wandering tendencies. The activities department will help monitor residents location and offer resident activity of choice. The SSD or designee will conduct 1:1 visits M-F and activities will monitor for wandering on the weekends. Section E of the MDS will be completed quarterly for Resident #7 and reviewed quarterly. Wandering policy was revised	12/7/15

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F 323	Continued From page 11 elopement precaution and care plan updated for an electronic mechanism . . ." Review of Resident #7's medical record occurred on all days of survey. Diagnoses included anxiety, dementia with behavioral disturbance, wandering, and Alzheimer's disease. Review of a quarterly Minimum Data Set (MDS), dated 10/10/15, identified severely impaired cognition, physical behaviors and wandering occurred one to three days in the assessment period, and independent with transfers, walking and bed mobility. Resident #7's Interdisciplinary Notes identified the following: * 04/11/15, 3:30 p.m., "Saw this resident at the entrance door. 'I am worried about my niece, she died, I can't even see her' . . ." * 04/12/15, untimed, ". . . Resident ambulates per self [without] devices. She has cognition problems and impaired decision making . . ." * 04/13/15, untimed, ". . . Res [resident] walks the hallways of facility multiple times during the day. . . ." * 04/18/15, 2:30 p.m., "Resident standing by front entrance crying . . ." * 05/05/15, 9:00 p.m., "Resident very anxious this evening she had been observed walking about facility as if looking for something. . . ." * 05/06/15, 8:45 p.m., "Resident wandering et [and] looking like she was looking for someone . . ." * "5/04/15 (Late entry) 1230 [12:30 p.m.] Resident between front door to building and outside door. She was in entryway. Wander guard applied to residents ankle to prevent elopement."	F 323	to include wandering assessment tool. Every staff member who is responsible for creating the MDS for Resident #7 was given a copy of the current RAI Manual with emphasis to review Section E for an increase in behaviors. 2. Corrective Action for Residents that May be Affected by this Deficiency: The behavioral assessments, interventions, were reviewed to ensure implementation and documentation of interventions used. 3. Corrective Measures put into place to ensure this Deficiency Will Not Recur: The nursing staff will check the placement of the wander guard on the Resident #7 TID and document if wander guard device is in place and location of the wander guard device in the TAR. DON or Social Services staff will monitor all resident for potential elopement quarterly and document in residents chart. Wander-guard policy has been revised to include a wander/elopement assessment tool. All staff will in-serviced on updated policy on December 7th, 2015. 4. Measures to be Implemented to Monitor the Plan of Correction	

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	355042	A. BUILDING _____ B. WING _____	10/29/2015

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F 323	Continued From page 12 * 06/28/15, 6:00 p.m., "Resident walked out of the building X [times] 2 Wanderguard put on residents right wrist." * 07/12/15, untimed, "Resident is now wearing a wander guard as had exited building X 2 earlier this month . . . Resident nearly on daily basis will make statement that her sister had died. Staff reassure her this is not the case. . . ." A physician's progress note, dated 06/29/15, stated, ". . . The patient has been having more behavioral issues. She wandered multiple times out of the facility over the weekend. Wander guard was placed again. Whether patient continues to wear it is yet to be seen. . . ." Resident #7's current physician order sheet identified an order, dated 06/29/15, "Wander Guard PLACED ON RIGHT WRIST CHECK FOR PLACEMENT AND WORKING ORDER." Review of the treatment administration record (TAR) for May 2015 failed to identify a wander guard. The TARs, dated from June 28, 2015 until current identified a wander guard to the right wrist and checked three times a day. Review of Resident #7's current care plan stated, "Problem: Wandering/Ambulating around facility and outside. Interventions: [Resident #7] needs assistance when ambulating outside to monitor for wandering and fall risk. Monitor for need of wander guard. Monitor safety and location in facility. Path to ambulate outside around facility to be established and followed when out. 7/28 [07/28/2015] Wander guard on [check] function [and] placement daily . . ." During an interview on 10/29/15 at 8:30 a.m., an	F 323	The Social Services/Designee will report to the quality assurance committee quarterly the results of the monthly audits for residents identified with elopement behaviors. The Charge Nurse will monitor all residents with wander guards to ensure their wander guards are in place once weekly X 4 weeks, then once a month X 11 months. The results of this audit will be reported at the quarterly QA committee meeting. 5. Expected Date of Compliance for this Deficiency The expected date of compliance for this Deficiency is December 7th, 2015.	

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F 323	Continued From page 13 administrative nurse (#2), when asked how the facility monitors residents with wander guards stated, "staff should mark on the TAR when they check it daily." When asked if Resident #7 had a wander guard placed on 05/04/15, the nurse (#2) was unable to verify the date the wanderguard was implemented. Prior to 06/28/15, staff failed to provide documentation or knowledge of when the resident had a wander guard in place. Staff's failure to consistently communicate and implement interventions placed Resident #7 at risk for elopement and injury.	F 323		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		12/7/15

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a medication regimen free from unnecessary medication for 1 of 3 sampled residents (Resident #4) who received an as needed (PRN) antianxiety medication. Failure to distinguish between the resident's need for pain medication or a PRN dose of antianxiety medication may have resulted in Resident #4 receiving unnecessary antianxiety medication and experiencing adverse reactions or consequences related to its use. Findings include: Review of Resident #4's medical record occurred on all days of survey. Diagnoses included anxiety, insomnia, osteoarthritis, urine retention, sleep apnea, and subdural hematoma. A significant change Minimum Data Set (MDS), dated 06/08/15, identified intact cognition, verbal behaviors and receiving a scheduled pain medication. Resident #4's physician order sheet identified the following: * 04/28/15, Tylenol (pain medication) 325 milligram (mg) 2 tablets every 4 hours PRN for pain/fever * 05/14/15, Tylenol ES (extra strenght) 500 mg 2 tablets daily for osteoarthritis pain * 06/04/15, Valium (an antianxiety medication) 5	F 329	F329 1. Corrective Action for Residents Found to be Affected by this Deficiency: Nursing Staff instructed/educated on 11/25/2015 by consulting pharmacists to give either antianxiety or pain medication and allow time to evaluate if effective before giving other PRN medication and then only if needed. 2. Corrective Action for Residents that May be Affected by this Deficiency: All Residents on PRN psychotropic and pain medications have the potential to be affected. 3. Corrective Measures put into place to Ensure this Deficiency Will Not Recur: Policy was developed for medication administration to administer only one PRN medication at a time so that effect of the medication can be evaluated. In-service to nursing staff on new policy on 12/04/2015. 4. Measures to be Implemented to Monitor the Plan of Correction.	

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F 329	Continued From page 15 mg BID (twice a day) PRN for agitation * 07/02/15, Tramadol (pain medication) 50 mg TID (three times a day) PRN for pain * 07/24/15, Tramadol 50 mg TID for pain Resident #4's physician and/or physician assistant psychiatric clinical nurse specialist (PA CNS) progress notes identified the following: * 05/29/15, ". . . He is currently on Valium 5 mg b.i.d. for bladder spasms. He has urinary retention . . . He is very demanding and often will holler out 'help me, help me' . . ." * 06/17/15, ". . . He has Valium ordered b.i.d p.r.n. He was receiving it for urinary retention, but currently the nurses report that they have not had to cath [catheterization] him for residual. He has been getting Valium in the middle of the night. . . . At this time I will discontinue his Valium and increase the melatonin . . ." Resident #4's Interdisciplinary notes identified the following: * 05/31/15, 8:50 a.m., "Med nurse heard resident fall from recliner. She stated, 'I heard his head hit the floor' . . . Resident [complained of] neck pain . . . Ambulance taking resident to hosp [hospital] . . . 1205 [12:05 p.m.] Resident admitted . . ." * 06/04/15, 10:30 a.m., " Readmit . . . diagnosis subarachnoid bleed. . . . He denies any pain. He is alert and oriented and is talking to staff. . . ." * 06/16/15, 1:20 a.m., Resident awake . . . He has been yelling out continuously and when ask what he needed his reply was 'I don't know'. this yelling went on for over 1 [hour] [with] staff answering his calls . . . Medicated at this time [with] Ativan and Tylenol." The medical record failed to show a physician's order for Ativan. * 06/18/15, 1:40 a.m., "Resident has been yelling	F 329	The DON or designee will review the MARS of two residents with orders for both PRN psychotropic and PRN pain medications weekly x 4 weeks, then q 2 weeks x 2 months, then quarterly x 3 quarters. The results will be reported to the QA committee quarterly meetings. 5. Expected Date of Compliance for this Deficiency The expected date of compliance for this deficiency is December 07, 2015.	

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F 329	Continued From page 16	F 329		

out and turning on call light [every] few minutes. Initially he said 'I can't pee' then he said 'I need the urinal' . . . the urinal was in place. . . . Fluids have been given [with] his behavior continuing. Valium given [with] Tylenol . . ."
* 06/18/15, untimed, "New order to DC [discontinue] Valium . . . Resident may rest in recliner in day area at noc [night] if not sleeping."
* 06/30/15, 4:30 p.m., " [doctor's name] returns call . . . Tramadol 50 mg TID prn for pain. Resident has c/o neck pain @ 6/10 intensity for 4 days. Tramadol ordered for pain management . . ."

Resident #4's care plan identified the following regarding pain management: "Pain Management r/t [related to] arthritis . . . Interventions: When [Resident #4] is experiencing pain offer PRN pain med . . . Assess and document on the Pain Flow Sheet findings. Assess [Resident #4] using the 0-10 Mumeric [sic] Pain Scale. Review pain assessment and pain medication effectiveness. Notify the physician for abnormal findings. . . ."

During an interview on the morning of 10/29/15, an administrative nurse (#2) lacked awareness staff had administered Valium and Tylenol together. When shown the documentation regarding the Ativan given, staff member (#2) stated, "they must have meant Valium."

Review of Resident #4's June 2015 medication administration record (MAR) identified PRN Valium and Tylenol administered together on two occasions. This practice does not allow staff to evaluate the effectiveness of each medication and may result in the resident receiving unnecessary medications.

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