STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE AT HI-ACRES MANOR	1300 2ND PL NE JAMESTOWN, ND 58401

(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 02/06/12 and completed on 02/09/12, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review. The sample included 7 additional residents to verify specific concerns during the survey.	F 000	**REVISED CORRECTED POC 3/20/12**	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	1. Licensed staff involved with noted issues with resident #4 and #9 have been re-educated on the *Hypoglycemic Event* policy of notification of physician. Physicians reviewed the charts of Residents #4 and #9 with their rounds previously. 2. Audits have been completed on physician notification per policy and no other residents with low blood sugars and no MD notification identified with chart reviews and audits. 3. Eventide policy was reviewed and continues to be appropriate as updated 2/06/12. Policy was reviewed at the nurses' meeting on 2/15/12 to re-educate all nursing staff on the same. This policy was also reviewed at 3/13/12's nurses' meeting. Facilities standing orders were updated to contain parameters on every diabetic resident, unless the MD orders specific parameters. 4. Thirty-five (35) days from the date of survey, which is 3/15/12. 5. Audits of three (3) diabetic residents will be completed weekly by designated staff for four (4) weeks, then in one (1) month, then quarterly for two (2) quarters.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Douglas W. Panchot, NHA	Campus Administrator	3/20/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to notify the resident's physician for 2 of 7 sampled residents with insulin dependent diabetes (Resident #4 and #9) following low blood sugar readings. Failure to contact the providers regarding low blood glucose levels did not allow the provider to make timely adjustments in each resident's insulin orders and/or determine causative factors for the low blood sugars readings. This resulted places other diabetic residents at risk of experiencing hypoglycemia (abnormally low level of blood sugar). Findings include: Review of the facility policy and procedure titled "Accident/Emergency Policy" included the facility policy for hypoglycemic blood reactions, and occurred on 02/08/12. This document, dated 11/22/00, stated ". . . Hypoglycemic Reaction Symptoms: Sweating, tremor, pallor, tachycardia, palpitations, nervousness, H/A [headache] confusion, slurred speech, lack of coordination, light-headedness. A. Do Tracer check to determine capillary blood glucose level. B. Give orange juice orally or place honey sublingually. C. Monitor swallowing ability. If resident is unable to swallow or glucose level remains low, contact physician. . . . Notification of Changes in Resident's Condition. In event of a significant	F 157	then based on compliance for appropriate notification of physician related to low blood sugars will continue to be completed as needed by nursing management or designee. Additional education will be provided to individuals as necessary. Audit data will be forwarded to Quality Assurance.	

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F 157	Continued From page 2	F 157		

change in resident's condition, the following people shall be notified: 1. Resident's physician. 2. Resident's next of kin or responsible party . . . A Significant Change Shall be Described As: . . . 2. A significant change of blood pressure. 3. Any alarming or unusual physical change . . . All nurses must watch for and recognize any significant changes in the condition of the residents and take necessary action. . . ."

Review of the facility policy and procedure titled "Hypoglycemic Reaction" occurred on 02/08/12. This document, dated 02/06/12, stated, ". . . POLICY, To stabilize a resident following a hypoglycemic episode . . . PROCEDURE, If a diabetic resident has an insulin reaction, either of the following may be implemented unless otherwise ordered by the resident's physician. 1. If conscious, administer Glutose, 1 tube (15 Gm. [gram]) may be given . . . For blood sugar less than 60, recheck blood sugar. Repeat in 15 minutes if no response. If no response after second dose, notify physician. a. Update resident's primary care physician via fax after incident. 2. If unconscious or unable to swallow, give Glucagon, 1 mg [milligram] I.M. [intramuscular] . . . a. When Glucagon is given, the resident's primary care physician will be notified immediately by fax or phone . . ." Both policies lacked blood sugar parameters for each resident.

- Review of Resident #4's record occurred on all days of survey. Current diagnoses included Alzheimer's disease and insulin dependent diabetes mellitus (IDDM).

Record review indicated the physician was not

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F 157	Continued From page 3 notified for the following blood sugars below 60 between 01/22/12 and 02/06/12: * 01/22/12 at 4:30 a.m.: 41 mg/dl * 01/23/12 at 4:40 a.m.: 43 mg/dl * 01/25/12 at 6:00 a.m.: 53 mg/dl; at 6:15: 58 mg/dl * 01/26/12 at 6:00 a.m.: 52 mg/dl * 01/29/12 at 6:15 a.m.: 49 mg/dl * 01/31/12 at 6:00 a.m.: 49 mg/dl * 02/05/12 at 6:00 a.m.: 58 mg/dl * 02/06/12 at 9:00 p.m.: 37 mg/dl; at 9:40 p.m. 55 mg/dl Resident #4's current physician orders for the sliding scale provided sliding scale orders for blood sugars beginning at 200-250 mg/dl and stated to call the medical doctor (MD) for a blood sugar above 450. The record lacked the established blood sugar parameters for Resident #4. During an interview on 02/07/12 at 2:15 p.m. a staff nurse (#6) stated no blood sugar parameters had been established on when to notify the physician for Resident #4. - Review of Resident #9's record occurred on all days of survey. Current diagnoses included dementia and IDDM. Record review showed Resident #9 currently Lantus and Humalog insulin to treat diabetes. Review of a Blood Sugar Flow Sheet showed four low (below 60) blood sugars between 07/22/11 and 09/29/11. The record lacked evidence of physician	F 157		

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F 157	Continued From page 4 notification of the low blood sugars experienced by Resident #9. During an interview on 02/08/12 at 5:00 p.m., an administrative nurse (#2) stated nursing staff should fax the physician with low blood sugars even if the resident is not symptomatic. Failure to notify the resident's physician immediately regarding low blood sugars, does not allow the resident's physician the opportunity to make insulin adjustments/determine causative factors, and avoid further low blood sugars and possible hypoglycemic reactions. Refer to F309.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide cares in a manner that maintained or enhanced the dignity of residents 4 of 4 supplemental residents (Resident #26, #27, #28, and #29) assisted with eating during 1 of 4 meal observations (noon meal on 02/07/12). Failure of staff to sit at the table with the resident while assisting them with eating does not provide a dignified dining experience. Findings include:	F 241	1. CNA involved was educated regarding resident #26, #27, #28, and #29. Nursing staff have been re-educated on the policy and dignity concern presented as well as assistive devices use with meals. 2. Audit form updated and random audits have been completed. 3. Eventide policy was reviewed and continues to be appropriate. Policy was reviewed at the nurses' meeting on 3/6/12, also on 3/13/12, and at CNA meeting on 3/14/12. 4. Thirty-five (35) days from the date of survey, which is 3/15/12. 5. Audits will continue to be completed during several meals per week by designated meal monitor on an ongoing basis and as needed by nursing management or designee. Additional education will be provided to individuals as necessary. Audit data will be forwarded to Quality Assurance.	

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F 241	Continued From page 5 On 02/07/12 from 11:50 a.m. to 12:30 p.m., observation showed a certified nurse assistant (CNA) (#4) standing between Resident #26 and Resident #27 and assisting them with eating. Observation showed a chair positioned at the table between Resident #26 and #27, which the CNA failed to sit on. The CNA brought a spoonful of soup to Resident #26's mouth and he opened his mouth and sipped the soup. Next the CNA placed a spoonful of Resident #27's soup to her mouth and she sipped the soup. The CNA then walked around to the other side of the table and assisted Resident #28 by holding a cup of milk to her lips to drink. The CNA returned to stand between Resident #26 and #27 and repeated the pattern of alternately feeding the residents until all three finished their meals. At 12:25 p.m., Resident #29 arrived at the table and the CNA (#4) set up her tray, positioning the plate guard with the opening at the top of the plate. The CNA failed to place the plate guard opening to Resident #29's left side, causing the resident to reach over the top of the guard for a forkful of hotdish. During this time, the CNA stood on Resident #29's right side and assisted her to eat, by giving her bites of food. The CNA failed to offer conversation to these residents other than limited direct questions regarding the food, and stood throughout the meal. During an interview on 02/09/12 at 8:10 a.m., an administrative staff nurse (#1) stated staff should never stand to feed residents, as it changes the position of their head possibly preventing the	F 241		

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F 241	Continued From page 6 resident from tucking their chin with swallowing. During an interview the morning of 02/09/12, a nurse administrator (#2) stated staff should not stand when feeding residents, and agreed the CNA positioned the plate guard incorrectly for Resident #29.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, review of the North Dakota Department of Health facility files, record review, and staff interview, the facility failed to provide an ongoing, meaningful activity program to meet the physical, mental, and psychosocial needs for 3 of 3 sampled residents (Resident #4, #9 and #21) residing in the Special Care Unit (SCU) identified with behaviors. Failure to provide meaningful activities designed to reflect each resident's interests and lifestyle has the potential to increase resident's behaviors, and negatively impact a resident's sense of self-worth and belonging. Findings include: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, this facility has not sustained correction of	F 248	1. Resident #4 will be encouraged to attend and assisted to group activities on the unit and off the unit as appropriate. Staff will encourage resident to attend group activities which include socials, devotions, games and music. Resident #4 will be assisted off the unit for activities as appropriate. Resident #9 will be assisted to group activities on the unit that she enjoys such as music, sing-along, reading groups and devotions as identified on her care plan. Activities in group and individual basis will be provided to attempt to diminish periods of anxiety. Resident #21 care plan includes small group activities, devotions, music programs, and towel folding. Staff to encourage group activities. Staff also encourage coloring, cutting paper, TV, music in room, manipulative items, and reading material to decrease anxiety. 2. Activities are reviewed at IDT meetings as behavior/anxiety or residents are discussed. 3. Facility staff will provide engaging and meaningful activities to all residents. These activities will include physical,	

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F 248	Continued From page 7 this issue. This requirement was found to be out of compliance during previous surveys completed on 03/04/10 and 01/18/07. Review of the facility policy titled "Activity Department SPECIAL CARE UNIT" occurred on 02/09/12. The undated policy stated, "Activity Programming: A variety of activities are offered on the special care unit. . . ." They included sensory stimulation program in small groups or 1 on 1, and activities for behavior intervention such as anxiety, agitation, combativeness, pacing, wandering, loneliness, sadness, and depression. The following observations occurred in the SCU on 02/06/12: * 3:50 p.m.: Resident #4 sat in the front commons area in his wheelchair watching TV with his wife present. * 3:50 p.m.: Resident #9 sat in a merrywalker in the back commons area. At 5:00 p.m. the resident walked the unit in the merrywalker. The following observations occurred in the SCU on 02/07/12: * 7:55 a.m.: Resident #4 sat in a wheelchair eating breakfast. Observation on all days of survey showed Resident #4's only activity as watching TV. * 8:10 a.m.: Resident #9 sat at the breakfast table asleep. Shortly after, she awoke and stood, her chair alarm went off. Observation on all days of survey showed Resident #4's only activity as wandering in the unit in her merrywalker or sitting at the dining table for meals. * 8:45 a.m.: Resident #4 and his wife sat at the breakfast table. No activities occurred in the	F 248	cognitive, creative, spiritual, and music activities. These activities will be provided in scheduled groups and individual activities daily. A revised SCU activity attendance record was put into place on 3/01/12. Off-unit activities are noted on the calendar. Staff education for the Special Care Unit was provided on 3/8/12, 3/9/12, and 3/12/12. 4. Thirty-five (35) days from the date of survey, which is 3/15/12. 5. A QA process is in place to assure that the activity plan of care for all residents on the unit is followed. Audits of ten (10) residents will be completed weekly by designated staff for four (4) weeks, then in one (1) month, then quarterly for two (2) quarters, then based on compliance will continue to be completed as needed by Activity Director or designee. Additional education will be provided to individuals as necessary. Audit data will be forwarded to Quality Assurance.	

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F 248	Continued From page 8 commons area. * 10:20 a.m.: 10 of 16 residents living in the SCU sat in chairs in the front commons area with no activity interventions. Observation showed a television turned on, and occasionally a resident or two watching the TV. *11:50 a.m.: Nine residents in front common area having lunch: at least two eating in the back common area. * 12:50 p.m.: Resident #4 in room after lunch until 2:10 p.m. sitting in his wheelchair watching TV. * 4:20 p.m.: Eleven residents in the front common area, TV on. All eleven residents were not watching TV. The following observations occurred in the SCU on 02/08/12: * 8:50 a.m.: Resident #9 sat in her merrywalker in the back common area hollering "Please help me. Oh, God please hear my prayer." A random certified nursing assistant (CNA) walked out of the dining area and CNA approached the resident. The resident stated, "I don't know what to do." * 1:20 p.m.: A visitor exited the unit with a large dog. A CNA (#10) stated the visitor is a volunteer who brings her dog to the unit once a week. Observation showed Resident #4 laying in bed asleep. * 1:30 p.m.: Resident #21 sitting in a wheelchair in the front common area with a chair alarm. Observation showed the resident with a flat affect. Another resident sat in a wheelchair next to her and attempted to stand and a CNA told her to sit down. Observation showed a chair alarm on this resident's wheelchair. Three residents sat in recliners in the commons area, all three asleep, one resident sat in a chair watching TV, and one	F 248		

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F 248	Continued From page 9 resident sat in a wheelchair conversing with a visitor. * 1:55 p.m.: Resident #21 sat in a chair in her room from 1:55 p.m. until 3:30 p.m. in front of her TV, with her TV on, holding the same book the entire time. At 4:35 p.m., after two CNAs provided personal cares for Resident #21, observation showed the resident sitting at a dining table at 4:30 p.m. with two drinks. * 4:35 p.m.: Resident #9 stated to a random CNA she wanted to do something. The resident stated, "I'm going out of my mind." Resident #4 sat in his room watching TV. The following observation occurred in the SCU on 02/09/12: * Only one room out of 14 had an activity calendar posted in the room. The observed activity calendar, dated January 2012, described activities occurring outside of the SCU. (The facility maintains a separate activity calendar for the SCU.) The SCU activity was not available in any of the residents rooms. The SCU activity calendar showed the following activities scheduled for 02/07/12: Games & Puzzles, Social Time, and Sorting act. The calendar showed the following activities for 02/08/12: Craft Project, Music Video, and Ball Toss. Observation showed no organized activities in the unit including games & puzzles, sorting act/s, social time, church/or devotional services, and/or residents taken off the unit for an activity on February 07-08, 2012. - Review of Resident #21's record occurred on February 08-09, 2012. Resident #21's resided in the SCU, a locked unit. Resident #21's medical	F 248		

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diagnoses included Alzheimer's dementia, a pelvic fracture and a head injury sustained during a fall on 09/21/11 related to exit seeking behaviors and frequent administration of an antianxiety drug. Resident #21's current medication regimen included as needed (prn) oral (po) and injectable antianxiety medication and scheduled antipsychotic medications.

Review of Resident #21's current activities care plan identified the problem of "I am dependent on staff for activities, cognitive stimulation, social interaction r/t [related to] Cognitive deficits. I like to be busy." Interventions included: "I need reminders and escort to activity functions. . . . Invite my family to attend special events. Introduce me, residents with similar background . . . Invite me to scheduled activities off the unit: towel folding M-F [Monday - Friday], bingo, music programs. Provide me, with materials for individual activities as desired. I like . . . independent activities: household tasks, dusting, wiping off tables. Invite and encourage me to participate in unit activities: word games, bingo, devotions, socials, group exercise, reading group, craft projects. Provide 1-1 visits PRN [as needed]."

Observation showed Resident #21 currently wheelchair bound. Record review showed Resident #21 required two person physical assist for transfers, making it difficult for her to participate in household tasks.

Review of Resident #21's activity record for November through February 7, 2012 identified the following occurred daily: 1:1 visits on the day and evening shift, daily on the day and evening

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shift "Music/ Movies/ TV/ Radio," occasional "Games/Puzzles/Crafts," exercise three times in three months, and a "Religious" (devotions) activity three times in three months. The activity record lacked evidence of any household tasks, towel folding, word games, bingo, music programs, group exercise, socials, consistent devotions, reading groups,and no craft projects as identified in Resident #21's care plan.

- Review of Resident #9's record occurred on all days of survey. Resident #9 resided on the SCU. Resident #9's diagnoses included dementia, depression, and agitation. Resident #9's current medication regimen included a scheduled antianxiety drug and two prn (as needed) antianxiety medication orders (oral and injectable) as well as a scheduled antipsychotic medication.

Resident #9's current activities care plan identified the problem of "I am dependent on staff for activities, cognitive stimulation and socialization r/t Cognitive deficits" with interventions including "My preferred activities are: Music programs (esp. [especially] Old time music) church on the unit, socials, reading group. Encourage ongoing family involvement . . . Offer assist and direction as needed to activities. Provide me with materials for individual activities as desired. I like the following independent activities: reading magazines, picture books, assist with TV in room as needed, manipulative items. Provide 1-1 visits PRN. When I choose not to participate in organized activities, turn on TV, music in room/lounge to provide sensory stimulation."

Review of Resident #9's activity record for

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November 2011 through February 7, 2012 identified the following occurred: daily 1:1 visits, daily "Music/Movies/TV/Radio," occasional "Games/Puzzles/Crafts," reading 19 times in three months, exercise one time in three months, and two "Religious" (devotions) activity in three months. The activity record lacked evidence of any music programs, socials, picture books, manipulative books or sensory stimulation occurring.

- Review of Resident #4's record occurred on all days of survey. Resident #4 resided on the SCU. Resident #4's diagnoses included Alzheimer's disease, dementia with behavioral disturbances, depressive disorder, agitation, and anxiety state. Resident #4's current medication regimen included a prn antianxiety medication, a scheduled antianxiety medication, and an antipsychotic medication all for behaviors.

Resident #4's current care plan for activities identified the problem as "I need reminders and encouragement to attend group activities on the unit. I often refuse activities" with interventions including: "I enjoy the following independent activities: reading the [local paper] . . . watching TV in my room, I use my remote myself. I need reminders of activity functions. My preferred activities are: Music programs, church service. . . . Remind me that I may leave activities at any time . . . Provide 1-1 visits PRN."

Review of Resident #4's activity record for November 2011 through February 7, 2012 identified the following occurred: daily 1:1 visits, daily "Music/Movies/TV/Radio," occasional "Games/Puzzles/Crafts," reading 35 times in

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three months, exercise one time in three months, and one "Religious" (devotions) activity in three months. The activity record lacked evidence of any music programs, group activities on the unit, and minimal church services.

Review of Resident #21, #9, and #4's care plan identified the following:
* Review of Resident #21's care plan identified the problem of Dementia/Alzheimer's with behaviors including poor decision making ability, verbal/physical abuse, and exit seeking behavior.
* Resident #9's care plan identified the problem of impaired cognitive function/Dementia with anxiety.
* Resident #4's care plan identified the resident with sexually aggressive behaviors. Refer to F 250

The facility has not provided meaningful activities as interventions for Resident #4, #9 and #21's anxiety, dementia, or inappropriate behaviors.

Observation within the SCU showed several residents in the commons area with chair alarms, including Resident #4, #9, #21, and #25 and the nurse on duty and/or direct care staff frequently responding to the alarms when residents would attempt to stand unattended. The frequent sounding of alarms in a SCU fails to reduce sensory stimulation and increase anxiety.

During interview on 02/09/12 at 8:15 a.m., a supervisory activity staff member stated an activity staff member comes to the SCU every day at 10:30 a.m., and CNAs are expected to do the activities as listed on the activity calendar. The staff member stated the activities listed on

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F 248	Continued From page 14 the activity calendar may not always "work." The staff member stated yesterday she did crafts for an activity. When asked how many residents attended, she stated 3-4 and stated the rest were either watching TV or asleep. The staff member stated 1:1's by CNAs should be done by sitting and interacting with residents and not while performing personal cares.	F 248		
F 250 SS=E	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 record review, policy review, and staff interview, the facility failed to assess factors affecting/contributing to the behavior of 3 of 3 sampled residents (Resident #4, #9, and #21) and 1 supplemental resident (Resident #25) identified with behaviors, and develop/implement appropriate interventions to modify/control behaviors and provide alternatives to drug therapy. The failure to individualize and identify target behaviors, assess the reason/causative factors for the behaviors, implement appropriate individualized interventions and accurate on-going monitoring of the behaviors resulted in Resident #21 experiencing falls and injury, not receiving the care/services desired to promote full recognition of her individuality and not offered the opportunity to function at her optimum level of overall well-being.	F 250	1. The facility will provide care and service to attain and maintain the highest practical physical, mental and psychosocial well-being of each resident. Each resident #4, 9, 21, 25, as well as all residents, will be assessed using new mood and behavior tools which asks very detailed and specific behavior. The collected data will be used to determine what changes need to be made in the new plan of care. This will be done on an ongoing basis. 2. The newly developed tools will be utilized throughout the facility on an ongoing basis. 3. New tools were developed to better identify specific data as well as study data to make any necessary changes to the plan of care. The tools include forms to identify individualized interventions for all residents. Education has been provided to nursing staff, CNAs, activity staff, and social workers on 3/06/12, 3/07/12, 3/08/12, 3/13/12 and 3/14/12. 4. Thirty-five (35) days from the date of survey, which is 3/15/12.	

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F 250	Continued From page 15 Findings include: Review of the facility's policy "Behavior Intervention Plan" occurred on 02/09/12. The policy stated: "A behavior intervention plan will be developed for residents who have behavioral concerns which include, but are not limited to, combativeness with cares, wandering, anxiety, paranoia (particularly when on a PRN [as needed] psychotropic mediation) and self-injurious behavior. A behavioral intervention plan will be used on residents who are experiencing any of these behaviors as they increase the resident's potential for neglect or conflict with staff, family, visitors, and/or other residents. A behavior intervention plan will be incorporated into the resident's overall plan of care. . . ." - Review of Resident #21's record occurred on February 08-09, 2012. Resident #21's admission to the SCU, a locked unit, occurred in October 2010. Resident #21's medical diagnoses included Alzheimer's dementia, osteoarthritis, and a pelvic fracture and a head injury sustained during a fall on 09/21/11. Resident #21's current medication regimen included the following: * 09/21/11 Lorazepam (generic for Ativan) (antianxiety medication) 0.5 mg oral (po) three times a day (tid) prn * 09/21/11 Zyprexa 5 mg intramuscularly (IM) every 2 hours prn (discontinued on 01/04/12) * 09/21/11 Zyprexa 5 mg sublingual every 2 hours prn for dementia with aggression (discontinued on 01/04/12)	F 250	5. Audits for 12 residents will be completed weekly by LSW or designated staff for four (4) weeks, then in one (1) month, then quarterly for two (2) quarters, then based on compliance Additional education will be provided to individuals as necessary. Audit data will be forwarded to Quality Assurance.	

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F 250	Continued From page 16 * 09/23/11 Lorazepam 1 mg IM every 8 hours prn * 09/23/11 Risperdal (antipsychotic medication) 0.5 mg po every day in the morning (decreased on 01/24/12 to 0.25 mg) * 11/23/11 Risperdal 0.5 mg po every day at 2 p.m. (decreased on 01/24/12 to 0.25 mg) * 01/24/12 Risperdal 0.25 mg po every day at 7 p.m. Review of Resident #21's care plan included the following problem and intervention (initiated 03/04/11 and revised 10/10/11): "Thought Process: I have Dementia/Alzheimer's which has left me w/poor [with/poor] decision making ability and need for cues. I am verbally abusive to other residents when they are to me. I am constantly packing up in preparation to go home even w/cues. I become angered and will be verbal/physical noted by: kicking out, banging on doors, etc. I am very suspicious and paranoid of staff and others. Threats to harm self and statements of: 'Life not worth living.' I am an ELOPEMENT RISK" . . . " Review of mood/behavior data sheets for the months from August 2011 through February 8, 2012, identified Resident #21's mood or behavior on each shift. Three of the six CNA charting notes in August and six of seven CNA charting notes in September referenced Resident #21's desires to go home. The remaining data sheets lacked any specifics regarding the behavior. Lack of sufficient information/data does not allow for determining causative factors/circumstances precipitating the behaviors and patterns/trends associated with specific behavior occurrences, consequently appropriate measures/approaches	F 250		

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F 250	Continued From page 17 can not be determined and established to prevent, decrease and/or minimize the frequency of behavior episodes. Observation on all days of survey showed Resident #21's room located close to the main entrance/exit door of the SCU, within visual and hearing distance of staff and visitors entering and exiting the unit. This location had increased noise levels affecting anxiety level and behaviors. A "Psychotropic Medication Review," data sheet completed for the six months between July-December 2011 showed monitoring of the resident for the following "Target Behaviors" and noted the frequency of each as: * verbal aggression, physical aggression (10 times), nervousness/restlessness (20 times), apathy/social withdrawal (six times), weeping/crying/sad (one time), elopement (one time "frequently wanting to leave"), suicidal verbalization (two times), short tempered/easily annoyed (36 times), delusional (two times), and tired/little energy (three times). The review failed to determine the effectiveness of the current interventions. The facility failed to identify alternative social or activity interventions that could be implemented to substitute for medications for each behavior episode. Review of Resident #21's nurses notes nursing staff administering an antianxiety medication (Xanax or Ativan): * 09/03/11: At 2:00 p.m. for "looking for her car," becoming paranoid, exit seeking, agitation, hitting a nurse. * 09/05/11 at 7:30 p.m.: Given 2 mg IM Ativan for yelling, banging on the exit doors, and hitting	F 250		

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F 250	Continued From page 18 staff. * 09/07/11 at 4:00 p.m.: Given 1 mg IM Ativan for yelling at staff & screaming which escalated to pushing and slapping staff. * 09/09/11 at 6 p.m.: Given Ativan 0.5 orally for anxiety she ". . .relates she is going home . . ." * 09/10/11 at 9:15 p.m., after medicating Resident #21 with Ativan 2 mg IM at 8:45 p.m. on this evening as well as administering scheduled dose of one mg at 4:00 p.m. the resident fell on the floor in her room and received no apparent injuries. * 09/13/11 at 10:45 a.m., nursing staff administered Resident #21 her two scheduled 1 mg doses of Ativan at 8:00 a.m. and 4:00 p.m. Nursing staff administered Ativan 0.5 mg po at 11:15 a.m. (nearly 3 hours after a scheduled dose of one mg) for agitation and exit seeking behavior. At 1:30 p.m. nursing staff administered Ativan 2 mg IM. The record showed the resident experienced an unobserved fall in her room at 8:45 p.m. and sustained a head injury and after transfer to the Emergency room found to have sustained a pelvic fracture as well. Resident #21 remained hospitalized until 09/21/11. Resident #21 experienced a decline in activities of daily living following the fall, including her ambulation ability. A physical therapy consult upon return from the hospital identified her independent with ambulation prior to hospitalization and on contact guard assistance, utilizing a front wheeled walker, high risk for falls, and with mobility alarms in place. Upon return from hospitalization, nursing staff continued to administer Ativan to deal with the resident's behaviors including on:	F 250		

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F 250	Continued From page 19 * 09/22/11 at 4:45 p.m.: Ativan 0.5 mg given for statements of wanting to go home and attempts to stand alone many times. * 09/23/11 at 3:20 p.m.: Ativan 1 mg IM for wanting to go home and trying to stand independently and rude sarcastic statements. * 09/24/11 at 1:30 p.m.: Ativan 1 mg IM, same reasons as 09/23/11 at 3:20 p.m. * 09/25/11 at 12:30 a.m.: Ativan 1 mg IM given at 12:20 a.m. with the assistance of four staff for yelling, trying to stand up, refusing to take oral Ativan. * Staff administered Ativan 1 mg IM on 10/01/11 at 1 p.m. for a behavior identified as standing up in wheelchair, agitation and wanting to go home; for refusing to keep her seatbelt on, becoming defensive, being short-tempered, and getting very annoyed with any staff intervention. * 10/02/11: At 5:25 a.m., Ativan 1 mg IM given assist of 3 staff for hitting/yelling at staff with the assist of 3 staff. Review of Resident #21's Team Meeting Review sheets for this period of time failed to identify possible contributing factors, any changes in interventions/plan of care, any possible related issues, and ensure they were included in the plan of care. Review of Social Service progress notes addressed frequent reference to Resident #21's behaviors with medication management. Social service progress notes did not address Resident #21's increased behaviors nor did the notes indicate how the facility assessed, monitored and implemented measures to address Resident #21's mood and behavior needs/problems. Failure of the facility to adequately assess,	F 250		

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F 250	Continued From page 20 implement and monitor appropriate individualized approaches/interventions contributed to Resident #21's further psychosocial and mental decline. - Review of Resident #9's record occurred on all days of survey. Resident #9 resided on the SCU. Resident #9's diagnoses included dementia, insulin dependent diabetes mellitus, peripheral neuropathy, depression, and agitation. Resident #9's current medication regimen included: * Ativan 0.5 milligrams (mg) intramuscularly (IM) ordered 07/28/11 prn and 0.5 to 1 mg every two hours prn for agitation * Ativan 0.5 mg orally (po) ordered 08/24/11 prn for agitation * Risperdal (an antipsychotic medication) 0.125 mg po two times a day (bid) * Ativan 0.5 mg po bid ordered 09/27/11 Review of Resident #9's admission MDS, dated 03/15/11, identified the resident as able to be understood, sometimes able to understand others, with severe cognitive impairment (BIMS score of 3), no mood behaviors, verbal behaviors towards others one to three days per week, and other behavioral symptoms not directed towards others four to six days per week, but less than daily. The MDS identified the resident wandered daily, "placing the resident at significant risk of getting to a potentially dangerous place," and "significantly intrudes on the privacy or activities of others." Review of Resident #9's quarterly MDS, dated 09/20/11 showed the resident showing mild depression (score of 8 for mood frequency), other behavioral symptoms not directed towards others	F 250		

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F 250	Continued From page 21 four to six days per week, but less than daily, and wandering daily. A quarterly MDS, dated 12/20/11 showed the resident with minimal depression, other behavioral symptoms not directed towards others one to three days per week, and wandering occurring one to three days per week. Review of Resident #9's care plan included the following problem and intervention (initiated 03/10/11 and revised 10/12/11): "I have issues impaired [sic] impaired cognitive function/Dementia w/anxiety [with/anxiety] noted by constant movement. I can be verbal to others and disruptive. I am crying, not sleeping, poor appetite, short tempered at times, little interest/pleasure, tired/little energy and statements of feeling bad about self. 'States life is not worth living." Interventions included: * "Administer meds [medications] as ordered by MD [medical doctor]. Monitor effects/side effects. Psych med review sheets per protocol. Mood assessment quarterly + [plus] prn. Mood/behavior monitoring sheets in place. Started on an antidepressant 10/12/11. . . ." * COGNITION: The resident is able to: remember single instructions for a short period of time, read, sit for an hour, look at magazines, fold towels. * Discuss concerns about confusion, disease process, NH [nursing home] placement with resident/family/caregivers). [sic] * Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. * Provide the resident with a homelike environment: recliner in room, visible clocks, a calendar, low-glare night light . . . familiar objects,	F 250		

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reduced sensory noise.
* Reminisce with the resident using photos of her family and friends. Provide her w/continued reassurance/ TLC [tender loving care] as needed.
* Use task segmentation to support short term memory deficits.
* I was moved to the SCU . . . per families consent."
The goals set for the care plan included: ". . . My disruption/verbal abuse will not be intrusive to others ongoing. My sadness/crying will diminish by next review w/ current meds in place. My constant movement/irritability will diminish w/use of prn."

Observation within the SCU showed several residents in the commons area with chair alarms, and the alarms sounding when residents would attempt to stand unattended. The frequent use of alarms in a SCU fails to reduce sensory stimulation, thus increasing anxiety for Resident #9.

Review of nurses notes identified Resident #9 received Ativan one mg IM on 07/28/11 at 4:35 p.m. for verbal aggression and ". . . Has hit staff & con't to yell out" and four hours later fell.

Review of the PRN Medication Log showed nursing staff administered Resident #9 14 PRN doses of Ativan in September 2011; 20 doses in October 2011; 11 doses in November 2011; 10 doses in December 2011; three in January 2012 and so far one in February 2012. On September 27 Resident #9 started receiving a scheduled dose of 0.5 mg of Ativan two times a day..

Review of Mood/Behavior Data Sheets for

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F 250	Continued From page 23 Resident #9 included the following: * December 2011: Eight episodes on the night shift of "Trouble falling or staying asleep or sleeping too much" Review of a PRN Medication log showed at least on three occasions nursing staff medicated Resident #9 with Ativan 0.5 mg for the following reasons: anxiety; whining, crying, [up in] merrywalker; and "Please help me. Doesn't know what for." The effect each time documented included "Resting" or "to bed and Asleep." Seven episodes on the night shift of "Other behaviors" not affecting others, with an emphasis of "disruptive sounds" (underlined): each time nursing staff administered Resident #9 Ativan 0.5 mg orally (by mouth). * January 2011: Three episodes between January 15 and January 31 of nursing staff administered Ativan 0.5 mg orally for: yelling/crying; crying, talking loudly; and agitation/crying. * February 2011: An episode on 02/02/12 nursing staff administered Ativan one mg IM for "yelling, crying, mean." Review of the nursing note accompanying this stated nursing administered the med at 8:10 a.m., focus: "Behavior: Res [Resident] has been crying & yelling out for help. Res. states, 'I want to go home. It's my mother's birthday and I need to help get ready for the party.' Did assist res to the bathroom and then helped to table for breakfast. Res did eat breakfast, but stood up to leave x 4 [four times]. Gave res a book. Res cont [continues] [with] behaviors. Ativan 1 [one] mg IM given @ [at] this time for [increased] agitation." Review of mood/behavior data sheets failed to provide any specifics regarding Resident #9's behavior. The December and January data sheets lacked evidence of physical behaviors or	F 250		

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EVENTIDE AT HI-ACRES MANOR	1300 2ND PL NE JAMESTOWN, ND 58401

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verbal behaviors toward caregivers or toward others, and identified occasional wandering "on own wing, out of own room/bathroom." The February data sheet showed two episodes of verbal behavior towards other however and the nurse's notes and logs failed to identify the specific behavior.

The facility failed to provide interventions based on behavior monitoring besides medications as ordered.

- Review of Resident #4's record occurred on all days of survey. Resident #4 resided on the SCU. Resident #4's diagnoses included Alzheimer's disease, insulin dependent diabetes mellitus, dementia with behavioral disturbances, depressive disorder, agitation, anxiety state, and hearing loss.

Resident #4's medication regimen included:
* Ativan 0.5 mg po ordered 04/27/11 po prn for agitation
* Ativan 0.5 mg po daily ordered 04/27/11
* Lithium (antipsychotic often used to treat mania) 300 mg two times a day started on 12/01/11, decreased to 150 mg two times a day on 01/30/12, given for Resident #4's sexual behaviors

Resident #4's care plan addressed the sexually aggressive behaviors "to staff, others and my wife. . . ." as a problem and included interventions of keeping the family aware, a silent bed alarm, rearranging the room to separate the resident from his spouse, notifying the physician of "concerns ongoing and make recommendations as to what to put in place per family and Nursing

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home staff. Meds as order per MD and will monitor effects and side effects. Psych med review sheet as per protocol. Mood/behavior monitoring sheets in place to document issues. . . . Staff is to enter my room w/1-2 assist prn on days and pm and 2 at noc [night]. When I am making sexual comments/gestures, they are to firmly redirect me by telling me that this is not appropriate or allowed. . . . If I continue, staff is to leave the room and re-approach at a later time as long as I'm in a safe situation. . . . 12/1/11 Started on Lithium per MD for Dementia w/sexually aggressive behaviors.

Review of mood/behavior data sheets occurred for the months of November and December 2011, and January 2012. November included four descriptions of specific sexual behaviors which occurred with staff and December included one sexual behavior which occurred with staff. The sheets included predominately physical behaviors toward caregivers during cares, and other behaviors. The data sheets each lacked what preceded each behavior, what staff attempted for interventions (specific care plan interventions), and the effectiveness of the intervention.

Review of Resident #4's Team Meeting Review sheets for this period of time monitored Resident #4's medication use and failed to identify possible contributing factors, any changes in interventions/plan of care, any possible related issues, and ensure inclusion in the plan of care. The team failed to utilize non-drug approaches.

During interview on 02/08/12 at 5:00 p.m., an administrative staff nurse (#2) when addressing the plans of care developed in relation to the

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behaviors of the residents in the SCU, utilizing Resident #9 as an example, agreed the care plan did not address the resident's exit seeking behavior and how staff should address this besides medication management, and lacked specific individualized interventions. The nurse agreed the current behavior monitoring logs lacked the antecedent which occurred to the behavior, the interventions utilized by staff, and an evaluation of the intervention to ensure effective behavior management occurred without/prior to prn medication management with antianxiety medication.

- Review of Resident #25's record occurred on 02/09/12. Resident #25's diagnoses included Alzheimer's dementia with behavioral agitation and hallucinations. The record identified physician's orders for clonazepam (an antianxiety) 0.5 milligrams (mg) daily at 12 noon for agitation, Seroquel (an antipsychotic) 25 mg at 8:00 a.m. and 12 noon for Alzheimer's with agitation and hallucinations, and Ativan (lorazepam - an antianxiety) 0.5 mg every six hours as needed for agitation.

An admission MDS, dated 09/09/11, identified physical behavior symptoms directed toward others on 1 to 3 days of the past 7 days, trouble falling asleep or staying asleep 2 to 6 days of the past 14 days, and limited assistance of one person with transfers and walking in the room and corridor. A quarterly MDS, dated 12/04/11, identified physical behavior symptoms directed toward others, verbal symptoms directed toward others, other behavioral symptoms not directed toward others, and wandering on 1 to 3 days of the past 7 days, trouble falling asleep or staying

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F 250	Continued From page 27 asleep 2 to 6 days of the past 14 days, and supervision of one person with transfers and walking in the room and corridor. Resident #25's care plan, dated 12/02/11, stated, " I have mood/behavior issues . . . anxiety s/s [signs symptoms], poor sleep, . . . both verbal/physical and ELOPEMENT RISK/wander, looking for a paticular [sic] person or way to get home/fidgety, feeling bad/crying, poor appetite and short tempered." Approaches to the problem included, "Communicate with family/caregivers . . . Placement in SCU 09/15/11. Cue, reorient, and supervise as needed, Keep the resident's routine consistent . . . Present one thought, idea, question or command at a time. Reminisce with the resident . . . Review medications and record possible causes of cognitive defecit [sic] . . . Medications as ordered. Mood/behavior monitoring sheets in place. LSW [Licensed Social Worker] to visit prn [as needed] and assess for any needs/concerns . . ." Resident #25's progress notes, from September 2010 - January 2011, identified staff administered Ativan for the following behaviors without first attempting non-pharmacological interventions for the behaviors: * Agitation/restlessness - 5 times * Anxiousness/yelling - 4 times * Wandering - 2 times * Refusing to sit on the toilet - 1 time * Exit seeking - 5 times An interview with an administrative nurse (#2) occurred on 02/09/12 at 11:30 a.m. regarding the lack of planned interventions for Resident #25's anxiety, sleep issues, and exit seeking behaviors	F 250		

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F 250	Continued From page 28 which resulted in staff administering Ativan without prior attempts to alleviate the behavior through non-pharmacological means. The nurse provided no additional information. Review of Resident #4, #9, #21, and #25's data sheets and/or nurses notes lacked what preceded each resident's behavior, lacked individualized care plan interventions, what staff attempted for interventions, the effectiveness of the intervention, and what harm to self or others warranted the use of the antianxiety medication. In addition, monitoring (via "Psychotropic Medication Review" and/or "Team Meeting/Review of Mood/Behavior") lacked evidence of tracking and trending the behavior to determine the time of day, day of the week, staff member(s) involved, what environmental factors may have contributed to the behavior, what other factors preceded the behavior, the interventions attempted by staff prior to medicating the resident, what interventions worked with other staff members, and what other measures nursing considered besides medication management in all the above situations. Resident #4, #9, #21, and #25's care plans lacked individualized interventions staff should implement to address each resident's anxiety symptoms, including verbal and physical behaviors, sleep issues, elopement risk, crying, yelling, anxiety, agitation, disruptive sounds, standing up, aggressiveness, and wandering behavior. The lack of planned individualized interventions for these residents resulted in staff administering antianxiety medication without always attempting to alleviate the behavior through non-pharmacological interventions.	F 250		

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, review of a professional reference, and staff interview, the facility failed to ensure 2 of 7 sampled residents with insulin dependent diabetes (Resident #4 and #9) received the necessary care and services regarding low blood glucose levels. Failure to treat low blood glucose levels and failure to update a resident's physician to allow for timely adjustments to treatment places all diabetic residents at risk for harm. Findings include: Managing Diabetes in the Long-Term Care Setting, Clinical Practice Guideline, American Medical Directors Association (AMDA), 2002, stated ". . . Treating Hypoglycemia: Hypoglycemia is defined as a blood glucose level less than 60 mg/dL [milligrams per deciliter]. Symptoms may or may not be present . . . " Review of the facility policy and procedure titled "Accident/Emergency Policy" included the facility policy for hypoglycemic blood reactions, and	F 309	1. Licensed staff involved with noted issues with resident #4 and #9 have been re-educated on notification of physician. Physicians reviewed the charts of Residents #4 and #9 with their rounds previously. 2. Audits have been completed on physician notification per policy and no other residents with low blood sugars and no MD notification identified with chart reviews and audits. 3. Eventide's policy regarding hypoglycemic events and notifying MDs was reviewed and continues to be appropriate as updated 2/6/12. Policy was reviewed at the nurses' meeting on 2/15/12 and 3/13/12 to re-educate all nursing staff on the same. Facility's standing orders were updated to contain parameters on every diabetic resident, unless the MD orders specific parameters to allow for timely adjustments to treatment to reduce resident's risk for harm. 4. Thirty-five (35) days from the date of survey, which is 3/15/12. 5. Audits will continue to be completed as needed by nursing management or designee. Additional education will be provided to individuals as necessary. Audit data will be forwarded to Quality Assurance.	

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F 309	Continued From page 30 occurred on 02/08/12. This document, dated 11/22/00, stated ". . . Hypoglycemic Reaction Symptoms: Sweating, tremor, pallor, tachycardia, palpitations, nervousness, H/A [headache] confusion, slurred speech, lack of coordination, light-headedness. A. Do Tracer check to determine capillary blood glucose level. B. Give orange juice orally or place honey sublingually. C. Monitor swallowing ability. If resident is unable to swallow or glucose level remains low, contact physician. . . . Notification of Changes in Resident's Condition. In event of a significant change in resident's condition, the following people shall be notified: 1. Resident's physician. 2. Resident's next of kin or responsible party . . . A Significant Change Shall be Described As: . . . 2. A significant change of blood pressure. 3. Any alarming or unusual physical change . . . All nurses must watch for and recognize any significant changes in the condition of the residents and take necessary action. . . ." Review of the facility policy and procedure titled "Hypoglycemic Reaction" occurred on 02/08/12. This document, dated 02/06/12, stated, ". . . POLICY, To stabilize a resident following a hypoglycemic episode . . . PROCEDURE, If a diabetic resident has an insulin reaction, either of the following may be implemented unless otherwise ordered by the resident's physician. 1. If conscious, administer Glutose, 1 tube may be given . . . For blood sugar less than 60, recheck blood sugar. Repeat in 15 minutes if no response. If no response after second dose, notify physician. a. Update resident's primary care physician via fax after incident. 2. If unconscious or unable to swallow, give Glucagon, 1 mg [milligram] I.M. [intramuscular] . . . a. When	F 309		

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F 309	Continued From page 31 Glucagon is given, the resident's primary care physician will be notified immediately by fax or phone . . ." Review of the residents (#4 and #9) care plans for diabetes mellitus stated, ". . . monitor/document/report to MD PRN s/sx [signs and symptoms] of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait. . . ." - Review of Resident #4's record occurred on all days of survey. Resident #4's diagnoses included Alzheimer's disease and insulin dependent diabetes mellitus (IDDM). Review of Resident #4's current medication orders on 02/07/12 identified the following insulin orders: * 01/19/12 Novolog sliding scale fasting (before breakfast) and at 9:00 p.m. * 01/19/12 Novolog 15 units every day at 7:30 a.m. * Novolog 17 units every day at 11:00 a.m. * Novolog 15 units every day at 5:00 p.m. * 01/25/12 Levemir 54 units at 4:00 p.m. daily The Nursing 2011 Handbook, pages 1065, 1067 states Levemir is a long acting insulin which peaks in 6-8 hours and has a duration of 6-23 hours; and Novolog insulin is a rapid acting insulin which peaks in 1-3 hours and has a duration of 3-5 hours. Resident #4's nurses notes identified the following: * 02/06/12 at 9:00 p.m.: Nursing staff obtained a	F 309		

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blood glucose (tracer) of 37 milligrams/deciliter (mg/dl). The nurses notes stated, "Responsive. Skin W/D [warm and dry]. Consumes a chocolate milkshake [with] peanut butter." A repeat blood glucose at 9:40 p.m. read 55 mg/dl.
* 01/29/12 at 6:15 a.m., "Blood sugar check is 49 mg/dl. Alert, answers questions. Took snack et milk. Breakfast to follow shortly." The record lacked evidence of a recheck.
* 01/25/12 at 5:30 a.m.: "Resident has morning sugar of 53. Was given glass of chocolate milk. Denied feeling flushed/weak/shaky."

Review of a Blood Sugar Flow Sheet showed low (below 60) blood sugars between 01/22/12 and 02/06/12 included the following:
* 01/22/12 at 4:30 a.m.: 41 mg/dl
* 01/23/12 at 4:40 a.m.: 43 mg/dl
* 01/25/12 at 6:00 a.m.: 53 mg/dl; at 6:15: 58 mg/dl; at 6:45: 74 mg/dl
* 01/26/12 at 6:00 a.m.: 52 mg/dl
* 01/31/12 at 6:00 a.m.: 49 mg/dl
* 02/05/12 at 6:00 a.m.: 58 mg/dl
* 02/06/12 at 9:00 p.m.: 37 mg/dl; at 9:40 p.m. 55 mg/dl; at 10:30 p.m. 88 mg/dl

Record review showed a nurse faxed the physician regarding the low blood sugars on 01/23/12 at 2:30 p.m. and again on 01/25/12 at 12:30 p.m. prior to the blood sugars obtained above.

Resident #4's current physician orders for the sliding scale provided sliding scale orders for blood sugars beginning at 200-250 mg/dl and stated to call the medical doctor (MD) for a blood sugar above 450.

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F 309	Continued From page 33 The record failed to identify what measures nursing staff implemented for all of the above low blood sugars other than on 01/25/02, 01/29/02 and 02/06/12 and whether the resident was symptomatic for hypoglycemia. During an interview on 02/07/12 at 2:15 p.m. a staff nurse (#6) stated no blood sugar parameters had been established on when to notify the physician for Resident #4. - Review of Resident #9's record occurred on all days of survey. Resident #9's diagnoses included dementia, IDDM and peripheral neuropathy. Review of a Blood Sugar Flow Sheet showed low (below 60) blood sugars between 07/22/11 and 09/29/11 included the following: * 07/22/11 at 11:00 a.m.: 59 mg/dl * 07/27/11 at 9:00 p.m.: 55 mg/dl * 08/01/11 a "PRN" blood sugar at an unspecified time of 49 mg/dl * 08/04/11 at 9:00 p.m.: 59 mg/dl Resident #9's nurses notes identified the following: * 08/01/11: "Resident was lethargic, sweating at [2:20 p.m.] A) [Assessment] PRN [as needed] blood sugar taken at [2:30], BS level was 49 mg. Glass of orange juice given. R) [Response] Resident is now up walking in merry walker feeling a lot better." * 08/01/11: 5 p.m. Blood sugar 83 - alert. 7 p. Pale, listless - BS [blood sugar] 57 - OJ [orange juice] + jelly sandwich given." Nursing completed a follow-up blood sugar and assessment at midnight and found a blood sugar reading of 126 mg/dl and the resident "easily responds when	F 309		

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F 309	Continued From page 34 spoken to and verbalizing. . . ." * 10/05/11 at 8:00 p.m.: (not documented on Blood Sugar Flow Sheet) "Resident sweaty, shaky and lethargic responds verbally. BS 45 A) OJ (2 glasses) given along [with] HS [bedtime] snack ice cream bar. Will recheck in 1-2 [hours]. The nurses notes lacked evidence of a recheck as the next entry occurred on 10/06/11 at 7:50 a.m. and next blood sugar recording at 2:00 p.m. on 10/06/11. During an interview on 02/07/12 at 4:50 p.m., a supervisory nursing staff member (#3) stated resident's blood sugar parameters are established by each resident's physician and if not, then nursing staff go by the facility policy. During an interview on 02/08/12 at 5:00 p.m., an administrative nurse (#2) stated nursing staff should fax the physician with low blood sugars even if the resident is not symptomatic. The nurse stated the facility implemented a new policy this week (02/06/12) when to notify the physician of a low blood sugar, and nursing staff received education on this policy on 01/18/12.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	1. On 2/20/12 resident #14 received diagnosis from medical practitioner to continue Foley catheter. Facility's policy has been reviewed and updated. 2. Charts of residents with catheters have been reviewed. No other concerns identified. Random audits have been completed on catheter use and diagnoses as applicable. 3. Policy was reviewed at the nurses' meeting on 3/13/12 to re-educate all nursing staff on the same.	

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F 315	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure proper medical diagnosis for catheter use for 1 of 1 sampled resident (Resident #14) who had an indwelling catheter without a clinical indication. Failure to discontinue the Resident's Foley catheter when not clinically warranted increased Resident #14's risk for pain, discomfort, and urinary tract infections (UTIs). Findings include: Review of Resident #14's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's dementia with behaviors, urinary incontinence, urinary frequency, dysuria (pain with urination), right hip fracture May 2011, and recurrent urinary tract infections with a daily physician order for prophylactic Nitrofurantoin (an antibiotic) due to urinary frequency and history of UTIs. Review of Resident #14's most recent Minimum Data Sets, dated 08/06/11 and 11/23/11, identified the resident had an indwelling catheter. Diagnoses listed do not provide a clinical indication for extended use of a indwelling urinary catheter after a hip fracture that occurred on 05/18/11 with surgery the next day. Review of the resident's Urinary Incontinence and Indwelling Catheter Care Area Assessment worksheet, dated 08/11/11, stated ". . . Resident continues with an indwelling catheter post	F 315	4. Thirty-five (35) days from the date of survey, which is 3/15/12. 5. Audits of one (1) resident will be completed weekly by designated staff for four (4) weeks, then in one (1) month, then quarterly for two (2) quarters, then based on compliance for appropriate notification of physician and will continue to be completed as needed by primary nurses, nursing management or designee. Additional education will be provided to individuals as necessary. Audit data will be forwarded to Quality Assurance.	

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F 315	Continued From page 36 surgically due to extremely frequent demands to be placed on the toilet. . . ." Review of Resident #14's care plan included an approach, dated 02/17/11. This approach stated, " . . . urology consult and tx [treatment] and f/u [follow up] as ordered . . ." Resident #14's medical record showed the resident's last urology consult note, dated January 2011 and the facility unable to provide documentation from a urologist in the past year. The resident's Activity Daily Living care plan, updated 05/23/11, identified Resident #14 as having an indwelling catheter. Review of a Clinical Fax Transmittal dated 06/22/11, stated, " . . . Resident continues with Foley catheter since hip Fx [Fracture] & she's still on Toviaz (a drug used for urinary frequency) 8 mg [milligrams] [daily] - could Toviaz be d/c'd [discontinued] (FYI - Resident is in need of Foley catheter due to freq [frequent] urination requests prior to this.) . . . Physician's Response: D/C Toviaz . . ." Observations on all days of survey showed Resident #14 with an indwelling urinary catheter. During an interview on 02/09/12 at 9:45 a.m., an administrative nurse (#2) confirmed Resident #14 had an indwelling catheter placed due to her hip fracture in May. This staff member agreed that urinary frequency, incontinence, and frequent UTIs lacked clinical indication for extended use of a urinary catheter, and that Resident #14's chart lacked a physician note or dictation related to a clinical indication for the use of the catheter.	F 315		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 37 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, review of a professional reference, and staff interview, the facility failed to establish and implement individualized behavioral interventions, monitor the effectiveness and make necessary changes/revisions as indicated for 3 of 4 sampled residents (Resident #6, #9, and #21) receiving antipsychotic and antianxiety medications for behavior management and 1 supplemental	F 329	1. Resident #6 continues with her current dose of Ativan. Her Seroquel was decreased 2/28/12 and South Central Human Service Center staff continues to follow. Resident #9 had her scheduled Ativan discontinued, as well as her Risperdal and Remeron. She continues with only a PRN Ativan dose, all per her medical practitioner. Resident #21 has had her Risperdal gradually decreased and then discontinued 3/14/12 and continues with her GDR. Her MD is reviewing again on next rounds. On 2/14/12 her PRN Ativan was discontinued. Resident #25 had her Ativan discontinued on 2/21/12. Her Seroquel is now discontinued and she is on Clonazepam per medical practitioner. Her Lexapro was decreased 2/22/12. 2. Charts of residents with psychotropic meds were reviewed. Faxes to MDs or SCHSC were sent to address GDR as indicated. Nurses must complete PRN psychotropic form to ensure all other non-medication interventions per individual care plan are attempted and then if no results PRN is given. 3. Nurses re-educated on 3/13/12 on nonpharmacological interventions and federal guidance on unnecessary medications. Facility updated *Psychopharmacological Medication Use* policy. Pharmacist will review federal guidelines and report any issues with compliance or follow-up to the nurse managers, DON, primary medical practitioner or Medical Director as needed. Nursing management will also keep records of GDR.	

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F 329	Continued From page 38 resident (Resident #25) who received both antianxiety and antipsychotic medications to control behaviors and had a dosage increase without attempts by the facility to minimize the behavior through other approaches/interventions. Failure to administer psychotropic medication with adequate indications for use (Resident #9 and #21) resulted in Resident #21 experiencing a fall, pelvic fracture and head injury. Failure to consider a gradual dose reduction (GDR) (Resident #6) and failure to ensure an adequate indication for increased medication dosage (Resident #25) resulted in residents receiving unnecessary medications with adverse and potential adverse consequences. Findings include: Review of facility policy titled "Psychotropic Medication Monitoring and Review for Sedatives/Hypnotics and Anxiolytics" occurred on 02/09/12. This policy, dated 03/10/09, stated, "POLICY: A psychotropic medication review will be completed on any resident receiving sedative/hypnotics and/or anxiolytics. PURPOSE: To review the psychotropic medications on a quarterly basis attempting to evaluate harmful side effects and promote the use of the lowest possible dose. . . . " Review of facility policy titled "Psychotropic Medication Monitoring and Review for Antipsychotics" occurred on 02/09/12. This policy, dated 03/10/09, stated, "POLICY: A Psychotropic Medication Review will be completed on any resident receiving antipsychotic medications. PURPOSE: To review the psychotropic medications on a quarterly basis attempting to	F 329	4. Thirty-five (35) days from the date of survey, which is 3/15/12. 5. Audits of three (3) residents will be completed weekly by designated staff for four (4) weeks, then in one (1) month, then quarterly for two (2) quarters, then based on compliance and will continue to be done as needed by consulting pharmacist, nursing management or designee per previous schedule. Additional education provided as necessary. Audit date will be forwarded to Quality Assurance.	

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F 329	Continued From page 39 evaluate harmful side effects and promote the use of the lowest possible dose. . . ." PROCEDURE: . . . 2. Review diagnostic list for appropriate diagnosis. Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following "specific conditions"": a. Schizophrenia . . . 3. Antipsychotics should not be used if one or more of the following is/are the only indication: a. Wandering b. Poor self-care c. Restlessness d. Impaired memory e. Unsociability f. Indifference to surroundings g. Fidgeting h. Nervousness i. Uncooperativeness j. Unspecified agitation that does not represent a danger to others . . . 5. Document frequency of target behaviors displayed during each shift using code as identified on the Mood/Behavior Data Sheet . . . 6. Document side effects as observed and at least quarterly with care plan review. 7. Continue to utilize non-drug approaches as determined by the behavior team. . . ." The 2011 Nursing Drug Handbook, page 696 and 697, identified indications for Lorazepam (Ativan) as ". . . Anxiety . . . Insomnia from anxiety . . ." and dosages for elderly patients as "1 to 2 mg [milligrams] P.O. [by mouth] daily in divided doses. . . ." for anxiety usage. The handbook identified adverse reactions including drowsiness, sedation and unsteadiness. - Review of Resident #21's record occurred on February 08-09, 2012. Resident #21's admission to the Special Care Unit (SCU) occurred in October 2010. Resident #21's medical diagnoses included Alzheimer's dementia, osteoarthritis, and a pelvic fracture and head injury due to a fall sustained 09/21/11.	F 329		

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F 329	Continued From page 40 Resident #21's current medication regimen included the following: * Lorazepam (generic for Ativan) (antianxiety medication) 0.5 milligrams (mg) oral (po) three times a day (tid) prn * Lorazepam 1 mg IM every 8 hours prn * Risperdal (antipsychotic medication) 0.5 mg po every day in the morning (decreased on 01/24/12 to 0.25 mg) * Risperdal 0.5 mg po every day at 2 p.m. (decreased on 01/24/12 to 0.25 mg) * Risperdal 0.25 mg po every day at 7 p.m. Review of Resident #21's PRN medication log from 08/23/11 through 09/13/11 prior to hospitalization for the pelvic fracture and head injury showed nursing staff administered Xanax or Ativan (po and IM) 17 times for anxiety/agitation. Between 09/22/11 and 10/13/11, after Resident #21's return from her hospitalization, nursing staff administered Ativan 24 times (six times intramuscularly) for the following reasons: anxiety, worried about kids, wants to go home, hitting, yelling, and trying to get out of the wheelchair. Review of Resident #21's nurses notes identified nursing staff failed to implement measures including engaging the resident in an activity, reapproaching later or with another staff member, analyzing the resident's behavior, and developing an individualized care plan. In addition, staff agitated the resident with threats of a pill or injection. On 09/10/11, Resident #21 experienced a fall at 9:15 p.m. without injury one half hour after a two mg dose of IM Ativan. In addition, the resident received a scheduled 4:00 p.m. dose of	F 329		

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F 329	Continued From page 41	F 329		

Ativan (total of 3 mg within 6 hours). On 09/13/11, Resident #21 sustained a pelvic fracture and a head injury five hours after nursing staff administered three oral doses and one two mg injection of Ativan within an eight hour period (total of 4.5 mg). The suggested daily dosage is 1-2 mg in divided doses. Nurses notes also identified three and four staff members were required to hold Resident #21 in order for staff to administer injections on four occasions: 09/05/11, 09/07/11, 09/25/11, and 10/02/11.

Review of the behavior teams weekly meetings from 08/16/11 through 11/01/11 identified the date/time of each behavior and any medication adjustments, however, evidence is lacking the facility assessed factors affecting/contributing to Resident #21's behavior and developed/implemented appropriate interventions to modify/control the behaviors and provide alternatives to drug therapy.

- Review of Resident #9's record occurred on all days of survey. Resident #9's diagnoses included dementia, insulin dependent diabetes mellitus, depression, and agitation.

Resident #9's current medication regimen included:
* Ativan 0.5 mg IM ordered 07/28/11 prn and 0.5 to 1 mg every two hours prn for agitation
* Ativan 0.5 mg po ordered 08/24/11 prn for agitation
* Risperdal 0.125 mg po bid ordered on 08/24/11
* Ativan 0.5 mg po bid ordered 09/27/11

Nurses notes identified Resident #9 received Ativan one mg IM on 07/28/11 at 4:35 p.m. for

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F 329	Continued From page 42 "con't [continues] to be very verbally aggressive. Has hit staff & con't to yell out" and four hours later "Resident found on floor lying on her back in linen room - had been in merrywalker - admits to hitting her head on the back . . . unable to assess symptoms due to resident's cognition. Resident assisted to bed refuses any analgesics. Cooperative [with] staff." Review Resident #9's of the PRN Medication Log showed nursing staff administered 14 PRN doses of Ativan in September 2011. Resident #9 began receiving scheduled doses of Ativan on 09/27/11, however the resident received 20 doses of PRN Ativan in October 2011; 11 doses in November 2011; 10 doses in December 2011; three in January 2012 and so far one in February 2012. The record failed to identify interventions attempted or implemented prior to staff administering the Ativan. Resident #9's Mood/Behavior Data Sheets for December and January lacked evidence of physical behaviors or verbal behaviors toward staff or other residents. The February data sheet showed two episodes of verbal behavior toward other people however, the nurse's notes and PRN medications log failed to identify the specific behavior. Review failed to show adequate indications for nursing staff to administer the PRN Ativan. During interview on 02/09/12 at 11:10 a.m., an administrative staff nurse (#2) when informed of Resident #9 and #21's falls and resulting injuries following the administration of Ativan by the nursing staff, agreed the medication likely caused the fall. In addition, the facility failed to develop	F 329		

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F 329	Continued From page 43 appropriate behavior intervention plans to prevent the frequent use of Ativan on the SCU. - Review of Resident #25's record occurred on 02/09/12. Resident #25's diagnoses included Alzheimer's dementia with behavioral agitation and hallucinations. An admission MDS, dated 09/09/11, identified physical behavior symptoms directed toward others on 1 to 3 days of the past 7 days, trouble falling asleep or staying asleep 2 to 6 days of the past 14 days, and limited assistance of one person with transfers and walking in the room and corridor. A quarterly MDS, dated 12/04/11, identified physical behavior symptoms directed toward others, verbal symptoms directed toward others, other behavioral symptoms not directed toward others, and wandering on 1 to 3 days of the past 7 days, trouble falling asleep or staying asleep 2 to 6 days of the past 14 days, and supervision of one person with transfers and walking in the room and corridor. The record identified the facility admitted Resident #25 on 09/04/11 with physician's orders for clonazepam (an antianxiety) 0.5 milligrams (mg) daily at 12 noon for agitation and Seroquel (an antipsychotic) 25 mg at 8:00 a.m. for Alzheimer's with agitation and hallucinations. The record showed the physician added Ativan (an antianxiety) 0.5 mg every six hours as needed for agitation on 09/07/11 and initiated a 12 noon dose of Seroquel 25 mg on 11/10/11. Resident #25's care plan, dated 12/02/11, stated, " I have mood/behavior issues . . .anxiety s/s [signs symptoms], poor sleep, . . . both	F 329		

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F 329	Continued From page 44 verbal/physical and ELOPEMENT RISK/wander, looking for a paticular [sic] person or way to get home/fidgety, feeling bad/crying, poor appetite and short tempered." Approaches to the problem included, "Communicate with family/caregivers . . . Placement in SCU 09/15/11. Cue, reorient, and supervise as needed, Keep the resident's routine consistent . . . Present one thought, idea, question or command at a time. Reminisce with the resident . . . Review medications and record possible causes of cognitive defecit [sic] . . . Medications as ordered. Mood/behavior monitoring sheets in place. LSW [Licensed Social Worker] to visit prn [as needed] and assess for any needs/concerns . . ." Resident #25's care plan lacked individualized interventions staff should implement to address the resident's anxiety symptoms, including her verbal and physical behaviors directed toward others, sleep issues, wandering, and elopement risk. The lack of planned individualized interventions for Resident #25 resulted in staff consistently administering antianxiety medication without first considering factors that may have been causing the insomnia and/or anxiety (as per facility policy) and attempting to alleviate the behavior through non-pharmacological interventions. Resident #25's Physician's progress notes identified the following: * 11/03/11 - "[Resident #25] is seen on routine nursing home rounds today. She had a team meeting recently where her behavior was discussed. She has had some isolated episodes of walking/wandering and 1-2 episodes of being short tempered. Reviewed her mood/behavior	F 329		

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F 329	Continued From page 45 data sheet for Oct. [October] shows no episodes of physical behavior towards caregivers or towards other people. She's also had no verbal behavior towards other people. There are several days marked where she did have wandering although nursing staff admits that she does walk frequently about the wing . . . No consistent patterns identified with respect to behavior at this time. Continue current dose of Seroquel . . ." Resident #25's progress notes identified: * 11/08/11 at 11:55 a.m. - "Unit meeting held today . . . Faxed request for possible increase in Seroquel due to continued inappropriate behaviors this week. fidigity [sic] x [times] 4, short tempered x 3, verbal with care givers x 2, little interest x 1, verbal to others x 1, delusions x 2, physical with cares x 1, disruptive x 1." * 11/10/11 at 9:15 a.m. - "Order rec'd [received] via fax from [physician's name] to give Seroquel 25 mg po @ [12 noon] in addition to the [8:00 a.m.] dose. . . ." The record lacked evidence the facility attempted non-pharmacological behavior interventions prior to requesting an increase in the Seroquel dose. The facility failed to assess factors affecting/contributing to the behavior of Resident #25 and develop/implement appropriate interventions to modify/control behaviors and provide alternatives to drug therapy. An interview with an administrative nurse (#2) occurred on 02/09/12 at 11:30 a.m. regarding the lack of planned interventions for Resident #25's anxiety, sleep issues, and exit seeking behaviors which resulted in staff administering Ativan for anxiety symptoms and increasing the Seroquel	F 329		

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F 329	Continued From page 46 dose for behaviors without prior attempts to alleviate those anxiety symptoms and behaviors through non-pharmacological means. The nurse provided no additional information. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included depression, anxiety, and mood disorder not classified elsewhere. Medications included Ativan (antianxiety) 0.5 mg every morning (AM) and 1 mg every hour of sleep (hs), Seroquel (antipsychotic) 50 mg every AM and 75 mg every hs, and Venlafaxine (antidepressant) 75 mg TID. Resident #6's annual Minimum Data Set (MDS), dated 01/19/12, and quarterly MDS, dated 10/19/11, indicated only one item in the Mood section (feeling tired or having little energy nearly every day) and no items in the Behavior section. The Mood/Behavior Data Sheets for January-February 2012 showed episodes of sleepiness, feeling down, depressed, and short tempered/annoyed. A psychiatric progress note, dated 12/02/11, stated, ". . . There are no reports of behavioral concerns. . . . By her report and report of staff, the client is doing fairly well. There are no reports of side effects with her medications. . . . diagnosis continues Major Depressive Disorder, Recurrent, Mild and Generalized Anxiety Disorder. . . . Based on our discussion the client will continue: 1. Ativan 0.5 mg per tube q [every] AM and 1 mg per tube hs. 2. Seroquel 50 mg per tube AM and 75 mg per tube hs. 3. Venlafaxine 75 mg per tube tid." Review of the psychiatric progress notes, dated 09/02/11, 06/03/11, and 03/04/11 showed Resident #6 on the same dose of medication.	F 329		

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F 329	Continued From page 47 The progress notes failed to identify why a GDR was clinically contraindicated.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's consultant pharmacist failed to identify and report medication regimen irregularities for 3 of 4 sampled residents (Resident #6, #9, and #21) and 1 supplemental resident (Resident #25) receiving both antianxiety and antipsychotic medications. Failure to recognize and report medication irregularities, such as administering psychotropic medication without adequate indications for use (Resident #9 and #21), lack of gradual dose reduction (GDR) (Resident #6), and increased medication dosage without adequate indication (Resident #25) may result in residents receiving unnecessary medications and experiencing adverse consequences related to these medications, such as Resident #21 experiencing a fall with a pelvic fracture and head injury.	F 428	1. Resident #6 continues with her current dose of Ativan. Her Seroquel was decreased 2/28/12 and South Central Human Service Center staff continues to follow. Resident #9 had her scheduled Ativan discontinued, as well as her Risperdal and Remeron. She continues with only a PRN Ativan dose, all per her medical practitioner. Resident #21 has had her Risperdal gradually decreased and then discontinued 3/14/12 and continues with her GDR. Her MD is reviewing again on next rounds. On 2/14/12 her PRN Ativan was discontinued. Resident #25 had her Ativan discontinued on 2/21/12. Her Seroquel is now discontinued and she is on Clonazepam per medical practitioner. Her Lexapro was decreased 2/22/12. Consultant Pharmacist was notified of missing drug regimen review information on resident #9 on 3/19/12 (she was out on FMLA and was unable to be reached, but MD had already addressed). Nursing has discussed concerns noted with #6, #9, #21, and #25 with their medical practitioners and medication reductions, and discontinuations of medications were completed as ordered. DON reviewed with pharmacist the need to follow-up in	

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F 428	Continued From page 48 Findings include: - Review of Resident #21's record occurred on February 08-09, 2012. Resident #21's medical diagnoses included Alzheimer's dementia, osteoarthritis, and a pelvic fracture and head injury due to a fall sustained 09/21/11 following administration of 4.5 milligrams (mg) of Ativan (an antianxiety medication) by nursing staff within an eight hour period. Nursing staff also administer three mg of Ativan within a six hour period on 09/10/11 which also resulted in a fall for the resident without injury. Refer to F250 and F329 Review of Resident #21's PRN medication log from 08/23/11 through 09/13/11 prior to hospitalization for the pelvic fracture and head injury showed nursing staff administered Xanax or Ativan (po and IM) 17 times for anxiety/agitation. Between 09/22/11 and 10/13/11, after Resident #21's return from her hospitalization, nursing staff administered Ativan 24 times (six times intramuscularly) for anxiety/agitation. The 2011 Chronological Record of Drug Regimen Review completed for September and October 2011, by the consultant pharmacist failed to address the frequent use of the antianxiety medication. The "Condensed comment/recommendation" for September stated "Reviewed nursing notes regarding behavior, increased paranoia, UA [urinalysis] negative - continue to monitor." The October recommendation noted the starting of Risperdal and the hip fracture and lacked recommendations.	F 428	the consultant notes with residents per federal guidelines. 2. Audits have been completed on physician notification per policy. Charts of residents with psychotropic meds were reviewed. Faxes to MDs or SCHSC were sent to address GDR as indicated. Nurses must complete PRN psychotropic form indicating all other non-medication interventions appropriate for that resident are attempted and then if no results PRN is given. 3. Facility policy for *Unnecessary Medication Policy* was updated. Facility will continue to follow this policy in conjunction with Consultant Pharmacist recommendations. Consultant pharmacist will review GDR forms and identify residents on psychotropics and whether they need to be considered for GDR. Consultant pharmacist will review federal guidelines and report any issues with compliance or follow-up to Unit Managers, DON, primary medical practitioner or Medical Director as needed. Necessary information will be forwarded to Unit Managers for review at IDT meeting. 4. Thirty-five (35) days from the date of survey, which is 3/15/12. 5. Audits of ten (10) residents will be completed weekly by designated staff for four (4) weeks, then in one (1) month, then quarterly for two (2) quarters, then based on compliance and will continue to be done as needed by Consultant Pharmacist, Medical Director, nursing management or designee per pervious schedule. Additional education will be provided to individuals as necessary. Audit data will be forwarded to Quality Assurance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE AT HI-ACRES MANOR	1300 2ND PL NE JAMESTOWN, ND 58401

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F 428	Continued From page 49 During interview on 02/09/11 at 10:20 a.m. with a supervisory pharmacy staff member (#5), the staff member stated she did not notify the physician or director of nursing regarding Resident #21's prn Ativan usage after the resident's fall and fracture. The staff member (#5) stated she did not identify and report the use of 4.5 mg of Ativan utilized within 8 hours on the day of the fall. - Review of Resident #9's record occurred on all days of survey. Resident #9's diagnoses included dementia, insulin dependent diabetes mellitus, depression, and agitation. Nurses notes identified Resident #9 received Ativan one mg IM on 07/28/11 and fell four hours later. Review of the Resident #9's PRN Medication Log showed nursing staff administered Resident #9 14 PRN doses of Ativan in September 2011; 20 doses in October 2011; 11 doses in November 2011; 10 doses in December 2011; three in January 2012 and so far one in February 2012. The 2011-2012 Chronological Record of Drug Regimen Review completed monthly by the consultant pharmacist for Resident #9 failed to address the frequent use of the antianxiety medication. During interview on 02/09/11 at 10:20 a.m. with a supervisory pharmacy staff member (#5), the staff member stated she did not notify the physician or director of nursing regarding nursing staff's frequent administration of prn Ativan to Resident #9.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 50 - Review of Resident #25's record occurred on 02/09/12. Resident #25's diagnoses included Alzheimer's dementia with behavioral agitation and hallucinations. The record identified the facility admitted Resident #25 on 09/04/11 with physician's orders for clonazepam (an antianxiety) 0.5 milligrams (mg) daily at 12 noon for agitation and Seroquel (an antipsychotic) 25 mg at 8:00 a.m. for Alzheimer's with agitation and hallucinations. The record showed the physician added Ativan (an antianxiety) 0.5 mg every six hours as needed for agitation on 09/07/11 and initiated a 12 noon dose of Seroquel 25 mg on 11/10/11. Resident #25's record identified staff consistently administered antianxiety medication and increased the Seroquel dose without first considering factors that may have been causing the resident's symptoms of insomnia and/or anxiety and attempting to alleviate the behavior through non-pharmacological interventions. Refer to F250 and F329. Review of Resident #25's "Chronological Record of Drug Regimen Review" forms from September 2011 - January 2012 lacked evidence the consulting pharmacist identified the lack of indications for the PRN Ativan use and the increase in the Seroquel dose. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included depression, anxiety, and mood disorder not classified elsewhere. Medications included Ativan (anxiolytic) 0.5 milligram (mg) every morning (AM) and 1 mg every bedtime (hs), Seroquel (antipsychotic) 50 mg every AM and 75	F 428		

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F 428	Continued From page 51 mg every hs, and Venlafaxine (antidepressant) 75 mg three times daily (TID). A psychiatric progress note, dated 12/02/11, stated, ". . . There are no reports of behavioral concerns. . . . By her report and report of staff, the client is doing fairly well. There are no reports of side effects with her medications. . . . diagnosis continues Major Depressive Disorder, Recurrent, Mild and Generalized Anxiety Disorder. . . . Based on our discussion the client will continue: 1. Ativan 0.5 mg per tube q [every] AM and 1 mg per tube hs. 2. Seroquel 50 mg per tube AM and 75 mg per tube hs. 3. Venlafaxine 75 mg per tube tid." Review of the psychiatric progress notes, dated 09/02/11, 06/03/11, and 03/04/11 showed the same medication dosages as the 12/02/11 note, and failed to indicate why a GDR was clinically contraindicated. The 2011 Chronological Record of Drug Regimen Review completed monthly by the consultant pharmacist for Resident #6 failed to identify and report the need to consider a GDR for Resident #6.	F 428		