STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355116	A. BUILDING _____ B. WING _____	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE LUTHERAN HOME	501 3RD AVE W LISBON, ND 58054

(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 05/23/16 and completed on 05/26/16, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000		
F 222 SS=E	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure 3 of 5 sampled residents (Resident #1, #5 and #7) with as needed (PRN) psychopharmacological medications remained free of chemical restraints utilized for the purposes of controlling resident behavior. Failure to assess and implement behavioral interventions to manage residents behaviors resulted in the frequent utilization of psychotropic medications. Findings include: On the morning of 05/26/16, the facility provided the following policies regarding behavior management. Review occurred on 05/26/16: * "Unmanageable Residents:" undated, stated:	F 222	F222 The Care plans for resident's #1, #5 and #7 were reviewed and updated on 6/10/16 to include resident specific behavioral interventions based on assessment. No Prn psychopharmacological medications have been administered to residents #1, #5, or #7 since 5/24/16. All residents have the potential to be affected should the facility fail to use non-pharmacological interventions for resident behaviors. A facility "Behavior Management plan" as well as a "Behavior Management Program" were developed for the facility on 6/13/16. All facility nurses were in-serviced on the said policies/ procedures on 6/13/16 and CNA's were	6/29/16

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

Electronically Signed | 06/24/2016

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 222	Continued From page 1 "Policy Statement: Each resident will be provided with a safe place of residence. Policy Interpretation and Implementation: 1. Should a resident's behavior become abusive, hostile, assaultive, or unmanageable in any way that would jeopardize his or her safety or the safety of others, the Nurse Supervisor/Charge Nurse must immediately: a. Provide for the safety of all concerned . . . b. Notify the resident's Attending Physician for instructions . . . Every effort shall be made to calm the resident. However, personal safety must always be considered. . . . 2. The Director of Nursing Services has the authority to order emergency restraint use in accordance with our facility's established restraint policy. . . . 5. Unmanageable residents may not be retained by the facility. . . ." * "WANDERING RESIDENT: Residents that have the potential to wander/elope . . . care plan team . . . will write an individualized care plan to identify the need for the use of the Code alert bracelet. Interventions will be implemented to keep the wandering resident safe and assure the safety of other residents who may be affected by the wandering. . . ." * "Medication Utilization and Prescribing - Clinical Protocol: Assessment and Recognition: 1. When a medication is prescribed in response to an identified problem, condition, or risk, . . . considering the resident's age, conditions, risks, health status, and existing medication regimen. . . . try to identify likely causes and pertinent non-pharmacological interventions. c. A diagnosis by itself may not be sufficient justification . . . does not necessarily require a	F 222	in-serviced on the policies/ procedures on 6/15/16. All PRN pharmacological administrations will be reviewed by the antipsychotic team as part of the QAPI meeting held each week for the next 3 months and then every other week thereafter for the next year. The Director of nursing or designee will partcipate in the weekly meeting to audit for the assessment and implementation of interventions to manage resident behavior. Results of the audits will be reported by the DON at the quarterly QA Committee meeting. In addition the facility has partnered with the Great Plains Quality Innovation Network in the South East North Dakota Pilot project addressing all antipsychotic medications both Prn and scheduled. Results of the QAPI meetings as well as results from the pilot project will be reported to the QA Committee on a quarterly basis by the Director of Nursing.	

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F 222	Continued From page 2	F 222		

treatment and the treatment may be something besides, or in addition to, medication. . . ."

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, and mood disorder. The significant change Minimum Data Set (MDS), dated 05/20/16, identified cognition as moderately impaired, sometimes makes self understood and sometimes understands others, and physical behavioral symptoms directed at others. The current care plan stated, " . . . Problem: Altered thought process d/t [due to] Dx [diagnosis] dementia r/t [related to] forgetful of surroundings and resistive w/cares [with cares]. . . . Approaches: . . . Res [resident] may get resistive w/cares (scratch/hit). Be creative- alt [alternate] staff, come back @ a different time. Res calms down w/1-1 staff rather than numerous staff present. . . . Problem: Altered thought process d/t delusions m/b [manifested by] believes her kids are missing. . . .Approaches: . . . Get in res world & comfort her when she has altered thought process. Attempt to redirect res to an alt act [activity]. . . ."

Physician orders for Resident #5's included the following psychoactive medications:
* 01/05/15 Diazepam (antianxiety) 5 milligrams [MG] per oral [PO] or intramuscular [IM] every 6 hours PRN
* 10/20/15 Seroquel (antipsychotic) 100 MG PO three times daily [TID] (0800 [8:00 a.m.], 1400 [2:00 p.m.] & hours of sleep [HS]).
* 03/06/16 Lorazepam (antianxiety) 0.5 MG PO one time
* 04/04/16 Haldol (antipsychotic) 5 MG IM now
* 04/12/16 Zoloft (antidepressant) 150 MG PO

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F 222	Continued From page 3 daily [QD] for anxiety/depression. Medication administration records (MAR) showed nursing staff administered either PRN diazepam, haldol, or lorazepam: * May 2016: zero times * April 2016: 7 times varying on all three shifts for the reasons of "crying, upset, increased agitation, hitting, increased psychotic behaviors." * March 2016: 7 times varying on all three shifts for the reasons of "yelling, combative, increased anxiety, increased behaviors, grabbing at staff, crying." * February 2016: five times on evening shifts for the reasons of "hit out on nurses hand, psychotic behaviors, restless, crying, looking for her children, hitting wall, doors, and people." * January 2016: 12 times varying on all three shifts for the reasons of "anxiety, increased psychotic behavior, restless, anxious, hitting out." * December 2015: 8 times varying on days and evening shifts for the reasons of "agitated, restlessness, combative, wandering." * November 2015: 8 times varying on days and evening shifts for the reasons of "anxiety, restless, agitation, crying, confused." Resident #5's nursing progress notes included the following behavior episodes, interventions, and administration of PRN diazepam or haldol: * 11/01/15 9:10 a.m. Diazepam 5 mg PO per MAR for "increase anxiety." No further documentation on behavior. * 11/03/15 8:30 p.m. "Res very restless agitated going into other rooms did throw a garbage can in rm 12. Valium 5 mg given. Will monitor." Diazepam 5 mg PO at 8:00 p.m. * 11/09/15 8:15 p.m. "Res has been restless	F 222		

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going into rms and down hallway pushed another res w/c from behind into the wall." Diazepam 5 mg IM at 8:15 p.m.
* 11/14/15 3:00 p.m. Diazepam 5 mg PO per MAR for "agitated." No further documentation on behavior.
* 11/15/15 11:00 p.m. "Resident is awake and roaming until 2240 [10:40 p.m.], mumbling words but calm. Diazepam 5 mg PO tab was given, resident is now on bed sleeping." Diazepam 5 mg PO at 10:40 p.m.
The resident exhibited no behaviors, yet was given psychotropic medication.
* 11/19/15 5:00 p.m. Diazepam 5 mg PO per MAR for "increase anxiety, crying, confused." No further documentation on behaviors.
* 11/27/15 7:30 p.m. Diazepam 5 mg PO per MAR for "increase restlessness and anxiety." No further documentation on behaviors.
* 12/02/15 4:45 p.m. Diazepam 5 mg PO per MAR for "agitation hitting out, going into rms." No further documentation on behaviors.
* 12/05/15 7:00 p.m. Diazepam 5 mg PO per MAR for "agitated." No further documentation on behaviors.
* 12/07/15 4:10 p.m. Diazepam 5 mg PO per MAR for "aggitated [sic] increase anxiety." No further documentation on behaviors.
* 12/10/15 5:30 p.m. Diazepam 5 mg PO per MAR for "agitation." No further documentation on behaviors.
* 12/15/15 11:00 a.m. "Res increase agitation going into other rms tub rm prn p.o. valium 5 mg given - much less anxiety an hr later." Diazepam 5 mg PO at 10:30 a.m.
* 12/18/15 4:00 p.m. "Resident agitated trying to hit staff, wandering in other residents rooms. Valium 5 mg PO given see MAR." Diazepam 5

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F 222	Continued From page 5 mg PO at 4:00 p.m. * 12/24/15 11:20 a.m. "Resident continues to have s/s [signs symptoms] of increase anxiety and agigiation [sic] noted, yelling and hitting out at author. Has had numerous attempts at re-directing. Resident crying - attempts made to give extra TLC [tender loving care]. Will continue to monitor." Diazepam 5 mg PO at 11:20 a.m. * 12/24/15 7:40 p.m. "Res. very combative with CNAs and nurse. PRN diazepam given. Res. Very restless up and down halls in W/C. Will monitor." Diazepam 5 mg PO at 7:40 p.m. * 01/06/16 7:00 p.m. Diazepam 5 mg PO per MAR for "anxiety." No further documentation on behaviors. * 01/07/16 2:00 p.m. Diazepam 5 mg PO per MAR for "increase psychotic behavior." No further documentation on behaviors. This note failed to describe specific behaviors exhibited by the resident that warrented the use of a psychotropic medication. * 01/10/16 7:30 p.m. Diazepam 5 mg PO per MAR for "anxiety/psychotic behavior." 7:30 p.m. Diazepam 5 mg IM per MAR for "anxiety/psychotic behavior." Both PO and IM medications charted. No further documentation on behavior. * 01/11/16 7:30 p.m. Diazepam 5 mg PO per MAR for "anxiety." No further documentation on behavior. * 01/15/16 10:45 a.m. Diazepam 5 mg PO per MAR for "increase anxiety." No further documentation on behavior. * 01/17/16 7:45 a.m. Diazepam 5 mg PO per MAR for "anxiety/hitting." No further documentation on behavior. * 01/18/16 7:00 a.m. Diazepam 5 mg IM per MAR for "increase psychotic behavior." No further	F 222		

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F 222	Continued From page 6 documentation on behavior. This note failed to describe specific behaviors exhibited by the resident that warrented the use of a psychotropic medication. * 01/19/16 2:50 p.m. Diazepam 5 mg PO per MAR for "increase psychotic behavior." No further documentation on behavior. This note failed to describe specific behaviors exhibited by the resident that warrented the use of a psychotropic medication. * 01/23/16 7:00 p.m. Diazepam 5 mg PO per MAR for "increase anxiety" No further documentation on behavior. * 01/24/16 3:45 a.m. "Resident has been awake since 0200 [2:00 a.m.], roaming in the hall and living room with mild to moderate anxiety noted. lorazepam 5 mg one tab was given." Diazepam 5 mg PO at 3:30 a.m., wrong medication charted in the nurses note. * 01/24/16 10:30 p.m. "Res. was agitated, hitting out at staff, restless. Transferred self into W/C from bed at 2215 [10:15 p.m.]. Res at 2215-2305 [10:15-11:05 p.m.] in w/c propelling self throughout facility with red bear in hand. Res states 'she's a son of a [cussword]' 'get her outta here' to this writer referring to CNA. Re-assured res that CNA was going home. Res then upset with other CNA coming onto shift, swinging at CNA, calling CNA names 'you [cussword]' 'Get out of here!' PRN diazepam adm. at 2230 [10:30 p.m.]. . . ." Diazepam 5 mg PO at 10:30 p.m. * 02/12/16 7:30 p.m. Diazepam 5 mg PO per MAR for "psychotic behavior -hitting, punching people - aggressive." No further documentation on behaviors. * 02/14/16 9:15 p.m. Diazepam 5 mg PO per MAR for "restless." No further documentation on behaviors.	F 222		

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F 222	Continued From page 7 This note failed to describe specific behaviors exhibited by the resident that warrented the use of a psychotropic medication. * 02/15/16 5:00 p.m. Diazepam 5 mg PO per MAR for "psychotic behavior hitting wall and doors and people." No further documentation on behavior. * 02/21/16 11:30 p.m. "At 2100 [9:00 p.m.] res became very upset and was hitting kicking and throwing things at staff. Attempted to talk to resident and give her a snack, but she did accept anything. Res continued to kick and wheel up and down the halls. At 2200 [10:00 p.m.], res did accept some ice cream and was given Clonazepam 5 mg at that time. Res is wheeling self around now and more relaxed. Will continue to monitor." Diazepam 5 mg PO at 10:00 p.m. The note failed to identify the correct medication in the nurses note. * 02/26/16 9:00 p.m. Diazepam 5 mg PO per MAR for "crying looking for her children." No further documentation on behaviors. * 03/04/16 11:20 a.m. "Res very agitated. Took off another res. hat and yelling at resident. Followed writer into another res. room - tried to punch writer, scratched and pinched writers hands when moving out of res' room. Res screaming 'help.' Other staff tried to calm/ redirect resident, res hitting out at other staff members. Administered PRN dose of Diazepam IM at this time per orders." Diazepam 5 mg IM at 11:20 a.m. * 03/06/16 8:30 p.m. "Resident increase aggitation [sic] with redirection, Res bite left wrist of [Name] CNA. Bite marks observed. Notified [Name] CNP [certified nurse practitioner] -Received a one time dose of Lorazepam 0.5 mg PO. Res took with 2000 [8:00 p.m.] meds is	F 222		

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currently sitting in TV area with red bear." No Lorazepam administration documented on MAR.
* 03/07/16 4:30 p.m. Diazepam 5 mg PO per MAR for "increase anxiety increase behavior." No further documentation on behaviors.
* 03/13/16 4:45 p.m. "Resident had been wandering in hall in w/c. Was found on knees with hands on floor. Denies injury. Assist of 3 with gait belt back to w/c. when residents vital signs were attempted resident became very combative. Refusing vital signs. Moving all extremities without difficulty. . . . 1655 [4:55 p.m.] In resident's agitated state, swinging at staff. Resident fell forward and bumped head on wall. Abrasion noted to right forehead Neuro check WNL [within normal limit]. Resident remains agitated hitting at staff refusing vital signs . . . 1700 [5:00 p.m.] Valium 5 mg PO given see MAR." Diazepam 5 mg PO at 5:00 p.m.
* 03/17/16 11:30 a.m. Diazepam 5 mg PO per MAR for "grabbing at staff, agitated." No further documentation on behaviors.
* 03/23/16 7:30 a.m. Diazepam 5 mg per MAR for "increase anxiety." No route documented, no further documentation on behaviors.
* 03/23/16 7:15 p.m. Diazepam 5 mg PO per MAR for "anxiety, crying, yelling." No further documentation on behaviors.
* 04/03/16 8:30 p.m. "Res was crying this shift and became very upset with redirection. Res was given clonazepam at 1900 [7:00 p.m.] with good relief. Res is resting in bed at this time. Will monitor." Diazepam 5 mg PO at 7:00 p.m. Wrong medication documented in nurses note.
* 04/04/16 10:00 a.m. "Res striking out at staff-scratching staff and self - kicking." Diazepam 5 mg IM at 10:00 a.m.
* 04/04/16 4:50 p.m. "Res hitting, scratching and

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biting staff - given diazepam 5 mg IM." Diazepam 5 mg IM at 4:50 p.m.
* 04/06/16 1:20 a.m. Diazepam 5 mg PO per MAR for "started to be aggressive." No further documentation on behaviors.
This note failed to describe specific behaviors exhibited by the resident that warrented the use of a psychotropic medication.
* 04/08/16 2:30 a.m. Diazepam 5 mg IM per MAR for "hitting and psychotic behaviors." No further documentation on behaviors.
* 04/08/16 12:00 p.m. Diazepam 5 mg PO per MAR for "increase agitation hitting, throw items." No further documentation on behaviors.
* 04/24/16 8:25 p.m. "Resident was crying, Given Ativan 5 mg PO." Diazepam 5 mg PO at 8:25 p.m. This note failed to identify the correct medication documented in the nurses note.

During an interview on 05/24/16 at 3:55 p.m., an administrative nurse (#1) stated that "a lot of times when she (Resident #5) is agitated I always start with an IM."

During an interview on 05/26/16 at 8:50 a.m., an administrative staff member (#4) stated that staff should have attempted other interventions with Resident #5 prior to administering psychotropic medications.

During an interview on 05/26/16 at 12:40 p.m., the medical director (#5) stated the standard of care expected is to attempt non-pharmacological interventions first then if symptoms persist, and if the resident is a danger to self or others, give PRN medications.

Failure to assess, develop and implement

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specific individualized interventions and monitor the effectiveness of the interventions used in response to specific behaviors resulted in Resident #5 being medicated with psychotropic medications to manage her behaviors.

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia and depression. Interdisciplinary progress notes (IDPN), dated 02/23/16, stated "admitted for increased confusion et needed more cares [with] her ADLs [activities of daily living]."

Current medications included Zoloft, an antidepressant, and no antipsychotic or antianxiety medications.

The care plan interventions prior to 05/05/16 identified the following problems and approaches:
* Upon admission: "Alteration in emotional status d/t dx [diagnosis] depression & on antidepressant" with approaches of "Give meds [medications] as ordered, Observe for s/e [side effects] of meds (i.e. dizziness) & report to CN [charge nurse]; observe for s/s of depression (i.e. increased sleep . . . Offer emotional support-visit & listen . . ."
* Two weeks after admission: "Alteration in cognition d/t dx dementia" with approaches of "At times res. gets confused - remind of meals, activities, etc. Gets overwhelmed w/ [with] too many choices. Offer 1-2 choices. Allow res. time to make choices."
* Three weeks after admission: "Resident does not enjoy 'joking around' (snickering, laughing loudly) Res. feels like people are making fun of

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her; d/t paranoia r/t dx dementia" with approaches of smiling at resident, not laughing too loudly or making jokes, and trying not to be loud when around resident.

IDPN stated:
* 02/23/16 at 7 p.m.: "Resident is very confused . . . wandering in hallway looking for family. Packing up belongings in room. Stating 'I'm going home.' Reorientation done frequently [without] success. Refused bath. Will continue to monitor." At 8:10 p.m.: "Daughter . . . stated 'her mother's sundowners starts around 5 p.m.' Stated to please call . . . daughter at any time if resident is getting agitated."
* 02/25/16 at 8:15 a.m.: ". . . Continues to have periods of confusion. . . ."
* 03/10/16 at 5:45 p.m.: "Res anxious, wandering 'I need to go home.' 'How do I get out of here?' 'I need to go home and et make supper.' Slightly difficult to re-direct. Angry [with] redirection." At 5:55 p.m.: "Still anxious and refuses to eat. Stating she needs to pickup ham/ham soup at the farm. Obtained order for Ativan [anti-anxiety medication] 0.25 mg po [every 8 hours as needed] . . . but ended up not using it because she [illegible word] calmed down after she got visitors by granddaughter and great grand [illegible]."
* 03/11/16 at 1:30 p.m.: ". . . [clinical nurse practitioner] notified of [no] further behaviors since 03/10/16 5:55 p.m. Order received to start Seroquel [anti-psychotic medication] @ [at] [2 p.m.] qd." At 2:00 p.m. "Res anxious. Wandering halls. 'I need to get out.' 'I have to feed my kids.' 'They are [with] their Grandma et they are in the street.' 'I have to get them out of the street.' 'Let me out of here.' 'If you don't let me out of here,

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there will be heck to pay.' Becoming angry [with] redirection. Hit out @ [at] CNA." At 2:25 p.m. "Res remains undirectable, angry. Verbally threatening staff. Call placed to . . . requesting prn Lorazepam, [after] different attempts [with] different nurses." Between 2:50 p.m. and 5:45 p.m. the IDPN notes stated the resident's daughter visited and was "calm. Pleasant et cooperative." At 3:00 p.m. the nurse administered the first dose of Seroquel and wrote the resident had no delusions or increased confusion noted.
* 03/12/16 at 1:00 p.m.: "Res starting to get agitated [with] staff after dinner. PRN Ativan administered per orders. Will monitor." At 2:00 p.m. a nurse administered the "Seroquel dose as ordered." At 3:00 p.m. the resident removed her wanderguard bracelet from her wrist and the nurse documented the resident became "upset & agitated" when staff attempted to reapply the bracelet.
* 03/13/16 at 4:00 p.m., "Wanderguard placed on res walker. PRN Ativan given at [2:00 p.m.], res had been out [with] family all morning and after dinner ref [refused] to take coat off . . ." At 2:45 p.m. ". . . Very agitated, wanting to go . . . find her car & kids. Refused to take Ativan 0.25 mg @ [3 p.m.]. . . . daughter wants Ativan given . . ."
* 03/15/16 at 5:30 p.m.: "[Doctor] here, new orders received et carried." The MAR showed new orders for scheduled Ativan 0.25 mg every day at noon and every 8 hours as needed for anxiety, and Seroquel 25 mg every day at 8:00 a.m. for "dementia/acute psychotic mood disorder."

IDPN identified the resident fell twice on 03/27/16; symptoms of crackles in the left lower lobe with marked edema to the legs and hands

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beginning 04/02/16; continuation of the Ativan and Seroquel without behaviors noted; a diagnosis of pneumonia on 04/04/16; and a diagnoses of a urinary tract infection on 04/11/16. On 04/14/16, the facility transferred the resident to the emergency room for symptoms of weakness of the left hand and arm, and dragging the right leg. The hospital admitted Resident #1 and the resident returned to the facility on 04/21/16.

A physician's progress note, dated 04/27/16 stated, ". . . hospitalized for CHF [congestive heart failure] as well as pneumonia. The patient also does have know Alzheimer's as well as psychomotor agitation. The patient was taken off of the Seroquel as well as the Ativan when she was in the hospital as it was sedating her too much; however, the patient does have episodes where she will be asleep for hours and then she will be alert and combative."

The following changes occurred to the plan of care upon return from the hospital after the discontinuation of the Seroquel and Ativan:
* 05/10/16: "Behavioral symptoms d/t resists/rejects cares & @ times yells @ staff" with approaches of "When res. is resistive w/cares - Stop & come back later. Try alternate staff. Explain what you are going to do before you do it. Chart behaviors."
* 05/10/16: "Alteration in psychosocial well-being d/t decline in condition" with approaches of "Allow res. to stay in bed if she wishes - complete pericares, repositioning, oral cares, etc [as well] in bed. Family visits often. Sit w/res if she seems restless."

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Evidence suggests the facility staff utilized antipsychotic and antianxiety medications rather than non-pharmacological behavioral interventions until after the adverse effects identified during hospitalization.

- Review of Resident #7's medical record occurred on May 25-26, 2016. Diagnoses included Alzheimer's dementia, anxiety and, a diagnosis of psychiatric mood disorder added on 07/07/15.

Current medication orders and start dates included:
* Zoloft 100 mg every day for anxiety; started 04/27/15
* Clonazepam 0.5 mg every 8 hours as needed for anxiety; started 04/27/15
* Clonazepam 1 mg at bedtime every night; started on 04/27/15
* Clonazepam 0.25 mg at 2 p.m. daily for anxiety; started on 07/23/15
* Seroquel 50 mg two times a day at 8 a.m. and 2 p.m.; started 10/20/15. The medical record indicated the resident on Seroquel 25 mg twice a day prior to 10/20/15 (since 05/20/15).
* Seroquel 100 mg at 8 p.m.; started on 10/20/15

The current care plan interventions stated:
* "Alteration in emotional status R/T DX of anxiety & depression . . ." with approaches of "Res gets anxious at times-observe for pain or toileting needs & report to CN. Observe for S/E of med (i.e. dizziness) Offer emotional support - sit and visit about country life; observe for S/S of depression . . .
* "Behavioral symptoms D/T res wanders" with approaches of "Anticipate needs when res

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wanders; take res on a walk in w/c [wheelchair] when he starts to wander or appear anxious; report any increase in wandering behaviors or anxiety to CN"
* "Res hold baby doll & thinks it is real" with approaches of "Res will hold baby doll & rock it to sleep; Give res baby doll when he is anxious. This helps @ times to calm res down . . ."

The MAR showed nursing staff administered the prn Clonazepam:
* May 2016: three times on the night shift for reasons of restlessness and "awake several times"
* April 2016: three times on the night shift for reasons including being "awake" and "mild" restlessness
* March 2016: two times on the night shift for reasons of being "restless"
* February 2016: 10 times on the night shift, and once during the day for reasons of restlessness, agitation, and anxiety
* January 2016: 8 times varying on all three shifts for reasons of restlessness, anxiety, and for agitation
* December 2015: seven times for reasons including restlessness, pacing, agitation and wandering
* November 2015: three times between the night shift and day shift for reasons including "Pt yelling out @ 1/2 hr, restlessness, and agitation

IDPN identified the following:
* 11/12/15 at 10:50 p.m.: "Staff found pt on knees beside bed . . ." The MAR showed nursing staff administered Clonazepam at 4:30 p.m. for restlessness and agitation
* 11/13/15 at 1:30 a.m.: ". . . yelling out and c/o

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F 222	Continued From page 16 neck pain. . . ." The nurse administered Clonazepam and did not administer anything for the resident's pain. * 11/16/15 at 8:00 p.m. staff found the resident on the floor. Staff noted continued sleepiness through 11/19/15 at which time the nurse practitioner discontinued the scheduled 8:00 a.m. dose of Clonazepam "d/t sleepiness" * 11/27/15 at 1:00 p.m. the resident experienced an episode of being found on the floor "under the sink in the bathroom" * 12/03/15 at 8:45 a.m.: "Resident very restless this a.m. Unable to sit down. Pacing the hallways & other resident's rooms. PRN Klonopin given." * 12/05/15 at 10:15 a.m.: "Resident has been pacing since [8:00 a.m.]. Unable to redirect or [with] 1:1. PRN Klonopin given . . ." * 12/12/15 at 7:05 p.m.: A nurse found the resident on the floor in the spa room on his back. * 12/22/15 at 7:45 p.m.: Resident was found sitting on the floor in his room in front of the recliner. * 02/06/16 at 3:00 p.m.: Resident found sitting on the floor in his room. * 02/22/16 at 4:30 a.m.: "Res has been awake all shift. Res was up and ate cereal, drank milk and was given a PRN Clonazepam with no relief. . . ." * 03/18/16 at 4:30 p.m.: Resident experienced a fall to the floor upon standing up from his wheelchair IDPN failed to describe specific behaviors exhibited by the resident that warranted the use of a psychotropic medication. Failure to assess, develop and implement specific individualized interventions and monitor the effectiveness of the interventions used in	F 222		

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response to specific behaviors resulted in Resident #7 staff administering psychotropic medications to manage his behaviors, and resulted in multiple falls.

During an interview with two administrative staff members (#1 and #4) on 05/26/16 at 10:00 a.m., when describing the above instances when staff administered a psychotropic medication to address resident behaviors, both agreed behaviors including restlessness, anxiety and crying are not indicators for administering anti-anxiety and anti-psychotic medication. The staff member (#1) stated she felt "staff are using anti-psychotic medications too often." The staff member (#1) stated when the resident's physician/provider makes visits/rounds to the facility, a nurse does not provide information regarding the resident's behavioral status, although this information is provided with concerns during phone calls.

During interview with the medical director (#5) on 05/26/16 at 1:40 p.m., the director stated:
* When residents experience symptoms of anxiety, agitation, danger to self or others, and behavioral interventions aren't effective, the use of psychopharmacological interventions may need to be considered
* The standard of care is to use non-pharmacological interventions
* Would never prescribe medications just to control behavior
* Mid-level practitioners receive most of the phone calls regarding resident's behaviors/conditions and the medical director not sure they dictate a note regarding changes in treatment, including behaviors

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F 222	Continued From page 18 *"I have talked with the nurses regarding the use of non-pharmacological" interventions. Failure of the facility to appropriately assess and implement behavioral interventions to manage behaviors for Resident #1, #5 and #7's resulted in the frequent utilization/overuse of anti-anxiety and anti-psychotic medications.	F 222		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on information received from an anonymous individual (B), group interview (Resident A and D), individual resident interview (Resident #4), family interview (Individual C) and staff interviews, the facility failed to provide reasonable accommodation of needs regarding call light response on 4 of 4 days of survey (May 23-26). Failure to ensure the answering of call lights in a timely manner may result in falls, avoidable incontinence, increased behaviors, and a decreased quality of life. Findings include: Communication from an anonymous individual (B) received on 05/12/16 included resident	F 246	F 246 A memo to all staff in all departments directing them to answer a resident call light when observed. Should a non-nursing staff member answer a light and the resident requires a nursing function, the staff member shall leave the call light on and find the appropriate staff member to provide the necessary care. All residents have the potential to be affected by this deficient practice. All Staff were educated on said memo on 6/13/16 and 6/15/16. The job duties of the Dietary staff were revised to include helping with the meal service at the evening meal. In addition CNA/ Nurse break times were	6/28/16

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F 246	Continued From page 19 concerns with wait times to obtain assistance from facility staff. Review of the resident council meeting minutes for 02/16 through 04/16 occurred on 05/23/16. The minutes, dated 03/28/16, showed "New Business" included "Call light slow to answer." The facility did not provide follow-up/address the resident's concern at the April council meeting. During group interview on 05/23/16 at 3:00 p.m., two of five residents (Resident A and B) complained of having delayed response to call lights. One of the residents (Resident A) estimated wait times of 20 minutes. The resident stated the wait times are longer on weekends. - During a resident interview on 05/24/16 at 12:50 p.m., Resident #4 identified concerns of the facility being very short staffed and having long wait times to answer call lights up to 20 to 30 minutes. The resident stated this is worse in the evenings especially around the evening meal as one staff is pulled to serve food and cannot leave the dining room to answer call lights or assist residents. - During a family interview on the afternoon of 05/25/16, a resident's daughter (C) expressed a concern with no staff being present when the family comes to visit the resident, and is often concerned that her family member is sitting long periods of time without staff checking in as the resident cannot ask for help on her own. - During an interview on 05/25/16 at 2:25 p.m., two staff members (#6 & #7) stated: the average call light wait time is a minimum of 25 minutes on	F 246	changed to ensure maximum staff are available over meal service times. The Dietary manager or designee will audit meal time service three time per week varying the meals for the next 3 months to ensure meals are served at the posted meal times. If no issues are discovered audits will be conducted two times per month for the following 9 months. Results of the audits will be reported by the Dietary Manager at the Quarterly QA meeting. The Director of Nursing or designee will audit call light response times for one hour per week between the hours of 5:00 pm and 8:00 pm for the next 3 months to ensure timely response time to resident call lights. If no problems are discovered through the audits or no complaints are received through resident council or family members, the audits will be conducted two times per month for the next 9 months. Results of the audits will be reported by the Director of Nursing at the quarterly QA meeting.	

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F 246	Continued From page 20 average, residents have to wait around 30 minutes to be fed at meal times, meals will often start one hour late, during the evening meal residents' needs are not being met due to staffing, and the evening CNAs (certified nursing assistants) serve meals and feed residents. During an interview on the morning of 05/26/16, an administrative staff member (#1) agreed staffing is a concern on the units. This staff member described staffing on the evening shift as one CNA scheduled on the Whispering Winds unit, one CNA scheduled on the Cozy Cottage unit, and one CNA floats between the two units. The staff member stated the two evening CNAs are required to serve the evening meal and feed residents. The staff member stated the Cozy Cottage unit has four residents that require assistance with eating; Whispering Winds has one or two residents who require assistance with meals; and this assistance is provided after all the other residents' meals have been served by the CNAs. The staff member said these CNAs cannot leave the dining room if there are residents still eating and said this delays attending to resident needs i.e. toileting, transfers, bathing, etc. during that time. The staff member stated the nurse may or may not be able to watch in the dining room during this time, to allow a CNAs to leave and answer call lights or assist residents.	F 246		
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	F 248		6/29/16

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F 248	Continued From page 21 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and record review, the facility failed to provide individualized activities consistent with residents' needs, preferences and interests for 3 of 5 sampled residents (Resident #1, #5 and #7) dependent on staff for activities. Failure to provide and implement individualized activity programs may negatively impact residents' quality of life. Findings include: Review of the "Activity Policy" occurred on 05/26/16. The policy, undated, stated, "PURPOSE: To meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. . . . All residents, unable to participate in group activities will be visited by the Activity Director activity staff [sic], along with all staff to promote their mental and social wellbeing [sic]. . . . A balance of recreational activities including physical, social, religious, arts and crafts, diversional and intellectual are offered. . . ." Review of "Rec [recreational] Therapy-Group Attendance Detail" records showed the ability to monitor resident participation various activities including: "Recreation Therapy" which included games and exercise; "Mental Activity" which included games, cards, trivia and reminiscencing; "Spiritual/Emotional" which included religious services; "Creative Arts" which included	F 248	F 248 The Care Plans for Resident's #1, #5 and #7 were reviewed and revised on or before 6/10/16,to include resident specific activities based upon assessments. All residents have the potential to be affected should the facility fail to ensure individualized activities are implemented especially as an alternative to medication utilization. As part of the Antipsychotic review by the QAPI team, behaviors as well as interventions or activities attempted will be reviewed for PRN psychopharmacological medication administrations. All nursing staff were educated on the Behavioral Management policies which include activities attempted for residents who display behaviors. The DON or designee will audit the behavior management plans one time per week for the next three month to ensure activities are being implemented. If compliance is achieved the audits will be conducted one time per month for the following nine months. Results of the audits and summaries of the QAPI's review will be presented to the QA committee by the Director of Nursing at the quarterly QA meeting.	

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drawing/painting, tactile crafts, paper crafts, yarn/needle crafts, bingo, watching TV, eating experiences, clubs/organizations, outdoor activities; "Music/Entertainment" which included performances; "Visitors" by family/friends; "Special Events" which included birthday parties, seasonal parties, and cultural activities.

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia and depression. The record identified the resident "admitted for increased confusion . . ."

The care plan addressed the resident's activities with approaches of "Remind of & enc [encourage] daily act [activity]; assist to & from act of interest; Res is of Lutheran faith . . .; Res enjoys church, bingo, cards, crafts, music, kid's groups, games, trivia, baking, 1-1 visits, TV, reading newspaper, Res likes to keep busy." The care plan also identified problems of "Alteration in emotional status d/t [due to] dx [diagnosis] depression & on antidepressant" and "Alteration in cognition d/t dx dementia"

A "Social History & Activity Assessment," dated 02/24/16, identified the resident's interests included playing whist and all card games, "Games, Crafts/Arts, Sports, Music, Reading, Spiritual/Religious, Trips/Community Outings, Shopping, Being Outdoors, Watching TV/Movies, Talking/ Conversing, Helping Others, and Parties/Social Events."

Review of Resident #1's "Rec Therapy-Group Attendance Detail" records between 02/16 and 04/16 identified the resident participated in all

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F 248	Continued From page 23 types of activities offered. Progress notes identified the resident with behaviors including wandering, resistance to cares, confusion, anxiety, and anger beginning upon admission in 02/16. This progressed into staff administering the anti-anxiety medication (Ativan/Lorazepam) on a scheduled and as needed (prn) basis, and scheduled doses of the anti-psychotic medication (Seroquel) beginning in 03/16 through 04/16 (one month). The record showed nursing staff did not attempt to engage the resident in an activity of interest prior to administering as needed and scheduled anti-anxiety and anti-psychotic medications. - Review of Resident #7's medical record occurred on May 25-26, 2016. Diagnoses included Alzheimer's dementia, anxiety and, a diagnosis of psychiatric mood disorder added on 07/07/15. Care plan interventions identified the problem of the resident "rarely or never understood" in relation to activities. Approaches included to remind and encourage household/individual activities, to assist to and from activities, resident enjoys bingo, van rides, gardening, bird watching, church, music, entertainment, some TV, and 1:1 visit; "wife states too much stimulations causes agitation; res is not consistent in any" activity. The care plan also identified problems of wandering behavior, anxiety and depression, and utilizing a baby doll during episodes of anxiety. A "Social History & Activity Assessment," dated 04/10/15, identified the resident's interests	F 248		

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	355116	A. BUILDING _____ B. WING _____	05/26/2016

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included "Games, Sports, Music, Reading, Spiritual/Religious, Trips/Community Outings, Being Outdoors, Watching TV/Movies, Talking/ Conversing, and Parties/Social Events." The assessment stated "Wife states too much stimulation aggitates [sic] resident."

Review of Resident #7's "Rec Therapy-Group Attendance Detail" records between 12/04/15 and 05/23/16 identified the resident participated in most "Recreation Therapy," refused all mental activities, refused all but one "Spiritual/Emotional" activity, refused participation in all "Creative Arts" activities, would participate in many "Social Activities," one "Music/Entertainment," several "Visitor" visits, and no "Special Events."

Review of Resident #7's medical record showed nursing staff administered anti-anxiety and anti-psychotic medications without first attempting to engage the resident in an activity of interest.

- Review of Resident # 5's medical record occurred on all days of survey. Diagnoses included dementia, mood disorder, and confusion.

Care plan interventions included:
* "Activity info" with approaches of "Remind of & enc act of interest; Assist res to & from ACT & during PRN; Res enjoys crafts, music, church, 1-1 visits, Enjoys social & pleasant interaction."
* Alteration in emotional status . . . on antidepressant" with approaches of "Give meds as ordered; Observe for S/E of med & report to CN (i.e. dizziness); Offer emotional support; Observe for s/s of depression and report to

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F 248	Continued From page 25 CN/SS [social services] (i.e.: Increased sleeping, w/drawn from others, loss of interest in act.)." Progress notes identified the resident with behaviors including wandering, resistance to cares, confusion, anxiety, agitation, and restlessness beginning upon admission on 03/31/14. This progressed into the administration of anti-anxiety medication (Diazepam) on a PRN basis 48 times between 11/01/15 and 04/30/16. A "Social History & Activity Assessment," dated 04/01/14, identified the resident's interests included playing whist, and "Games, Crafts/Arts, Music (country western), Trips/Community Outings, Being outdoors (Doesn't like to garden), Watching TV/Movies, Talking/Conversing, Helping Others, and Parties/Social Events." Review of Resident #5's "Rec Therapy-Group Attendance Detail" records between 11/30/15 and 05/23/16 identified the resident refused most "Recreation Therapy," would participate in "Mental activity," participate in "Spiritual/Emotional" activity, participate in "Creative Arts" activity, would participate in "Social Activity," would participate in "Music/Entertainment" activity, "Visitor" visits, and "Special Events." Nursing progress notes showed nursing staff failed to utilize activities of the residents interest to divert, lessen, or alter Resident #5's behavior prior to the administration of multiple anti-anxiety and anti-psychotic medications. Refer to F222.	F 248		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		6/30/16

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F 281	Continued From page 26 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: MEDICATION ADMINISTRATION 1. Based on record review, review of professional literature, and staff interview, the facility failed to follow professional standards of practice for 2 of 5 sampled residents (Resident #5 and #7) receiving psychoactive medications. Failure to chart results of as needed (PRN) medications (Resident #5 and #7), failure to follow physician orders (Resident #5), and failure to chart the correct medication (Resident #5) placed the residents at risk of adverse health effects, and/or unnecessary medications. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, 2016, page 771-778, states, ". . . Process of Administering Medications: When administering any drug . . . the nurse must do the following: . . . 6. Evaluate the client's response to the drug. . . . In all nursing activities, nurses need to be aware of the medications that a client is taking and record their effectiveness as assessed by the client and the nurse on the client's chart. . . . Ten 'Rights' of Medication Administration . . . Right Time: Give the medication at the right frequency and at the time ordered . . . Skill 35-1 Administering Oral Medications: . . . Evaluation: Return to the client when the medication is	F 281	F 281 1. The medical record for resident #5 will be corrected with a late entry by the Director of Nursing to reflect the correct medication administered. Beginning July 1, 2016 the facility is converting to an Electronic Medical Record (EMR. As part of the system the Electronic Medication Administration Record (EMAR) will link directly from the EMAR portion of the program to the progress portion where the nurse will be directed to make an entry related to the PRN medication administered. All nurses were educated on charting the correct medication in the IDP notes as well as the facility Behavior Management Program which includes follow up documentation of medication efficacy. The ETAR program also requires a follow-up for PRN medications be charted by the nurse for the efficacy of the PRN medication administered. The Director of Nursing or designee will randomly audit 3 charts per week to verify that efficacy of PRN medications are recorded appropriately and that the nurses progress notes match the Medication Administration Record for PRN medications given. Results of the audits will be reported by the Director of Nursing at the Quarterly QA committee meeting.	

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F 281	Continued From page 27 expected to take effect (usually 30 minutes) to evaluate the effects of the medication on the client. Observe for desired effect . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, and mood disorder. The significant change Minimum Data Set (MDS), dated 05/20/16, identified cognition as moderately impaired, sometimes makes self understood and sometimes understands others. The current care plan stated, ". . . Problem: Altered thought process d/t [due to] Dx [diagnosis] dementia r/t [related to] forgetful of surroundings and resistive w/cares [with cares]. . . . Approaches: . . . Res [resident] may get resistive w/cares (scratch/hit). Be creative- alt [alternate] staff, come back @ [at] a different time. Res calms down w/1-1 [one to one] staff rather than numerous staff present. . . . Problem: Altered thought process d/t delusions m/b [manifested by] believes her kids are missing. . . . Approaches: . . . Get in res world & comfort her when she has altered thought process. Attempt to redirect res to an alt act [activity]. . . ." Physician orders for Resident #5 for prn psychoactive medications stated, "01/05/15 Diazepam (anti-anxiety) 5 milligrams [MG] per oral [PO] or intramuscular [IM] every 6 hours PRN. . . . 03/06/16 Lorazepam (anti-anxiety) 0.5 MG PO one time. . . . 04/04/16 Haldol (antipsychotic) 5 MG IM now." The following nursing notes identified the wrong medication charted by the nurse: * 01/24/16 3:45 a.m. "Resident has been awake since 0200 [2:00 a.m.], roaming in the hall and	F 281	2. PT/INR labs ordered for resident #1 have been completed since 5/5/16. All residents have the potential should the facility fail to ensure lab orders are completed per physician orders. On July 1, 2016 the facility is converting to an electronic Medical Record (EMR). The EMR program records all physician ordered labs ordered and creates a daily report for labs for the upcoming day. This will ensure that Labs ordered are completed in a timely manner. The Director Of Nursing or designee will randomly audit 3 daily reports per week to verify labs are completed per physician order. If no labs have been missed during the first 3 months the audits will be conducted monthly thereafter for the next year. Results of the audits will be reported by the Director Of Nursing to the QA committee at the quarterly QA meeting.	

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living room with mild to moderate anxiety noted. lorazepam 5 mg one tab was given." The MAR identified diazepam 5 mg PO given at 3:30 a.m., not lorazepam as documented in the nurses note.
* 02/21/16 11:30 p.m. "At 2100 [9:00 p.m.] res became very upset and was hitting kicking and throwing things at staff. Attempted to talk to resident and give her a snack, but she did accept anything. Res continued to kick and wheel up and down the halls. At 2200 [10:00 p.m.], res did accept some ice cream and was given Clonazepam 5 mg at that time. Res is wheeling self around now and more relaxed. Will continue to monitor." The MAR identified diazepam 5 mg PO given at 10:00 p.m., not clonazepam as documented in nurses note.
* 04/03/16 8:30 p.m. "Res was crying this shift and became very upset with redirection. Res was given clonazepam at 1900 [7:00 p.m.] with good relief. Res is resting in bed at this time. Will monitor." The MAR identified diazepam 5 mg PO given at 7:00 p.m., not clonazepam as documented in nurses note.
* 04/24/16 8:25 p.m. "Resident was crying, Given Ativan 5 mg PO." The MAR identified diazepam 5 mg PO at 8:25 p.m., not ativan as documented in nurses note.

Medication administration records (MAR) showed nursing staff administered either PRN diazepam, haldol, or lorazepam:
* April 2016: seven times varying on all three shifts for the reasons of "crying, upset, increased agitation, hitting, increased psychotic behaviors." The medical record lacked documentation of the effectiveness of the medication twice.
* March 2016: seven times varying on all three

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shifts for the reasons of "yelling, combative, increased anxiety, increased behaviors, grabbing at staff, crying." The medical record lacked documentation of the effectiveness of the medication once.
* February 2016: five times on evening shifts for the reasons of "hit out on nurses hand, psychotic behaviors, restless, crying, looking for her children, hitting wall, doors, and people." The medical record lacked documentation of the effectiveness of the medication once.
* January 2016: 12 times varying on all three shifts for the reasons of "anxiety, increased psychotic behavior, restless, anxious, hitting out." The medical record lacked documentation of the effectiveness of the medication five times.
* December 2015: 8 times varying on days and evening shifts for the reasons of "agitated, restlessness, combative, wandering." The medical record lacked documentation of the effectiveness of the medication three times.
* November 2015: eight times varying on days and evening shifts for the reasons of "anxiety, restless, agitation, crying, confused." The medical record lacked documentation of the effectiveness of the medication three times.

The following nurses notes identified errors in documentation on the MAR for Resident #5:
* 01/10/16 7:30 p.m. Diazepam 5 mg PO per MAR for "anxiety/psychotic behavior." 7:30 p.m. Diazepam 5 mg IM per MAR for "anxiety/psychotic behavior." Both PO and IM medications charted. No further documentation on behavior.
* 03/06/16 8:30 p.m. "Resident increase aggitation [sic] with redirection, Res bite left wrist of [Name] CNA. Bite marks observed. Notified

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[Name] CNP [certified nurse practitioner]
-Received a one time dose of Lorazepam 0.5 mg PO. Res took with 2000 [8:00 p.m.] meds is currently sitting in TV area with red bear." No Lorazepam administration documented on MAR.

The following MARs identified failure of the staff to follow the physician's order for "01/05/15 Diazepam 5 MG PO/IM every 6 hours PRN."
* March 7, 2016: Diazepam 5 MG given at 4:30 p.m. and 8:30 p.m.

- Review of Resident #7's medical record occurred on May 25-26, 2016. Diagnoses included Alzheimer's dementia, anxiety and, a diagnosis of psychiatric mood disorder added on 07/07/15. Resident #7's MARS showed administration of Clonazepam 0.5 mg every 8 hours as needed for anxiety since 04/27/15.

The MARS showed nursing staff administered the prn Clonazepam:
* May 2016: three times on the night shift for reasons of restlessness and "awake several times." The record lacked documentation of the effectiveness of the medication on one occasion.
* April 2016: three times on the night shift for reasons including being "awake" and "mild" restlessness. The record lacked documentation of the effectiveness of the medication on one occasion.
* March 2016: two times on the night shift for reasons of being "restless." The record lacked documentation of the effectiveness of the medication on one occasion.
* January 2016: eight times varying on all three shifts for reasons of restlessness, anxiety, and for agitation. The record lacked documentation of

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F 281	Continued From page 31 the effectiveness of the medication on three occasions. * December 2015: seven times for reasons including restlessness, pacing, agitation and wandering. The record lacked documentation of the effectiveness of the medication on one occasion. * October 2015: three occasions for agitation, restlessness. The record lacked documentation of the effectiveness of the medication on one occasion. FOLLOWING PHYSICIAN ORDERS 2. Based on record review and staff interview, the facility failed to ensure the completion of laboratory (lab) orders for 1 of 9 sampled residents (Resident #1). Failure to follow physician orders placed the residents at risk of adverse health effects. - Review of Resident #1's medical record occurred on all days of survey and diagnoses included coronary artery disease and history of deep vein thrombosis with pulmonary emboli. Physician's orders included Coumadin, a medication used to decrease the clotting tendencies of blood, adjusted as needed by the lab reports of protimes (PT) and INR (International Normalized Ratio) laboratory results. Orders included a PT/INR for 05/05/16. Review of the record did not contain the results of the PT/INR laboratory specimen as ordered by the medical provider scheduled for 05/05/16. On 05/24/16 at 2:00 p.m., a staff nurse (#3) called the laboratory at the local hospital to obtain the results and no report was available.	F 281		

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F 281	Continued From page 32 On 05/24/16 at 5:30 p.m., an administrative staff nurse (#1) confirmed the facility failed to ensure the completion of the 05/05/16 PT/INR lab order.	F 281		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policies, and staff interview, the facility failed to identify and implement non-pharmacological	F 329	F329 The drug regimen for all residents including residents #1, #5, #7, #8 and #9	6/28/16

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F 329	Continued From page 33 interventions for 5 of 9 sampled residents (Residents #1, #5, #7, #8 and #9) before administering as needed (PRN) and scheduled anti-anxiety medications, and scheduled antipsychotic medications. Failure to ensure adequate indications before utilizing anti-anxiety medication (clonazepam and lorazepam) and anti-psychotic medications (Haldol, Seroquel and Risperdal) placed Resident #1, #5, #7, #8 and #9 at risk of receiving unnecessary medications and suffering adverse consequences related to their use. Findings include: Review of the "Medication Utilization and Prescribing - Clinical Protocol" policy occurred on 05/26/16. The undated policy, stated,". . . When a medication is prescribed in response to an identified problem, condition, or risk, . . . try to identify likely causes and pertinent non-pharmacological interventions. c. A diagnosis by itself may not be sufficient justification . . . does not necessarily require a treatment and the treatment may be something besides, or in addition to, medication. . . ." Review of the "Medication Therapy" policy occurred on 05/26/16. The undated policy, stated: ". . . Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. Medication use shall be consistent with an individual's condition . . . All medication orders will be supported by appropriate care processes and practices. . . . All decisions related to medications shall include appropriate elements of	F 329	were reviewed on 6/7/16 by the consulting pharmacist. For Resident #1 the consultant Pharmacist noted Zoloft, Ativan and Seroquel. Resident currently receiving Zoloft 75 mg per day one time per day, and Gradual Dose Reduction (GDR) not recommended at this time. For Resident #5 the Consultant Pharmacist noted Diazepam, Seroquel, and Zoloft, The GDR was addressed by the physician on 4/16 progress note and this was No PRN psychoactive medications have been administered since last review. For Resident #7 the Consultant Pharmacist addressed Zoloft, Clonazepam, and Seroquel. GDR was addressed by the physician on the 5/16 progress note, on 6/16/16 all psychopharmacological medications were discontinued. For Resident #8 The Consultant Pharmacist addressed the Zoloft and Haldol use, with no GDR recommended at this time. For Resident #9 the Consultant Pharmacist noted that the GDR was addressed by the physician on 4/16 progress note, and no further recommendations were made at this time. The facility is converting to an Electronic Medical Record (EMR) on 7/1/2016. With this conversion more accurate documentation of behaviors as well as documentation of alternatives attempted prior to PRN psychopharmacological medication administration. In addition to the EMR implementation, the facility implemented a behavior management program. The Director of nursing or designee will partcipate in the weekly	

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F 329	Continued From page 34 the care process, such as: a. Adequately detailed assessment; b. Review of causes of symptoms; c. Consideration of the clinical relevance of symptoms . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, depression and symptoms of increased confusion upon admission. The admission Minimum Data Set (MDS), dated 03/06/16, identified severe cognitive impairment, no symptoms of delirium and mild depression symptoms. The resident's current physician's orders did not include orders for anti-psychotic or anti-anxiety medications.. The current care plan identified problems and approaches of: * 02/23/16: "New admit . . . allow res [resident] time to adjust to new environment. Introduce to staff & res on household. Observe for mood changes & [and] report to CN/SS [charge nurse/social services]." * 02/23/16: "Alteration in comm [communication] d/t [due to] HOH [hard of hearing]" with approaches of ". . . Speak clearly & distinctly, repeat as needed, increase speaker volume prn." * 02/23/16: "Alteration in emotional status d/t dx [diagnosis] depression & [and] on antidepressant" with approaches of "Give meds [medications] as ordered, Observe for s/e [side effects] of meds . . . & report to CN; observe for s/s [signs and/or symptoms] of depression . . . Offer emotional support-visit & listen . . ." * 03/11/16: "Alteration in cognition d/t dx dementia" with approaches of "At times res. gets	F 329	meeting to audit for the assessment and implementation of interventions to manage resident behavior, prior to administration of a psychopharmalogical medication. All antipsychotic medication usage will be reviewed by the consultant Pharmacist monthly, their reviews will be part of the EMR and reviewable by attending practitioners. The QAPI team as part of their antipsychotic medication review will be reporting quarterly at the facility QA meeting. In addition to this reporting the DON will also report results from the South East North Dakota Great Plains Quality Innovation Network's Pilot project to reduce antipsychotic medication use. These two additional QA processes will ensure that unnecessary medications are not being utilized by the facility.	

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confused - remind of meals, activities, etc. Gets overwhelmed w/ [with] too many choices. Offer 1-2 choices. Allow res. time to make choices."
* 03/17/16: "Resident does not enjoy 'joking around' (snickering, laughing loudly) Res. feels like people are making fun of her; d/t paranoia r/t dx dementia" with approaches of smiling at resident, not laughing too loudly or making jokes, and trying not to be loud when around resident.

The care plan included the addition of the following after the residents return from a week in the hospital on 04/21/16:
* "Behavioral symptoms d/t resists/rejects cares & @ times yells @ staff" with approaches of "When res is resistive w/cares [with cares], stop & come back later; Try alternate staff; Explain what you are going to do before you do it. Chart behaviors."
* "Alteration in psychosocial well-being d/t decline in condition" with approaches of "Allow res. to stay in bed if she wishes . . . Family visits often. Sit w/res if she seems restless"

A "Behavioral Symptoms" report, completed by certified nursing assistants (CNAs) showed between the resident's admission date (02/16) and hospitalization (04/16) evidence of two wandering episodes. One of those episodes identified the resident dangerous to herself. These incidents occurred on 03/15/16 (see progress note above) and one 03/27/16. The progress note on 03/27/16 did not identify any wandering behavior by the resident.

Progress notes identified the resident began experiencing episodes of anxiousness, wandering and anger with redirection on

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03/10/16. (The medical record did not define the type of re-direction given). On that date, the medical provider gave an order for Ativan [anti-anxiety] medication for staff to administer every 8 hours as needed. On 03/11/16, the midlevel practitioner ordered Seroquel [anti-psychotic medication] at 2:00 p.m. everyday. Nursing staff administered the prn Ativan for symptoms of wandering, confusion, and agitation on 03/12/16, 03/13/16, and 03/15/16. On 03/15/16, the medication administration record (MAR) showed new orders for scheduled Ativan 0.25 milligrams (mg) every day at noon and every 8 hours as needed for anxiety, and Seroquel 25 mg every day at 8:00 a.m. for "dementia/acute psychotic mood disorder." The resident was hospitalized on 04/14/16 and returned to the facility on 04/21/16, no longer on the Seroquel and Ativan.

The record showed nursing staff did not develop and implement specific individualized non-pharmacological interventions (including describing the "re-direction" utilized) prior to administering the prn Ativan. The record lacked indications for the scheduled Ativan and for the scheduled Seroquel.

Evidence suggests the facility staff utilized antipsychotic and antianxiety medications rather than non-pharmacological behavioral interventions until after the adverse effects identified during hospitalization.

- Review of Resident #7's medical record occurred on May 25-26, 2016. Diagnoses included Alzheimer's dementia, anxiety and, a diagnosis of psychiatric mood disorder added on

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F 329	Continued From page 37 07/07/15. Current medication orders and start dates included: * Zoloft 100 mg every day for anxiety; started 04/27/15 * Clonazepam 0.5 mg every 8 hours as needed for anxiety; started 04/27/15 * Clonazepam 1 mg at bedtime every night; started on 04/27/15 * Clonazepam 0.25 mg at 2 p.m. daily for anxiety; started on 07/23/15 * Seroquel 50 mg two times a day at 8 a.m. and 2 p.m.; started 10/20/15. The medical record indicated the resident on Seroquel 25 mg twice a day since 05/20/15 prior to this increase. * Seroquel 100 mg at 8 p.m.; started on 10/20/15 The current care plan included: * "Alteration in emotional status R/T DX of anxiety & depression . . ." with approaches of "Res gets anxious at times-observe for pain or toileting needs & report to CN. Observe for S/E of med (i.e. dizziness) Offer emotional support - sit and visit about country life; observe for S/S of depression . . . * "Behavioral symptoms D/T res wanders" with approaches of "Anticipate needs when res wanders; take res on a walk in w/c [wheelchair] when he starts to wander or appear anxious; report any increase in wandering behaviors or anxiety to CN" * "Res hold baby doll & thinks it is real" with approaches of "Res will hold baby doll & rock it to sleep; Give res baby doll when he is anxious. This helps @ times to calm res down . . ." Medication administration records (MAR) showed	F 329		

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F 329	Continued From page 38 nursing staff administered prn Clonazepam between 11/15 and 05/16 for the following reasons: * May 2016: three times on the night shift for reasons of restlessness and "awake several times" * April 2016: three times on the night shift for reasons including being "awake" and "mild" restlessness * March 2016: two times on the night shift for reasons of being "restless" * February 2016: 10 times on the night shift, and once during the day for reasons of restlessness, agitation, and anxiety * January 2016: eight times, throughout all three shifts for reasons of restlessness, anxiety, and for agitation * December 2015: seven times for reasons of restlessness, pacing, agitation and wandering * November 2015: three times between the night shift and day shift for reasons including "Pt yelling out @ 1/2 hr [hour]," restlessness, and agitation A "Behavioral Summary Form and Antipsychotic Drug Review" form, dated 05/11/16, identified the resident's behavior as wandering in and out of rooms and up and down halls, which did not pose a safety risk for the resident or others. The form identified the start date, the current psychotropic medications, and dosages. This included: "10-25-15 Seroquel 50 mg [orally two times a day] [every 8:00 a.m. & 2:00 p.m.] Dx psychotic mood disorder; 10-20-15 Clonazepam [one] mg [orally at bedtime] dx anxiety; 04-27-15 Zoloft 100 mg [orally every day] dx anxiety. . . . Last time does [sic] was reduced: 10-21-15." The physician completed the next section which stated the	F 329		

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resident's diagnoses included organic mental syndrome of "delirium, dementia, and amnestic and cognitive disorder with associated psychotic and/or agitated behaviors" and documented a dose reduction not warranted for this reason, "Still with negative behaviors and no evidence of side effects."

IDPN notes between 09/16/15 and 02/22/16 identified nursing staff administered the prn Clonazepam for reasons of being "very anxious and agitated;" for "resident restless trying to get out of bed wondering about a funeral service confused on time and place. . . ."; "Res found in spa room laying on the floor . . . Res agitated - swearing @ staff - uncooperative. . ." followed with increased agitation; "Res very agitated. Wanting to do work on combine. Will not lay in bed or sit in recliner;" "Staff found pt on knees beside bed . . ." and administered Clonazepam for restlessness and agitation; ". . . yelling out and c/o [complains of] neck pain. . . ."; for "Resident very restless this a.m. Unable to sit down. Pacing the hallways & other resident's rooms. PRN Klonopin [Clonazepam] given;" "Resident has been pacing since 0800. Unable to redirect or [with] 1:1. PRN Klonopin given . . ."; and "Res has been awake all shift. Res was up and ate cereal, drank milk and was given a PRN Clonazepam with no relief. . . ."

A physician progress note, dated 12/07/15, stated, ". . . he has been continuing to have the alternating days of increasing anxiety and then he will have days when he will sleep most of the day. Today he is sleeping. . . . He has stated at times that his knees will hurt when he is agitated and walking around the home more. He does

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have known advanced dementia. . . . I discussed [with wife] adjustments of his psychotropic medications but at this time no changes are made . . ." The note did not address interventions to implement regarding the resident's pain, however current physician's orders show the resident started on acetaminophen (Tylenol) 650 mg three times a day since 06/15/15 for "left rib pain/contusion." Antipsychotic and antianxiety medications continued the same as noted above.

A physician's progress note, dated 03/09/16, stated, ". . . The patient does have known Alzheimer's. He is currently on clonazepam, as well as Seroquel and the Zoloft. The nursing staff states that the patient has been having fewer behavioral incidents. . . . will be continued on his current medications of the sertraline [Zoloft], clonazepam, and Seroquel. . . ."

IDPN notes showed the facility staff administered psychotropic medications to manage Resident #7's behaviors without adequate indications, and this resulted in multiple falls. The medical record lacked indications for the continued need and/or use for the psychotropic medications.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, mood disorder, and confusion. The significant change MDS dated, 05/20/16, identified moderately impaired cognition, disorganized thinking, altered level of consciousness, and no depressive symptoms.

Progress notes identified the resident has experienced episodes of restlessness, agitation, wandering, combativeness, and confusion since

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F 329	Continued From page 41 admit on 03/31/14. Physician orders were initiated on the following dates for the following medications: * 01/05/15: Diazepam (antianxiety) 5 milligrams per oral [by mouth] or intramuscular [IM] every 6 hours PRN * 10/20/15: Seroquel (antipsychotic) 100 mg by mouth three times daily [TID] (0800 [8:00 a.m.], 1400 [2:00 p.m.] & hours of sleep [HS]). * 03/06/16: Lorazepam (antianxiety) 0.5 mg by mouth one time * 04/04/16: Haldol (antipsychotic) 5 mg IM now * 04/12/16: Zoloft (antidepressant) 150 mg by mouth daily [QD] for anxiety/depression. Nurse's progress notes identified consistently from May 2015 - May 2016 PRN medications were given without adequate indication or implementation of non-pharmacological interventions. The record lacked indications for the scheduled seroquel. - Review of Resident #8's medical record occurred on May 25-26, 2016. Diagnoses included mild cognitive impairment, and psychotic affective disorder. The quarterly MDS, dated 03/18/16, identified cognition intact, no symptoms of delirium, and no depressive symptoms. The current care plan stated, ". . . Alteration in cognitive impairment d/t mild cognitive impairment r/t has false beliefs. . . . Approaches. . . .At times res gets mixed up about what is real & what is not (i.e.: son's coming to visit, son's waiting for her to come back to [city]); When res has this belief, get in her world. Allow res to state her beliefs; Res guardian is aware of her wanting to return to [city]- Guardian does not believe this	F 329		

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is in res best interest. Res forgets her and guardian have had this conversation; Assist res to call guardian & SW as she wishes; Attempt to redirect res when she is upset (watch TV, visit about other topic). . . ."

Progress notes identified Resident #8 as being "difficult to redirect, demanding, and short tempered," since admit on 09/24/15. Physician orders included the following:
* 09/24/15: Cogentin 1 mg 1 tab by mouth BID [twice daily]
* 09/24/15: Haldol 5 mg by mouth QHS
* 02/25/16 Zoloft 50 MG PO QD

A "Behavioral Summary form and Antipsychotic Drug Review," dated 02/25/16, stated, "1. Brief summary of the residents behaviors: Refuses care, argues, wanders. . . . 3. The total number of incidents that have happened in the past 6 months. . . . 24. . . . 5. Does the behavior present a danger to the resident or to others? No. . . . 7. Does the resident exhibit behaviors screaming, yelling or pacing that are not dangerous but which cause the resident distress or impairment in functional capacity? Yes. Please comment: Res is hard to redirect at times. 8. Current psychotropic medications and dosage: 9/24/15 Haloperidol 5 mg PO QHS dx psychotic affective disorder. 02/10/16 Zoloft 25 mg one tab PO QD. . . . 10. Last time dose was reduced: 09/25/15." . . .The physician completed the next section which stated the resident's diagnoses included organic mental syndrome of 'delerium, dementia, and amnestic and cognitive disorder with associated psychotic and/or agitated behaviors' and documented a dose reduction not warranted for this reason, "Still negative behaviors need to

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F 329	Continued From page 43 increase zoloft, No obvious adverse side effects." A physician progress note, dated 04/27/16, stated, ". . . The patient is currently on Haldol. She does have the Ames [sic] testing done on a routine basis. i did review the lat two Ames [sic] tests. There is no sign of tardive dyskinesia. Will continue to monitor for this, as well as the patient is not having any adverse drug reactions in regard to the Haldol. Will continue at this time as it is contraindicated for a dose reduction or change. . . ." Progress notes from 09/24/15 - 05/23/16 identified behaviors for Resident #8 as: * "short tempered" * "demanding" * "hard to redirect" * "upset" * "angry" * "anxious" The medical record lacked adequate rationale for the scheduled haldol. - Review of Resident #9's medical record occurred on May 25-26, 2016. Diagnoses included anxiety. The quarterly MDS dated, 05/21/16, identified severely impaired cognition, no signs or symptoms of delirium, and no depressive symptoms. The current care plan with an original date of 05/05/16, stated, ". . . Alteration in emotional status d/t psychotic agitation & hx [history] PHQ-9 score [mood score] . . . . Give meds as ordered; Observe for side effects of med (IE: dizziness) & report to CN; Offer emotional support/listen &	F 329		

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visit with res; Observe for s/s of depression (IE: increased sleep, w/drawn from others) & report to SS/CN. . . . Act info . . . Enc res to come out of room; Visit to find interests PRN; Remind & enc act; Res belongs to assembly of God church; Res enjoys sunshine, flowers, dancing, TV, reading, 1-1 visits; direct to & from act."

Progress notes identified Resident #9 as having "rude, mean comments" since admit on 05/08/14. Physician orders were initiated on 12/07/14 for Risperdal 0.25 mg by mouth every morning & 0.5 mg by mouth every evening. The medical record lacked adequate rationale for the scheduled Risperdal.

A "Behavioral Summary form and Antipsychotic Drug Review" dated, 04/12/16, stated, "1. Brief summary of the residents behaviors: Sarcastic and rude comments. 2. When did the behaviors start to occur? Prior to her admission. 3. The total number of incidents that have happened in the past 6 months: four. . . . 5. Does the behavior present a danger to the resident or to others? No. . . . 7. Does the resident exhibit behaviors screaming, yelling or pacing that are not dangerous but which cause the resident distress or impairment in functional capacity? No. 8. Current psychotropic medications and dosage: 12/07/14 Risperdal 0.25 mg PO QAM & 0.5 mg PO QPM dx psychotic agitation." . . .The physician completed the next section which stated the resident's diagnoses included organic mental syndrome of 'delerium, dementia, and amnestic and cognitive disorder with associated psychotic and/or agitated behaviors' and 'psychotic mood disorder' and documented a dose reduction not warranted for this reason,

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"She has not tolerated dose reduction of psychotropic medications in past with severe psychological deteriation."

A physician progress note dated, 02/10/16, stated, ". . . Patient will continue on the current medications at this time. The patient is on the Risperdal. The patient is not experiencing any adverse drug reactions. It is contraindicated for a dose reduction at this time."

Nursing progress notes for 12/05/15 - 05/24/16, failed to document any behavior symptoms for Resident #9.

During interview with two administrative staff (#1 and #4) on 05/26/16 at 10:00 a.m., when describing the above interventions utilized by staff for resident behaviors, both agreed behaviors including restlessness, anxiety and crying are not indicators for administering anti-anxiety and anti-psychotic medication. The staff member (#1) stated she felt "staff are using anti-psychotic medications too often." The staff member (#1) stated when the resident's physician/provider makes visits/rounds to the facility, a nurse does not provide information regarding the resident's behavioral status or other information as this information is provided during phone calls.

During interview with the medical director (#5) on 05/26/16 at 1:40 p.m., the director stated:
* when residents experience symptoms of anxiety, agitation, danger to self or others, and behavioral interventions aren't effective, the use of psychopharmacological interventions may need to be considered

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F 329	Continued From page 46 * the standard of care is to use non-pharmacological interventions *"I have talked with the nurses regarding the use of non-pharmacological" interventions. This practice was not evident during the survey nor in review of the medical records. The facility failed to ensure adequate rationale for the use of antianxiety and antipsychotic medication, and to attempt non-pharmacological interventions prior to administering these medications which placed Resident #1, #5, #7, #8 and #9 at risk of receiving unnecessary medications.	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to properly maintain a walk-in freezer in 1 of 1 kitchen. Failure to ensure a walk-in freezer is properly maintained has the potential to affect the food quality of all who eat food prepared from the affected freezer. Findings include:	F 371	F371 The insulation on the condensation pipe of the walk in freezer was replaced with a upgraded form of insulation on 6/23/16. All residents have the potential to be affected by this deficient practice. This is the only walk-in freezer or compressor unit like this in the facility, hence the only	6/23/16

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F 371	Continued From page 47 During initial tour on 05/23/16 at 11:20 a.m., observation showed water frozen to the floor of the walk-in freezer in the kitchen. Observation on 05/25/16 at 9:50 a.m., showed a pipe attached to the fan in the walk in freezer with water condensation leaking onto boxes of frozen food items. The water was frozen to the ceiling as well as the floor. During an interview on 05/26/16 at 2:40 p.m., an administrative staff (#2) agreed that the walk-in freezer does leak and needs work.	F 371	possible piece of equipment to be effected by this deficient practice. The Freezer's condensation pipe was added to the facility's kitchen staff's weekly cleaning checklist. The Dietary manager will inspect the condensation pipe to ensure it is not collecting condensation build-up on the outside of the insulation three times per week for the next 3 months, if compliant the inspections will be done one time per month for the following nine months. Results of said inspections shall be reported by the Dietary manager to the QA committee at the quarterly QA meeting.	
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 review of facility policy and record review, the facility's consulting pharmacist failed to recommend a gradual dose reduction (GDR) to the attending physician for 4 of 9 sampled residents (Resident #5, #7, #8 and #9) identified on psychotropic medications. Failure to report	F 428	F428 The consulting Pharmacist reviewed all drug regimens of all residents including #5,#7,#8, and #9 on 6/7/2016. All Psychopharmacological medications were addressed (see POC F329).	6/29/16

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	355116	A. BUILDING _____ B. WING _____	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE LUTHERAN HOME	501 3RD AVE W LISBON, ND 58054

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F 428	Continued From page 48 any irregularities to the attending physician regarding the adequate indications and gradual dose reductions has the potential for residents to receive unnecessary medications and experience adverse side effects. Findings include: Review of the "Medication Therapy" policy occurred on 05/26/16. The policy, undated, stated, "Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. . . . The Consultant Pharmacist shall review each resident's medication regimen monthly. . . . The Medical Director and Consultant Pharmacist shall collaborate to address issues of medication prescribing and monitoring with the practitioners and staff." - Review of Resident #7's medical record occurred on May 25-26, 2016. Diagnoses included Alzheimer's dementia, anxiety and, a diagnosis of psychiatric mood disorder. The record identified the resident with wandering behaviors. Current psychopharmacological medication orders and start dates included: * Zoloft (anti-depressant) 100 milligrams (mg) every day for anxiety; started 04/27/15 * Clonazepam (anti-anxiety) 0.5 mg every 8 hours as needed for anxiety; started 04/27/15 * Clonazepam 1 mg at bedtime; started on 04/27/15 * Clonazepam 0.25 mg at 2 p.m. daily for anxiety; started on 07/23/15 * Seroquel (anti-psychotic) 50 mg two times a	F 428	With the facility converting to an Electronic Medical Record (EMR), this will increase access to information and will allow for documentation from the consulting Pharmacist that the monthly monitoring is occurring and what date a suggested Gradual Dose reduction will be recommended. All residents have the potential to be affected should the facility fail to ensure uneccessary medications are not administered. The consultant pharmacist will continue to review the provider progress notes, however the consultant Pharmacist will make independent recommendations within a 6 month period for antidepressants, antipsychotics and ant anxiolytic medications and within a 3 month period for hypnotic medication use. With each monthly review the consultant Pharmacist will document in the EMR each date that a GDR is recommended to be evaluated by the physician. The implementation of the EMR will also allow the consultant Pharmacist to review behaviors associated with the PRN medication use from month to month and document adverse reactions more readily and make recommendations based on findings. The DON will audit all pharmacy reviews for residents with a GDR to ensure physician follow-up on the Pharmacy recomendations. Results of the audits will be reported by the DON at the quarterly QA meeting.	

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F 428	Continued From page 49 day at 8 a.m. and 2 p.m.; started 10/20/15. * Seroquel 100 mg at 8 p.m.; started on 10/20/15 Review of Resident #7's "Consultant Pharmacist's Medication Review" forms, reviewed May 2015 through May 2016, addressed the Seroquel use on one occasion in June 2015 in regards to recommended laboratory studies due to the initiation of Seroquel. The reviews between July 2015 and May 2016 failed to address the use and frequency of the as needed (prn) Clonazepam, the use of the Seroquel, and the scheduled Clonazepam. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, and mood disorder. Current medication orders and start dates included: * 01/05/15 Diazepam (anti-anxiety) 5 mg by mouth or intramuscular (IM) every 6 hours prn * 10/20/15 Seroquel 100 mg by mouth three times daily (scheduled for 8:00 a.m., 2:00 p.m. and at bedtime) * 04/12/16 Zoloft (antidepressant) 150 mg by mouth every day for anxiety/depression. Review of Resident #5's "Consultant Pharmacist's Medication Review" forms, reviewed from May 2016 to May 2015, failed to address the frequent use of the PRN diazepam initiated on 01/05/15. - Review of Resident #8's medical record occurred on May 25-26, 2016. Diagnoses included mild cognitive impairment, and psychotic affective disorder.	F 428		

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F 428	Continued From page 50 Current medication orders and start dates included: * 09/24/1 Cogentin (used to control tremors and stiffness of the muscles due to certain antipsychotic medicines) one mg tab twice daily * 09/24/15 Haldol (anti-psychotic) 5 mg at bedtime Review of Resident #8's "Consultant Pharmacist's Medication Review" forms, from May 2016 to September 2015, identified a October 2015, review which addressed the benztropine [cogentin], haloperidol [haldol], and bisacodyl use as needing an approved indication. The review failed to address the frequency and use of cogentin and haldol initiated on 09/24/15 on a scheduled basis. - Review of Resident #9's medical record occurred on May 25-26, 2016. Diagnoses included anxiety. Current medication orders and start dates included: * 12/07/14 Risperdal (anti-psychotic) 0.25 mg by mouth every a.m. and 0.5 mg by mouth every evening Review of Resident #9's "Consultant Pharmacist's Medication Review" forms, reviewed from May 2016 to May 2015, identified none of the reviews addressed the use and frequency of the risperdal initiated on 12/07/14, on a scheduled basis.	F 428		
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS	F 507		6/24/16

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F 507	Continued From page 51 The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to include all laboratory (lab) reports in the resident's clinical record for 1 of 9 sampled residents (Resident #1) and one closed record resident (#10). Failure to contain all lab reports, including protimes (PT) and INR (International Normalized Ratio) in the resident's long-term care medical record does not provide facility staff access to all pertinent information necessary to provide clinical management to the residents in the facility. Findings include: Review of Resident #1's medical record occurred on all days of survey and diagnoses included coronary artery disease and history of deep vein thrombosis with pulmonary emboli. Physician's orders included Coumadin, a medication used to decrease the clotting tendencies of blood, adjusted as needed by the lab reports of PT and INR lab results. Orders included a PT/INR on 05/02/16 and 05/05/16. Review of the record showed nurses entered the PT/INR test results within the interdisciplinary progress notes (IDPN), however the record lacked the ordered PT/INR lab reports from 05/02/16 and 05/05/16. On 05/24/16 at 2:00 p.m., a staff nurse (#3) stated the clinic provider calls	F 507	F507 PT/INR labs have been completed and results retained for resident #1 up to and including 6/9/16. All residents have the potential to be affected should the facility fail to ensure completion of physician ordered lab tests, and the retention of the lab results on the required form of documentation. With the facility implementation of the EMR, lab tests ordered will be tracked through the EMR system to ensure completion of ordered tests. The procedure from the Laboratory has changed for reporting results to the facility, and a form containing required information of the testing laboratory will become part of the resident record on the day that results are made available to the practitioner. Nurses who receive the test results were educated on the new procedure on 6/23/16. We will now only require the signature of one practitioner prior to acceptance of lab results. the practitioner upon receiving the test results will review and sign the test results and will then fax to the facility a copy of said results. The Director of Nursing or Designee will audit 4 residents charts per week to ensure completion of lab tests as well as	

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F 507	Continued From page 52 the facility with the lab results and changes in orders. Upon the surveyor's request, the nurse called the local hospital and obtained the 05/02/16 PT/INR results, however no report was available for the 05/05/16 PT/INR results. On 05/24/16 at 5:30 p.m., an administrative staff nurse (#1) confirmed the facility failed to ensure the completion of the 05/05/16 PT/INR lab order. - Review of Resident #10's medical record occurred on 05/26/16. Diagnoses included atrial fibrillation and heart failure. Physician's orders included Coumadin. An IDPN, dated 05/19/16, included an entry of the lab result, however the medical record lacked the report from the lab. Actual lab reports identify normal parameters. Failure to obtain the reports and ensure the completion of physician orders for lab studies may affect/alter a resident's care.	F 507	retention of lab test results on the correct laboratory forms, for the next month and if found compliant the audits will be conducted 3 times per month. Results of the audits will be reported by the D.O.N. to the QA committee at the quarterly QA meeting.	