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	355101	A. BUILDING _____ B. WING _____	09/21/2011

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 09/19/11 and completed on 09/21/11 the sample included two residents for complete review, five residents for focused review, and one closed record for review. The sample included one additional resident to verify specific concerns during the survey.	F 000		
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	The RNAC who completes this section of the MDS has used a form that lists the psychoactive drugs into categories of antipsychotics, hypnotics, antidepressants, and antianxiety that is confusing and outdated. The form has been retyped with new drugs added, alphabetized, and entries under both generic and brand names for the drugs that are commonly used. This will be easier to read and code the drugs onto the MDS in to the correct categories. The list has also been given to the MDS back-up nurse for her use. In addition, the information contained in Chapter 3, Section N of the RAI user's manual has been reviewed by the RNAC and is earmarked for further reference if there are questions about this MDS section.	

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

Administrator / Vice Pres Brain Injury Services 10/12/11

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 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	F 278 The RNAC who completes this section of the MDS has used a form that lists the psychoactive drugs into categories of antipsychotics, hypnotics, antidepressants, and antianxiety that is confusing and outdated. The form has been retyped with new drugs added, alphabetized, and entries under both generic and brand names for the drugs that are commonly used. This will be easier to read and code the drugs onto the MDS in to the correct categories. The list has also been given to the MDS back-up nurse for her use. In addition, the information contained in Chapter 3, Section N of the RAI user's	

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VP of Bus Trans Services / Administrator 10/17/11

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to ensure Minimum Data Sets (MDSs) accurately reflected the residents' status for 5 of 7 sampled residents (Resident #1, #2, #3, #6, and #7) receiving psychoactive medications. Findings include: The Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, revised July 2010, page N-6 stated, "Code medications according to the drug's pharmacological classification, not how it is used. . . . Include any of these mediations given to the resident by any route . . . in any setting (e.g. [for example] at the nursing home, in a hospital emergency room) while a resident of the nursing home. Code a medication even if it was given only once during the look-back period. . . ." - Review of Resident #1's medical record occurred on all days of survey. An annual MDS, dated 11/22/10, and a quarterly MDS, dated 05/24/11, identified Resident #1 did not receive an antipsychotic medication during the 7 day look-back period. Review of the medical record identified Resident #1 received Seroquel (an antipsychotic) daily since 11/19/09. The Psychotropic Drug Use Care Area Assessment (CAA), dated 11/26/10, stated, "[Resident #1] is taking . . . Seroquel . . ."	F 278	manual has been reviewed by the RNAC and is earmarked for further reference if there are questions about this MDS section. Residents #1, 2, 3, 6 and 7 in the sample who have incorrect MDS's will have their most recent MDS corrected and submitted to CMS. The DON will check through the latest MDS's for the rest of the residents in the facility at the time of the survey. If there are psychoactive drugs incorrectly classified on those MDS's, they will be corrected and modification MDS's submitted to CMS. For the next six months, The ADON will check all of the resident's N0400 section of the MDS section after the RNAC has coded psychoactive medications to assure that the drugs were coded in the correct categories. After that time period, if the area has been coded correctly, the ADON will discontinue this practice.	

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F 278	Continued From page 2 The annual MDS, dated 11/22/10, and a quarterly MDS, dated 08/22/11, also identified Resident #1 received an antianxiety medication during the 7 day look-back period. Review of the resident's medical record failed to identify the resident received an antianxiety medication during the look-back period for the 11/22/10 and 08/22/11 MDSs. - Review of Resident #2's medical record occurred on all days of survey. A quarterly MDS, dated 05/17/11, indicated Resident#1 did not receive an antianxiety medication during the 7 day look-back period. Review of Resident #1's Medication Administration Records (MARs) for May 2011 showed the resident received Buspar (an antianxiety) 20 milligrams (mg) twice a day each day in May 2011. - Review of Resident #6's medical record occurred on all days of survey. An initial MDS, dated 07/18/11, identified Resident #6 received a hypnotic (medication to aid sleep) during the 7 day look-back period. Review of the medical record identified Resident #6 received Trazodone (classified as an antidepressant) at bedtime daily since 07/15/11, but has not received a hypnotic medication since his admission on 07/07/11. - Review of Resident #7's medical record occurred on September 20-21, 2011. Resident #7's current medications included the following: Buspar twice a day started in March 2010, Risperdal (an antipsychotic) twice a day started in June 2010, and Trazodone once daily started in January 2011. The annual MDS, dated 07/05/11, indicated Resident #7 did not receive an antipsychotic medication during the 7 day	F 278	At the QA meeting on October 12th, the RNAC reported the deficiency, giving the total miscalculations and MDS corrections to be submitted. The ADON will report the corrections needed to be made in subsequent QA meetings starting from the survey date forward.	10/24/11

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F 278	Continued From page 3 look-back period. The two quarterly MDS's completed prior to the above referenced annual MDS, dated 05/19/11 and 02/17/11, indicated Resident #7 did not receive an antipsychotic medication or an antidepressant medication during the 7 day look-back period for either assessment. - Review of Resident #3's medical record occurred on all days of survey. Resident #3's current medications include Trazodone once daily started on 02/09/11. Resident #3's admission MDS, dated 02/14/11, and a quarterly MDS, dated 08/15/11, indicated Resident #3 did not receive an antidepressant medication during the 7 day look-back period for either assessment. During an interview on 09/21/11 at 10:15 a.m., two administrative nurses (#1 and #2) confirmed staff incorrectly coded psychoactive medications for the above MDSs.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to follow professional standards for essential components of physician's orders for 1 of 1 sampled resident (Resident #6) and 1 supplemental resident (Resident #9) with physician's orders for sliding scale insulin (extra doses of insulin based on	F 281	F 281 Nursing staff at Dakota Alpha have administered insulin to Residents #6 and #9 of the sample appropriately with correct dosages and times. No errors have been made. Correct and complete dosage directions are in the individual's MARS. Areas of concern in this deficiency are in assuring that the orders are complete when they are written before they are transcribed by the nurse. In Resident #6 and Resident #9's	

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F 281	Continued From page 4 blood glucose test results). Failure to follow standards for complete physician's orders could cause confusion with interpretation of the orders and result in medication errors. Findings include: Berman, Snyder, Kozier, and Erb, "Fundamentals of Nursing, Concepts, Process and Practice," 8th edition, Pearson - Prentice Hall, New Jersey, pages 841-842 stated, ". . . Essential Parts of a Drug Order: . . . Dosage of the drug, Frequency of administration, Route of administration . . . The nurse should always question the primary care provider about any order that is ambiguous, unusual . . ." Review of the facility policy titled "Doctor's Order Sheet and Consultation Forms" occurred on 09/21/11. The undated policy stated, ". . . Write medication orders on the MAR [medication administration record] . . . Write the order on the 'Physician's Order Renewal' form. . . ." Observation of insulin administration for Resident #6 and #9 occurred on 09/19/11 at 11:40 a.m. MARs for Resident #6 and #9 identified both residents received sliding scale insulin. Observation showed: * A licensed nurse (#3) performed a blood glucose test for Resident #6 with results of 124 milligrams per deciliter (mg/dl). The nurse administered no insulin. Resident #6's MAR identified staff should perform blood glucose monitoring before each meal, and not administer sliding scale Apidra insulin for a blood glucose less than 150 mg/dl. * The nurse (#3) performed a blood glucose test	F 281	physician medication re-order sheets, the sliding scale insulin directions have been written out to include frequency (TID or QID), specific dosage levels based on the resident's blood glucose level, and route of administration as they are transcribed in the MAR. There are no other diabetic residents in the facility to potentially be effected. Policies and procedures have been re-written to address transcription of Doctor's orders to assure that all the essential areas of the order are specified. If an order is received from a physician, either in writing or over the telephone that does not include all the essential components, the nurse receiving or transcribing the order will call the physician for clarification and completeness of the order and it will be re-written/clarified as a telephone order. At the QA meeting on October 12th, the DON reported the deficiency and the corrective actions to the QA committee. The changes to the nursing protocol book were detailed by the ADON	

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F 281	Continued From page 5 for Resident #9 with results of 217 mg/dl and administered 2 additional units of Humalog insulin along with a scheduled dose of 6 units. Resident #9's MAR identified staff should perform blood glucose monitoring before meals and at bedtime and should administer 2 extra units Humalog insulin for a glucose level of 200-249. Review of physician's orders for Resident #6 and #9 occurred on the afternoon of 09/19/11. Resident #6's current orders identified an order, dated 07/07/11, which stated "Apidra sliding scale 1 unit for every 30 over 150." The order failed to identify the frequency, the specific dose based on the blood glucose level, and route of administration for the Apidra insulin. Resident #9's current physician's orders identified an order, dated 11/13/09, which stated, "Humalog sliding scale." The order failed to identify the frequency, the specific dose based on the blood glucose level, and route of administration for the Humalog insulin. During an interview on 09/21/11 at 10:15 a.m., an administrative nurse (#2) confirmed physician's orders for Resident #6 and #9 lacked specific doses, frequency, and route of administration for the sliding scale insulin.	F 281	and feedback from Dr. Eggert was obtained. The procedure for clarifying orders and the new policy/procedure will be discussed by the ADON with the nurses at the October 17, 2011 nurse's meeting. Nurses who are not at the meeting will read the minutes and sign off that they understand and will follow the procedure after the minutes are available on October 21, 2011. In the week before the subsequent QA meetings, the DON, ADON and other designated nurses will check all of the physician's orders from the prior quarter to assure the nurse's are understanding and complying with the new policy/procedure. The results will be reported to the QA committee. This will be done for the next four quarters and if the orders are being done correctly, we will discontinue this QA practice.	
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.	F 319	F 319 Resident #6 has been taught techniques for breathing that may alleviate his anxiety by his psychologist in Dickinson.	10/21/11

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F 319	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to ensure a resident received the appropriate treatment and services for 1 of 1 sampled resident (Resident #6) who displayed symptoms of psychosocial adjustment difficulty. Failure to implement techniques recommended by a psychiatric professional does not allow Resident #6 to reach his highest level of psychosocial functioning. Findings include: During an interview on 09/20/11 at 8:20 a.m., Resident #6 stated he becomes anxious when in crowds, has had frequent migraine headaches and nightmares, and sometimes has hallucinations. He stated, prior to his admission, he attended church every Sunday, but does not feel comfortable attending the local church. The resident indicated his home is approximately 80 miles from the facility, so he is unable to attend his home church. Review of Resident #6's medical record occurred on all days of survey. The record identified diagnoses including traumatic brain injury, post-concussion syndrome, depression, migraine headaches, and insomnia. A "Screening Summary," dated 06/29/11 (prior to his admission), stated, ". . . He also struggles with sleep issues as he has nightmares . . . In addition, he also has issues with being in crowds and with seeing things that are not there. . . ." A "Consultation Form" from a counseling session	F 319	The resident stated to the LSW on 10/3/11 that he does not want to use these techniques when he is out in the community as they make him feel "silly". The resident stated that he prefers just to leave the situation which is not what his psychologist advises. The resident's psychologist was called for further direction in this matter and he states that he does not feel that the staff needs to go over the technique with him consistently. He faxed a copy of the instructions for the technique. The care plan has been amended to state that the resident #6 will practice the technique with the LSW at their next weekly appointments on 10/19/11. Nursing staff will be shown the technique and have a written detail of it at their next nursing meeting on 10/17 and 10/18. Staff who are not at the meeting will sign off on the minutes so they know the technique. If resident #6 becomes	

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F 319	Continued From page 7 with a clinical psychologist, dated 08/17/11, stated, "[Resident #6] is to use anxiety reducing and breathing techniques taught in session. Pt [patient] is to continue outpatient therapy." Resident #6's current care plan, dated 07/26/11, stated, ". . . I have diagnoses of both depression and anxiety. Some of the way that this comes out is by me having migraine headaches . . . I am not at ease at going out with others and being around others as I used to be before my accident . . . I do not like to go places where there are a lot of people for long periods. I will have to let you know how things feel for me when I start going out on activities in the community. . . ." The care plan lacked interventions/approaches for staff to implement to assist Resident #6 to cope with his depression, anxiety, and "issues with being in crowds." A nurse's note dated 09/11/11 at 9:45 a.m. stated, "[Resident #6] had gone to church per transit. at about 9:20 A [a.m.] he called here & [and] said he was having a panic attack and would like to have a staff member come and pick him up. A staff nurse did go pick him up from church. He was given a Lorcet at this time for c/o [complaints of] 'pounding' headache. He said he felt like everything was 'closing in' on him at church. He said he is going to his room now to try & relax." The record lacked evidence staff implemented the anxiety reducing and breathing techniques taught during the counseling session on 08/17/11. Review of Resident #6's Social Service notes identified the following: 08/31/11: "[Resident #6] stated that he is	F 319	anxious, staff will remind resident #6 to use the technique on his own. If he states he does not remember how to do it, staff with go through it with him at that time. The facility is addressing resident #6 psychosocial needs by taking the resident to see his original psychologist in Dickinson as his wife cannot get here to transport her husband and we are also taking him to see a psychiatrist he had been seeing previous to his admission here in Bismarck. We will continue to have a dialogue with those professionals to see what other behavioral techniques they recommend for the resident to do or medication changes they recommend for him. We will also continue to seek guidance from resident #6 as to what works and what does not work for him as well as what he is willing to do and what he is not willing to do. Resident #6 has also met	

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F 319	Continued From page 8 frustrated as he continues to have nightmares and headaches. LSW [licensed social worker] stated that some things are out of our control and that he should not worry about these. . . ." 09/14/11: "LSW and [Resident #6] met for a social service visit where we discussed his home visit. [Resident #6] stated that he had fun and wished he did not have to come back . . . He stated that he got to attend church, but had to leave early as it was too stimulating for him . . ." The social services notes lacked evidence the LSW encouraged Resident #6 to implement anxiety reducing techniques and/or breathing techniques recommended by the clinical psychologist. During an interview on 09/20/11 at 4:35 p.m., an administrative nurse (#2) and a social services staff member (#5) stated Resident #6 came to the facility, in part because he had experienced panic attacks at home, including one at a school function he attended with his children. During an interview on 09/21/11 at 10:05 a.m., an administrative nurse (#2) and an occupational therapist (#6) stated both a psychiatrist and a psychologist have counseled Resident #6 regarding his panic attacks and nightmares. They stated facility staff have not assisted Resident #6 to use the anxiety reducing and breathing techniques the psychologist taught him during the counseling session on 08/17/11.	F 319	with the deacon from the church he wants to attend and he and the deacon have decided on a plan for him to feel more comfortable at church. He and resident #6 will give us feedback as to how it is working. The above information is in his care plan. No other residents have specific techniques or plans from their psychiatric professionals. When the nurse receives a psychiatric visit form back from the doctor that has orders or information that is unclear, she will telephone the practitioner and ask for more information. We have already implemented the practice of having the resident sign a release of information for psychiatric purposes before they go to a psychiatric appointment so we should be able to get the information. At the end of the month, the charge nurse or designee will call the medical records department to have them send any	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		

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F 329	Continued From page 9 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 professional literature, review of facility policy, and staff interview, facility staff failed to ensure each resident's drug regimen remained free of unnecessary medications for 1 of 2 sampled residents (Resident #2) receiving an as needed hypnotic (medication to aid sleep). Failure to ensure adequate indications for use and to attempt a gradual dose reduction could result in the resident receiving unnecessary medications and/or experiencing adverse consequences.	F 329	psychiatric reports from that month that have not been received. On 10/7/2011, the DON spoke to both the medical records department and the psychiatry office staff where we are having problems getting the psychiatric information. The office personnel stated that the reports should be sent if the resident has signed a specific psychiatric release of information and the psychiatrist agrees that it can be sent. If the psychiatric reports have not been received within a week of the request, the administrator and DON will meet with the clinic administrator. At the end of each month, the charge nurse will review all resident's psychiatric visit forms to see that all psychiatric practitioner notes have been received and that all new recommendations have been put into the care plan. This will be done for six months and if the psychiatric visit forms have been regularly received and the	

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F 329	Continued From page 10 Findings include: Review of the facility policy titled "Monthly Pharmacy Review" occurred on 09/21/11. The undated policy stated, "Sedative Hypnotics: For as long as a resident remains on a sedative/ hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated." Lippincott, Williams, and Wilkins, "Nursing 2011 Drug Handbook," 31st edition, page 788, stated, "Ambien . . . Alert: . . . Use drug only for short-term management of insomnia, usually 7 to 10 days. . . ." Review of Resident #2's medical record occurred on all days of survey. The record identified diagnoses including traumatic brain injury, personality disorder, and insomnia. A physician's order, dated 03/31/10, stated, "Ambien [a hypnotic] 5 milligrams [mg] po [orally] HS [hour of sleep] PRN [as needed]." Review of monthly nursing summaries identified, in 2011, Resident #2 received Ambien for sleep 25 times in January, 22 times in February, 24 times in March, 27 times in April, 29 times in May, 24 times in June, 21 times in July, and "most evenings" in August. Resident #2's Medication Administration record identified the resident received Ambien for sleep 19 times in the first 20 days of September 2011. The record lacked evidence staff attempted a quarterly gradual dose reduction for the Ambien as stated in facility policy. The record lacked	F 329	care plan has been updated, the monthly scheduled review will be discontinued. In the quarterly QA meetings, the charge nurse will report to the committee the progress in getting psychiatric information from the psychiatrists so the care plans can be updated as needed. We will continue this for one year if all the reports are being regularly received. This was discussed at the October 12th QA meeting. F 329 For this resident, the Ambien has been tapered off and discontinued; he is currently using another class of drugs for sleep. On the CNA care plan in his room under nighttime routine, there are routines other than medications listed that the CNA's try-- playing music, using lavender scented lotion, etc. so other interventions have been tried. At the time of the survey, the CNA care plan was not viewed by the surveyors. Insomnia and interventions to be tried were added to his care plan.	10/21/11

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F 329	Continued From page 11 evidence staff attempted non-pharmacological alternatives to promote sleep (such as special pillows/bedding, soft music, warm milk, etc.) prior to administering the hypnotic to Resident #6. The physician failed to identify the clinical rational for not attempting a dose reduction during the 18 months staff administered the Ambien to Resident #6. Resident #2's current care plan, dated 08/23/11, failed to identify insomnia as a problem, and lacked alternative interventions to promote sleep prior to administering the hypnotic. During an interview on 09/20/11 at 3:05 p.m. an administrative nurse (#1) stated Resident #2 not sleeping at night may be more of a behavior than insomnia. She stated the resident was attached to a particular CNA who worked the night shift and would "holler" for that CNA. On 09/21/11 at 11:15 a.m., an administrative nurse (#2) provided a progress note from Resident #2's psychiatrist, dated 03/31/10. The note stated, ". . . His favorite night staff is leaving the facility and it's unclear how that will affect [Resident #2's] behaviors . . . Begin Ambien 5 mg po hs prn . . ." The staff member also provided a progress note, dated 05/18/11, which stated, "Overall his behaviors are basically stable . . . Insomnia, improved . . ." The note lacked the clinical rational for failing to attempt a dose reduction for Resident #2's Ambien since the behaviors have stabilized.	F 329	A review of resident's charts to find all those on hypnotic medications was done by the DON. One resident has a PRN Ambien order but has not taken it since admission. When he returns from pass this week, his usage will be evaluated and it will be discontinued if he does not use it within one week. Another resident had a PRN order for Ambien but had not taken it in two months so it was discontinued. When residents are admitted on any hypnotic that needs strict monitoring, the charge nurse will let the DON know to put it on the resident's card in the psychotropic file box. The charge nurse will put a reminder in the Medical Director's book that the med needs to be evaluated within 7 to 10 days. The Medical Director can then reorder it for 30 days if necessary. At the end of the 30 days, it will then again be evaluated in terms of the risks versus the action accomplished. The psychiatrist will be consulted as necessary. Other classes of medication will be used to produce sleep if the resident needs them. When a resident is	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		

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F 428	Continued From page 12 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/29/10. Based on record review, review of facility policy, review of monthly pharmacy review forms, and staff interview, the facility's consultant pharmacist failed to identify medication regimen irregularities for 2 of 7 sampled residents (Resident #2 and #7) receiving psychoactive medications. Failure to recognize and report the need for an attempt at a gradual dose reduction for these medications could result in residents receiving unnecessary medications and experiencing adverse consequences related to these medications. Findings include: Review of the facility policy titled "Monthly Pharmacy Review" occurred on 09/21/11. The undated policy stated, "Antipsychotics: Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychoitc medication, the facility must attempt a Gradual Dose Reduction (GDR) in two separte quarters (with at least one month	F 428	taken off Ambien or any other hypnotic, the dosage will be tapered off according to pharmaceutical guidelines. Hypnotic use was discussed at the October 12th QA meeting and a baseline of use will be established. For the next four quarters, this will be discussed and if the problem is resolved, it will be discontinued. A meeting with the pharmacist was scheduled for October 10th at which the deficiencies, guidelines that need to be followed exactly and attendance at the Quarterly QA meetings were scheduled to be discussed. The morning of the meeting, a letter of resignation was received in which he stated that due to his current work schedule, he would not be able to continue as our pharmacy consultant. We are currently looking for a new consultant pharmacist who will have the guidelines for hypnotic use and will monitor and comment on the use in the monthly pharmacy reviews. The DON will monitor the monthly pharmacy review sheets for all residents who are on psychotropic	

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F 428	Continued From page 13 between the attempts), unless clinically contraindicated. After the first year a GDR must be attempted annually, unless clinically contraindicated. . . . Sedative Hypnotics: For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated." Lippincott, Williams, and Wilkins, "Nursing 2011 Drug Handbook," 31st edition, page 788, stated, "Ambien . . . Alert: . . . Use drug only for short-term management of insomnia, usually 7 to 10 days. . . ." Review of Resident #2's medical record occurred on all days of survey. The record identified diagnoses including traumatic brain injury, personality disorder, and insomnia. A physician's order, dated 03/31/10, stated, "Ambien [a hypnotic] 5 milligrams [mg] po [orally] HS [hour of sleep] PRN [as needed]." Review of monthly nursing summaries identified, in 2011, Resident #2 received Ambien for sleep 25 times in January, 22 times in February, 24 times in March, 27 times in April, 29 times in May, 24 times in June, 21 times in July, and "most evenings" in August. Resident #2's Medication Administration record identified the resident received Ambien for sleep 19 times in the first 20 days of September 2011. Review of the "Monthly Pharmacy Review" forms from October 2010 through August 2011 (except for June 2011, which was not available) occurred on 09/20/11. This form contained question 11.,	F 428	medications monthly for three months to see that the new pharmacist is recommending a GDR and the psychiatric visit forms and psychiatric notes to see that the psychiatrist is either recommending a GDR or is documenting the reasons why one should not be attempted. After three months, if the GDR is being implemented as mandated, the DON will choose one month of the quarter to monitor each resident's (who is on a psychotropic medication) pharmacy review sheet to check compliance. The DON will report to the QA committee the progress made in GDR on a quarterly basis for one year and the committee which includes the pharmacist will discuss methods of making this work more efficiently if it is not working well. If the pharmacist cannot be at the quarterly meeting, he/she will give pertinent information to the DON to report. Date of compliance will be October 17, 2011 pending hiring a pharmacy consultant.	10/17/11

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F 428	Continued From page 14 which asked, "Is the resident taking a medication(s) that attempts at or consideration of the possibility of tapering it should be made?" Although Resident #2 received the prn hypnotic most nights, the pharmacist circled "no" in answer to question 11 for every month reviewed. The pharmacist failed to make recommendations regarding Resident #2's continued use of Ambien and failed to suggest tapering the medication. - Review of Resident #7's medical record occurred September 20-21, 2011. Resident #7's current medications included Buspar (an antianxiety medication) 15 mg twice a day and Risperdal (an antipsychotic medication) 0.75 mg twice a day. Resident #7 received the current dose of Buspar since March 2010 and the current dose of Risperdal since July 2010. Review of the "Monthly Pharmacy Review" forms from October 2010 through August 2011 (except for June 2011, which was not available) occurred on 09/20/11. This form contained question 11., which asked, "Is the resident taking a medication(s) that attempts at or consideration of the possibility of tapering it should be made? Even though Resident #7 received antipsychotic and antianxiety medications, the pharmacist circled "no" in answer to question 11 for every month reviewed. The form failed to show any recommendations from the consulting pharmacist regarding Resident #7's continued use of Buspar and Risperdal or any trial dose reductions for these medications. During an interview on 09/20/11 at 10:15 a.m. two administrative nurses (#1 and #2) confirmed the pharmacist failed to recommend dose	F 428	F 428 Resident #2's Ambien has been discontinued; he is now taking another class of medication for sleep. Resident #7's medications were reviewed by the Nurse Practitioner for Resident #7's psychiatrist , Dr. Henke, who is currently out of the clinic. Resident #7's evening dose of Risperdal was reduced at this time. When he sees Dr. Henke in November, further GDR will be considered if appropriate. When residents are admitted on or started on any psychotropic medication that needs strict monitoring, the charge nurse will let the DON know to put it on the resident's card in the psychotropic file box. This box lists all psychotropic drugs for each resident with dates of ordering, dates of increase/decrease and dates the medication was discontinued. The pharmacist will have access to this box when he/she does the monthly medication review. The consulting psychiatrist will have access to this box when she reviews the resident's medications during their psychiatric visit in the facility. Residents who have psychiatrist	

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F 428	Continued From page 15 reductions/tapering for Resident #2 and #7.	F 428	visits outside of the facility will have a note on the psychiatric visitation sheet which also includes the GDR criteria.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the North Dakota Department of Health Division of Health Facilities provider files, record review, and staff interview, the facility failed to develop and implement appropriate plans of action to correct deficient practice and ensure compliance with federal	F 520	After the pharmacist completes the pharmacy sheet on each resident, the DON or ADON will review the sheets for GDR reductions using the psychotropic med file box as a check. If the pharmacist does not catch the GDR time frame, the DON or ADON will call him/her and have him/her amend the sheet. Psychiatry notes will be reviewed by the charge nurse to see that GDR issues are addressed once brought to the psychiatrist's attention via the monthly pharmacy review sheets. This will be done monthly for the first 6 months of the new pharmacist's completing the monthly pharmacy review and will be reduced to quarterly when compliance is reached. A meeting with the pharmacist was scheduled for October 10th at which the deficiencies, guidelines that need to be followed exactly and attendance at the Quarterly QA meetings were scheduled to be discussed. The morning of the	

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F 520	Continued From page 16 requirements. Failure of the facility to effectively utilize quality assurance (QA) contributed to the facility's continued non-compliance in the area of pharmacy reviews of resident's drug regimens. Findings include: The standard survey, conducted September 19-21, 2011 identified deficient practice with pharmacy reviews of resident's drug regimens (F 428). Refer to F 428 for those findings. Review of the state agency file found the facility also received a citation at F 428 during the previous standard survey completed 09/29/10. During the entrance conference on the morning of 09/19/11, an interview occurred with facility administrative staff members (#1, #2, and #4). During this interview, the administrative staff identified members of the QA Committee, which included the Licensed Social Worker (LSW) and the Pharmacist. The staff members indicated the LSW heads the committee and any questions about QA should be directed to her. An interview occurred on the afternoon of 09/20/11 with the LSW (#5). When asked what the QA committee has implemented to correct the pharmacy review citation (F 428) found during the previous survey, the LSW indicated the Director of Nursing (DON - #1) keeps track of the pharmacy information. The LSW indicated she knows this issue has been corrected. When asked about the last time the QA committee discussed the previous citation with pharmacy reviews, the LSW paged through a binder and indicated she looked back as far as November 2010 and couldn't find any documentation to	F 520	meeting, a letter of resignation was received in which he stated that due to his current work schedule, he would not be able to continue as our pharmacy consultant. We are currently looking for a new consultant pharmacist who will have the guidelines for GDR and will monitor and comment on the use in the monthly pharmacy reviews. Our new pharmacist, in QA meetings, will report the gradual dosage reductions to the QA committee on a quarterly basis. He/she will also involve the psychiatrists in suggesting a reduction or documentation that the medication cannot be reduced for a medical or behavioral reason. If the consulting pharmacist is not able to be at the meeting, he/she will give the information to the DON and, if possible, be available to answer questions via the telephone Date of compliance will be October 17, 2011 pending hiring a pharmacy consultant.	10/17/11

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F 520	Continued From page 17 show the committee had discussed the pharmacy issue. During this interview, the LSW confirmed the pharmacist is part of the QA committee. When asked when the last time the pharmacist attended a QA committee meeting, she could not provide a date. During interview at 4 p.m. on 09/20/11, the DON (#1) and the assistant DON (ADON - #2) provided a three-ring binder and indicated they provided this binder to the pharmacist following the survey in September 2010. Review of the binder found Pharmacy Review forms, information about medications, tapering guidelines, definitions of different types of medications, and federal regulations and interpretive guidelines relating to unnecessary medications and pharmacy reviews/responsibilities. The DON could not provide a date to show the last time the QA committee looked at the pharmacy reviews. During this interview, the ADON indicated she's worked at this facility since December 2010. When asked if she attended QA committee meetings, the ADON said she did. When asked if the pharmacist attended any of the meetings since she began, the ADON could not remember seeing the pharmacist at any meetings. Failure of the facility to develop/implement an appropriate plan of action and provide effective quality assurance oversight resulted in continued non-compliance at F 428, pharmacy review of resident's drug regimens.	F 520	F 520 Members of the QA committee are the Administrator, DON, LSW, ADON, Medical Director, Charge Nurse, Physical Therapist, Occupational Therapist, Speech Therapist, Housekeeping/Dietary, Maintenance, Consulting Psychologist, and when needed, outside consultants such as the Consulting Dietitian and Consulting Pharmacist. Meetings are held quarterly on Wednesday at noon as that is when the Medical Director can be present. The consulting pharmacist had notice of each of the quarterly meetings for the past year; he did not attend. The updated forms and pharmacy manual were given to the pharmacist after the last survey, it was presumed that he would carry out the duties he had been given. Formal oversight of seeing the deficiency was corrected was given to the former	10/26/11

ADON who had met with the pharmacist. When the ADON resigned, oversight was not assigned to anyone else. In July of this year, the DON realized the oversight and started to formulate a plan to get this area back into compliance. It did not happen before the survey team returned.

A meeting with the pharmacist was scheduled for October 10th at which the deficiencies, guidelines that need to be followed exactly and attendance at the Quarterly QA meetings were scheduled to be discussed. The morning of the meeting, a letter of resignation was received in which he stated that due to his current work schedule, he would not be able to continue as our pharmacy consultant. We are currently looking for a new consultant pharmacist

Our new pharmacist, in QA meetings, will report the gradual dosage reductions to the QA committee on a quarterly basis. He/she will also involve the psychiatrists in suggesting a reduction or documentation that the medication cannot be reduced for a medical or behavioral reason. If the consulting pharmacist is not able to be at the meeting, he/she will give the information to the DON and , if possible, be available to answer questions via the telephone.

The DON will maintain a file of all psychotropic medications with the dates of initiation, dose changes, discontinuation, and have it available for the pharmacist to do the monthly medication monthly. It will also be available to Dr. Henke, who will be seeing residents at the facility for psychiatric consultations rather than the clinic in October.

All the deficiencies from the survey in September were discussed with the QA committee on 10/12/11 and will be part of the QA process in following meetings. The Administrator will be responsible for checking with the DON and ADON to follow up on the progress of the deficiencies corrective action. He will check with the DON and ADON monthly for the first 6 months to see that the scheduled checks are occurring. After 6 months, the checks could be changed to quarterly if the corrective action is being reviewed as required.

If one of the persons responsible for monitoring the corrective action leaves their position, the Administrative team (Administrator, DON, and ADON) will meet to assign the corrective action to another staff member.

Date of compliance will be October 26, 2011 pending hiring a new pharmacy consultant.