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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the provider on 12/06/19.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/06/2019

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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desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 49 residents, with 14 residents reviewed including one for pain. Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for one of the 14 sampled residents including Resident (R) 29 for pain.

Findings included:

- Review of the "Physician Orders" (PO), dated 11/01/19, for Resident (R) 29 documented the resident with a diagnosis of osteoarthritis (degenerative changes to one or may joints characterized by swelling and pain) and low back pain.

The admission "Minimum Data Set," (MDS), dated 07/25/18, documented the resident with a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The resident required extensive assistance with dressing and limited to supervision with all other activities of daily living. She was on scheduled pain medication and denied complaints of pain. She was on opioid pain medication seven days of

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the look back period.

The "Cognition Care Area Assessment," (CAA), dated 07/25/19, documented the resident with moderate cognitive impairment. She had falls prior to admission and had a diagnoses of low back pain, malaise and osteoarthritis which could affect the resident activity tolerance.

The "ADL Functional/Rehabilitation Potential CAA," dated 07/25/19, documented the resident had a diagnosis of low back pain, malaise and osteoarthritis that can contribute to difficulty and discomfort with activities and tasks. She walked with a four wheeled walker and had an electric wheel chair for longer distances.

Pain did not trigger on the CAA, dated 07/25/19.

The quarterly MDS, dated 10/07/19, recorded R29 with a BIMS of 14, indicating cognition intact. Occasional pain present, on scheduled pain medication and rated at a five on a scale of one to ten. On the seven day look back period she was on opioids for seven days.

The care plan, dated 10/15/19, lacked a plan for pain management or to keep physician ordered pain cream at her bedside.

The care plan meeting, dated 10/15/19, documented the resident had occasional pain, rated a five (scale of 1 to 10 with 1 being less and 10 being worst) in her hands, and had cream she used for the hand pain. She takes gabapentin for nerve pain and Ultram as needed.

The PO, dated 11/01/19, were as follows:

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1. Tylenol extended release 650 milligrams (mg), twice a day for pain.
2. Ultram 50 mg every six hours for pain, while awake.
3. Gabapentin 300 mg daily for neuropathy
4. Voltaren gel 1%, apply to affected area, both hands PRN (as needed), may keep at bedside as resident is alert and oriented.
5. Nortriptyline 25 mg daily or peripheral neuropathy.
6. Self Administration of medication, ordered 08/20/19.

The progress note, dated 10/19/19 at 02:22 AM, documented R29 up to the bathroom and called for assistance due to needing her pain medication in which she rated her arthritic pain at 10 on a scale of 1 to 10.

On 11/27/19 at 09:56 AM, R29 was sitting in her chair in her room. She stated she does have pain, mostly at night. She did have some pain at that time and rated her pain level at a three. She went on to say she did have pain ointment at her bedside to use when she needed. She considered the pain medication effective.

On 12/02/19 at 02:33 PM, Licensed Nursing Staff H, confirmed the facility failed to develop a plan of care for pain for R29.

On 12/02/19 at 02:42 PM, Administrative Nurse G, confirmed there was no care plan for pain or for keeping the pain cream at the resident's bedside.

On 12/02/19 at 3:00 PM, Administrative Nursing Staff D stated that the expectation would be that if

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F 656	Continued From page 4 a resident had a history of pain and was on pain medication there should be a care plan and it should also include keeping the pain cream at the resident's bedside. The "Care Planning Policy", dated 02/19, documented "care plans promote continuity of care and communication among staff to prevent adverse events after admission. Care plans will be updated as needed with intervention pertaining to changes." The facility failed to develop a comprehensive care plan for pain management to ensure control of the resident's pain and maintain the resident's ability to self administer the physician ordered pain cream as needed.	F 656		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758		

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in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 49 residents, with 14 residents selected for review, including five for unnecessary medications. Based on observation, interview and record review, the facility failed to complete the Abnormal Involuntary Movement Scale (The AIMS records the occurrence of Tardive Dyskinesia (TD) in patients receiving neuroleptic medications. The AIMS test is used to detect TD and to follow the

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severity of a patient's TD over time.), to monitor for side effects associated with antipsychotic medication use for two of the five residents reviewed, including Resident (R) 42 and R37.

Findings included:

- Resident (R) 42's "Physician Orders" (PO), dated 11/02/19, documented the resident with a diagnosis of Anxiety Disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), Major Depressive Disorder (serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working.) and Depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).

The annual "Minimum Data Set," (MDS), dated 03/18/19, recorded the resident with a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition intact. She needed extensive assistance with personal hygiene, limited assistance with dressing, and supervision with all other activities of daily living (ADL's). On the seven day look back period she was on antipsychotic, antianxiety and antidepressant medication for seven days of the look back period.

The "Mood Care Area Assessment" (CAA), dated 03/18/19, documented the resident occasionally feels down, tired, and having little energy, increases the risk for social isolation.

The "Psychotropic Drug Use CAA," dated 03/18/19, documented she was currently taking

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antipsychotic and antidepressant medication which have side effects including tired, dizzy, drowsy and changes in appetite.

The quarterly MDS, dated 11/06/19, recorded the resident with a BIMS of 15, cognition intact. On the seven day look back period, the resident was on antipsychotic, antianxiety, and antidepressant medication for the seven days. On 10/17/19 there was a gradual dose reduction attempt and was found to be clinically contraindicated.

The care plan, dated 11/26/19, for psychotropic medication use, documented the resident with a diagnosis of Bipolar Disorder, Anxiety and Depression. She is currently taking daily antipsychotic, antianxiety and antidepressant medication whish can have side effects of dizziness, tiredness and changes in appetite. 04/01/19 - Abnormal Involuntary Movement Scale (AIMS) assessment (The AIMS records the occurrence of Tardive Dyskinesia (TD) in patients receiving neuroleptic medications. The AIMS test is used to detect TD and to follow the severity of a patient's TD over time.), to be done quarterly and as needed.

The care plan, dated 11/26/19, for Abilify Black Box Warning documented to monitor for joint stiffness, muscle twitching, swallowing difficulty, fatigue, severe muscle weakness, flushing, mental or behavioral changes, hallucinations, restlessness, irritability, slurred speech, vision impairments, Parkinson type symptoms, Tardive Dyskinesia (a disorder that results in involuntary, repetitive body movements. This may include grimacing, sticking out the tongue, or smacking the lips).

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The PO, dated 11/02/19, revealed:

1. Abilify (an antipsychotic) 10 mg at bedtime for Major Depressive Disorder, ordered 06/27/19.

On 06/03/19, staff completed a a quarterly MDS assessment, however, failed to complete the AIMS assessment, as planned.

On 08/02/19, the pharmacy review revealed the AIMS assessment appeared past due, last completed 03/29/19,and was required every three months while on Abilify.

On 08/19/19, staff completed a quarterly MDS assessment, however failed to complete the AIMS assessment, as planned.

On 11/06/19, staff completed a quarterly MDS assessment, however failed to complete the AIMS assessment, as planned.

On 11/27/19 at 09:54 AM, observed R42 sitting in her room watching TV.

On 12/02/19 at 04:00 PM, Administrative Nursing Staff G confirmed that in the last year the AIMS should have been completed at least quarterly and was incomplete for the months of June and November.

On 12/02/19 at 04:07 PM, Administrative Nurse D stated the expectation of a person who is on an antipsychotic medication should be completed quarterly.

The revised policy "MDS Assessment ", "The facility must conduct initially and periodically a

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comprehensive assessment. To provide ongoing assessment information necessary to develop a care plan and care/services based on the resident's status.

The facility lacked a policy and procedure for completion of the AIMS for residents who received antipsychotic medication.

The facility failed to consistently complete the AIMS assessment to monitor the resident for side effects associated with antipsychotic medication use.

- Resident (R) 37's "Physician Orders" (PO), dated 09/18/19, documented the resident with a diagnosis of Alzheimer's Dementia (a type of dementia that causes problems with memory, thinking and behavior), Anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), Depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), Psychotic disorder (a mental disease that includes symptoms like delusions or hallucinations that show impaired contact with and perception of reality).

The quarterly "Minimum Data Set," (MDS), dated 09/06/19, recorded the resident with a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. She needs extensive assistance with all activities of daily living, is independent in feeding herself and uses a wheelchair and a walker. On the seven day look back period she was on a antipsychotic and a antidepressant medication for seven days

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of the lookback period.

The "Psychotropic Drug Use Care Area Assessment," (CAA), dated 10/22/19, documented she was currently taking antidepressant medication daily for anxiety and not being able to participate in her BIMS signifies severely impaired cognition, her safety awareness was impaired.

The significant change MDS, dated 11/06/19, recorded the resident with a BIMS of 99, indicating severe impaired cognition. The resident has long and short term memory problems. On the seven day lookback period, she received an antipsychotic for six days.

The care plan, dated 10/29/19, for psychotropic medication use, documented she had the potential for drug related complications with use of psychotropic medication of Seroquel. Staff will monitor for target behaviors/symptoms and document. Mental health consults as warranted. Staff will observe for uncharacteristic behaviors. AIMS (Abnormal Involuntary Movement Scale) assessment (The AIMS records the occurrence of Tardive Dyskinesia (TD) in patients receiving neuroleptic medications. The AIMS test is used to detect TD and to follow the severity of a patient's TD over time.) to be done with MDS schedule and as needed.

The care plan, dated 10/29/19, for Seroquel administration related to diagnosis of psychosis, indicated the medication had a Black Box Warning to monitor for lethargy, severe muscle weakness, mental/behavior changes such as distress, excitement, nervousness, confusion, disorientation, hallucinations, restlessness,

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irritability, akathisia (a state of agitation, distress, and restlessness that is an occasional side-effect of antipsychotic and antidepressant drugs.), parkinsonism (progressive nervous system disorder that affects movement), and Tardive Dyskinesia (a neurological disorder characterized by involuntary movements of the face and jaw).

The PO, dated 09/18/19, revealed Seroquel 25 milligrams (mg) twice daily for visual hallucinations, ordered 4/10/19.

On 07/01/19, staff completed a a quarterly MDS assessment, however, failed to complete the AIMS assessment, as planned.

The pharmacy review, dated 08/02/19, revealed the identification of the past due AIMS, required every three months.

On 12/02/19 at 04:00 PM, Administrative Nursing Staff G confirmed that staff failed to complete the AIMS with every MDS to monitor the resident for side effects associated with the administration of an antipsychotic medication.

On 12/02/19 at 04:07 PM, Administrative Nurse D stated the expectation for a resident who is on a antipsychotic medication staff should the AIMS with the MDS.

The revised policy "MDS Assessment," "The facility must conduct initially and periodically a comprehensive assessment. To provide ongoing assessment information necessary to develop a care plan and care/services based on the resident's status.

The facility lacked a policy and procedure for

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F 758	Continued From page 12 completion of the AIMS for residents who received antipsychotic medication. The facility failed to consistently complete the AIMS as planned to monitor the resident for side effects associated with antipsychotic medication use.	F 758		