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	175419	A. BUILDING _____ B. WING _____	03/21/2019

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LINCOLN PARK MANOR INC	922 N 5TH ST LINCOLN, KS 67455

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The sample included 13 residents of which 6 residents were reviewed for (ADLs) Activities of Daily Living. Based on observation, record review and interview the facility failed to complete an assessment to accurately reflect restorative status for 4 of 6 sampled residents. (#2, #12, #14, #17) Findings included: - Resident #2's quarterly (MDS) Minimum Data Set assessment, dated 3/20/19, recorded the resident had severely impaired cognition, and required extensive to total staff assistance with bed mobility, transfers dressing, grooming, and eating. The MDS recorded the resident received restorative services for bed mobility, transfers, dressing and grooming, and eating 7 days a week. The 2/20/19 care plan recorded the resident had a self care deficit related to dementia (progressive mental disorder characterized by failing memory and confusion) and required extensive staff assistance with ADLs. The care plan lacked documentation staff provided	F 641		

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

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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restorative exercises or services for the resident.

The medical record lacked documentation staff provided the resident with a restorative program to maintain or improve activities of daily living function.

On 3/20/19 at 2:03 PM, observation revealed the resident sat in bed and staff assisted the resident with a snack.

On 3/20/19 at 9:07 AM, Nurse G stated the facility had no (RA) Restorative Aide and the (CNA) Certified Nurse Aides had not provided restorative exercises or services for the resident.

On 3/20/19 at 1:29 PM, Nurse Aide M stated the facility had no Restorative Aide and the CNAs had not provided restorative exercises or services for the resident.

On 3/21/19 at 9:02 AM, Administrative Nurse D stated the facility had no restorative program to provide exercises and services to maintain or improve the resident's ADL function.

The (RAI) Resident Assessment Instrument 3.0 Manual recorded a dressing and grooming restorative program should be individualized to maintain the resident's self-performance in dressing, bathing, washing, and other personal hygiene. The RAI manual recorded an (RN) Registered Nurse or (LPN) Licensed Practical Nurse must supervise the resident's restorative nursing program, and complete a periodic evaluation of the restorative program in the resident's medical record.

The facility's Restorative Nursing Services Policy,

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F 641	Continued From page 2	F 641		

dated 10/28/18, recorded restorative services should be individualized to maintain the resident's strength, safety and ADL function, and the restorative services should be recorded on the resident's care plan. The restorative policy directed nursing staff to supervise the restorative program and complete periodic evaluations to monitor restorative services and the resident's status.

The facility failed to complete an assessment to accurately reflect restorative status for Resident #2, placing the resident at risk for a decline in ADL function.

- Resident #12's quarterly (MDS) Minimum Data Set assessment, dated 2/06/19, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 5 (severe cognitive impairment), and physical and verbal behaviors. The MDS recorded the resident required extensive staff assistance with bed mobility, transfers, dressing, grooming, and staff supervision with eating. The MDS recorded the resident received restorative services for bed mobility, transfers, eating, and dressing and grooming 7 days a week.

The 2/19/19 care plan recorded the resident required extensive staff assistance with (ADLs) Activities of Daily Living, had physical and verbal behaviors and refused cares at times . The care plan lacked documentation staff provided restorative exercises or services for the resident.

The medical record lacked documentation staff provided the resident with a restorative program to maintain or improve activities of daily living function.

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On 3/20/19 at 11:13 AM, observation revealed the resident propelled his/her wheelchair to the dining room.

On 3/20/19 at 9:07 AM, Nurse G stated the facility had no (RA) Restorative Aide and the (CNA) Certified Nurse Aides had not provided restorative exercises or services for the resident.

On 3/20/19 at 1:29 PM, Nurse Aide M stated the facility had no Restorative Aide and the CNAs had not provided restorative exercises or services for the resident.

On 3/21/19 at 9:02 AM, Administrative Nurse D stated the facility had no restorative program to provide exercises and services to maintain or improve the resident's ADL function.

The (RAI) Resident Assessment Instrument 3.0 Manual recorded a dressing and grooming restorative program should be individualized to maintain the resident's self-performance in dressing, bathing, washing, and other personal hygiene. The RAI manual recorded an (RN) Registered Nurse or (LPN) Licensed Practical Nurse must supervise the resident's restorative nursing program, and complete a periodic evaluation of the restorative program in the resident's medical record.

The facility's Restorative Nursing Services Policy, dated 10/28/18, recorded restorative services should be individualized to maintain the resident's strength, safety and ADL function, and the restorative services should be recorded on the resident's care plan. The restorative policy directed nursing staff to supervise the restorative program and complete periodic evaluations to

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monitor restorative services and the resident's status.

The facility failed to complete an assessment to accurately reflect restorative status for Resident #12, placing the resident at risk for a decline in ADL function.

- Resident #14's annual (MDS) Minimum Data Set, dated 1/07/19, recorded the resident had a (BIMS) Brief interview for Mental Status score of 13 (cognitively intact), required extensive staff assistance with bed mobility, transfers, dressing, and grooming. The MDS recorded the resident received restorative services for bed mobility, transfers, and dressing and grooming 7 days a week.

The 2/19/19 care plan recorded the resident had a self care deficit related to anxiety (mental or emotional reaction characterized by uncertainty and irrational fear) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and hopelessness) and required extensive staff assistance with transfers and dressing. The care plan lacked documentation staff provided restorative exercises or services for the resident.

The medical record lacked documentation staff provided the resident with a restorative program to maintain or improve activities of daily living function.

On 3/21/19 at 7:48 AM, observation revealed the resident propelled his/her wheelchair to the dining room.

On 3/20/19 at 9:07 AM, Nurse G stated the facility

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had no (RA) Restorative Aide and the (CNA) Certified Nurse Aides had not provided restorative exercises or services for the resident.

On 3/20/19 at 1:29 PM, Nurse Aide M stated the facility had no Restorative Aide and the CNAs had not provided restorative exercises or services for the resident.

On 3/21/19 at 9:02 AM, Administrative Nurse D stated the facility had no restorative program to provide exercises and services to maintain or improve the resident's ADL function.

The (RAI) Resident Assessment Instrument 3.0 Manual recorded a dressing and grooming restorative program should be individualized to maintain the resident's self-performance in dressing, bathing, washing, and other personal hygiene. The RAI manual recorded an (RN) Registered Nurse or (LPN) Licensed Practical Nurse must supervise the resident's restorative nursing program, and complete a periodic evaluation of the restorative program in the resident's medical record.

The facility's Restorative Nursing Services Policy, dated 10/28/18, recorded restorative services should be individualized to maintain the resident's strength, safety and ADL function, and the restorative services should be recorded on the resident's care plan. The restorative policy directed nursing staff to supervise the restorative program and complete periodic evaluations to monitor restorative services and the resident's status.

The facility failed to complete an assessment to accurately reflect restorative status for Resident

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#14, placing the resident at risk for a decline in ADL function.

- Resident #17's quarterly (MDS) Minimum Data Set, dated 2/09/19, recorded the resident had a (BIMS) Brief interview for Mental Status score of 14 (cognitively intact), required extensive staff assistance with transfers and walking. The MDS recorded the resident received restorative services for bed mobility, transfers, and walking 7 days a week.

The 3/13/19 care plan recorded the resident frequently complained of back and knee pain, and required extensive staff assistance with a walker for transfers and ambulation. The care plan lacked documentation staff provided restorative exercises or services for the resident.

The medical record lacked documentation staff provided the resident with a restorative program to maintain or improve activity of daily living function.

On 3/20/19 at 2:10 PM, observation revealed the resident transferred independently to his/her walker, and ambulated independently with a walker in his/her room.

On 3/20/19 at 9:07 AM, Nurse G stated the facility had no (RA) Restorative Aide and the (CNA) Certified Nurse Aides had not provided restorative exercises or services for the resident.

On 3/20/19 at 1:29 PM, Nurse Aide M stated the facility had no Restorative Aide and the CNAs had not provided restorative exercises or services for the resident.

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F 641	Continued From page 7 On 3/21/19 at 9:02 AM, Administrative Nurse D stated the facility had no restorative program to provide exercises and services to maintain or improve the resident's ADL function. The (RAI) Resident Assessment Instrument 3.0 Manual recorded a dressing and grooming restorative program should be individualized to maintain the resident's self-performance in dressing, bathing, washing, and other personal hygiene. The RAI manual recorded an (RN) Registered Nurse or (LPN) Licensed Practical Nurse must supervise the resident's restorative nursing program, and complete a periodic evaluation of the restorative program in the resident's medical record. The facility's Restorative Nursing Services Policy, dated 10/28/18, recorded restorative services should be individualized to maintain the resident's strength, safety and ADL function, and the restorative services should be recorded on the resident's care plan. The restorative policy directed nursing staff to supervise the restorative program and complete periodic evaluations to monitor restorative services and the resident's status. The facility failed to complete an assessment to accurately reflect restorative status for Resident #17, placing the resident at risk for a decline in ADL function.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		

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(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 28 residents. The sample included 13 residents. Based on observation, record review and interview, the facility failed to review and revise the care plan for 1 of 13 sampled residents who had an indwelling urinary catheter (#1).

Findings included:

- Resident #1's physician order sheet, dated 2/6/19, documented diagnoses of severe sepsis (a life-threatening complication of an infection), retention of urine, abnormal findings on

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microbiological (refers to studies or tests related to very small living things such as bacterial and their effects on people) examination of urine, and neuromuscular (dysfunction of the urinary bladder caused by a lesion of the nervous system) dysfunction of the bladder.

The admission (MDS) Minimum Data Set assessment, dated 12/17/18, recorded the resident had intact cognition, required extensive assistance of 1 to 2 staff for bed mobility, transfers, toilet use, personal hygiene, bathing, and had an indwelling urinary catheter (flexible plastic tube inserted into the bladder to drain the urine into a collection bag). The MDS further documented the resident had a neurogenic (dysfunction of the urinary bladder caused by a lesion of the nervous system) bladder and a urinary tract infection in the past 30 days.

The urinary incontinence and indwelling catheter (CAA) Care Area Assessment, dated 12/20/18, documented the resident had a urinary catheter for a diagnosis of a neurogenic dysfunction of the bladder.

The care plan, dated 12/12/18, recorded the resident had an indwelling catheter related to moisture related skin damage due to uncontrollable urinary incontinence, and the catheter had been discontinued on 10/13/18.

The physician's progress note, dated 10/26/18, recorded the resident continued with an indwelling catheter, and discussed at length with the resident, the reason for his/her catheter.

On 3/20/19 at 7:46 AM, observation revealed the resident in the dining room, finishing breakfast,

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F 657	Continued From page 10 with a urinary catheter drainage bag and tubing secured under his/her wheelchair, within a privacy bag. On 3/20/19 at 2:02 PM, Administrative Nurse D verified the indwelling urinary care plan should have been revised to include reinsertion of the urinary catheter with staff direction for care. The facility's Person Centered Care Plan and Catheter Care policy, dated 10/28/18, directed staff to attain or maintain the resident's highest practical physical, mental, psychosocial well-being, and reflect currently recognized standards of practice for problem areas and conditions. The facility failed to reinstate an indwelling catheter care plan for Resident #1, with staff instructions for proper care and maintenance of indwelling catheter to prevent urinary tract infection, placing the resident at risk for serious urinary catheter issues.	F 657		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his	F 676		

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or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

§483.24(b) Activities of daily living.
The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 28 residents. The sample included 13 residents of which 6 residents were reviewed for (ADLs) Activities of Daily Living. Based on observation, record review and interview the facility failed to provide a restorative program to maintain or improve activities of daily living function for 4 of 6 sampled residents. (#2, #12, #14, #17))

Findings included:

- Resident #2's quarterly (MDS) Minimum Data Set assessment, dated 3/20/19, recorded the

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resident had severely impaired cognition, and required extensive to total staff assistance with bed mobility, transfers dressing, grooming, and eating. The MDS recorded the resident received restorative services for bed mobility, transfers, dressing and grooming, and eating 7 days a week.

The 2/20/19 care plan recorded the resident had a self care deficit related to dementia (progressive mental disorder characterized by failing memory and confusion) and required extensive staff assistance with ADLs. The care plan lacked documentation staff provided restorative exercises or services for the resident.

The medical record lacked documentation staff provided the resident with a restorative program to maintain or improve activities of daily living function.

On 3/20/19 at 2:03 PM, observation revealed the resident sat in bed and staff assisted the resident with a snack.

On 3/20/19 at 9:07 AM, Nurse G stated the facility had no (RA) Restorative Aide and the (CNA) Certified Nurse Aides had not provided restorative exercises or services for the resident.

On 3/20/19 at 1:29 PM, Nurse Aide M stated the facility had no Restorative Aide and the CNAs had not provided restorative exercises or services for the resident.

On 3/21/19 at 9:02 AM, Administrative Nurse D stated the facility had no a restorative program to provide exercises and services to maintain or improve the resident's ADL function.

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The (RAI) Resident Assessment Instrument 3.0 Manual recorded a dressing and grooming restorative program should be individualized to maintain the resident's self-performance in dressing, bathing, washing, and other personal hygiene. The RAI manual recorded an (RN) Registered Nurse or (LPN) Licensed Practical Nurse must supervise the resident's restorative nursing program, and complete a periodic evaluation of the restorative program in the resident's medical record.

The facility's Restorative Nursing Services Policy, dated 10/28/18, recorded restorative services should be individualized to maintain the resident's strength, safety and ADL function, and the restorative services should be recorded on the resident's care plan. The restorative policy directed nursing staff to supervise the restorative program and complete periodic evaluations to monitor restorative services and the resident's status.

The facility failed to provide a restorative program to maintain or improve activities of daily living function for Resident #2, placing the resident at risk for a decline in ADL function.

- Resident #12's quarterly (MDS) Minimum Data Set assessment, dated 2/06/19, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 5 (severe cognitive impairment), and physical and verbal behaviors. The MDS recorded the resident required extensive staff assistance with bed mobility, transfers dressing, grooming, and staff supervision with eating. The MDS recorded the resident received restorative services for bed mobility, transfers, eating, and

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dressing and grooming 7 days a week.

The 2/19/19 care plan recorded the resident required extensive staff assistance with (ADLs) Activities of Daily Living, had physical and verbal behaviors and refused cares at times . The care plan lacked documentation staff provided restorative exercises or services for the resident.

The medical record lacked documentation staff provided the resident with a restorative program to maintain or improve activities of daily living function.

On 3/20/19 at 11:13 AM, observation revealed the resident propelled his/her wheelchair to the dining room.

On 3/20/19 at 9:07 AM, Nurse G stated the facility had no (RA) Restorative Aide and the (CNA) Certified Nurse Aides had not provided restorative exercises or services for the resident.

On 3/20/19 at 1:29 PM, Nurse Aide M stated the facility had no Restorative Aide and the CNAs had not provided restorative exercises or services for the resident.

On 3/21/19 at 9:02 AM, Administrative Nurse D stated the facility did not have a restorative program to provide exercises and services to maintain or improve the resident's ADL function.

The (RAI) Resident Assessment Instrument 3.0 Manual recorded a dressing and grooming restorative program should be individualized to maintain the resident's self-performance in dressing, bathing, washing and other personal hygiene. The RAI manual recorded a (RN)

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Registered Nurse or (LPN) Licensed Practical Nurse must supervise the resident's restorative nursing program, and complete a periodic evaluation of the restorative program in the resident's medical record.

The facility's Restorative Nursing Services Policy, dated 10/28/18, recorded restorative services should be individualized to maintain the resident's strength, safety and ADL function, and the restorative services should be recorded on the resident's care plan. The restorative policy directed nursing staff to supervise the restorative program and complete periodic evaluations to monitor restorative services and the resident's status.

The facility failed to provide a restorative program to maintain or improve activities of daily living function for Resident #12, placing the resident at risk for a decline in ADL function.

- Resident #14's annual (MDS) Minimum Data Set, dated 1/07/19, recorded the resident had a (BIMS) Brief interview for Mental Status score of 13 (cognitively intact), required extensive staff assistance with bed mobility, transfers, dressing, and grooming. The MDS recorded the resident received restorative services for bed mobility, transfers, and dressing and grooming 7 days a week.

The 2/19/19 care plan recorded the resident had a self care deficit related to anxiety (mental or emotional reaction characterized by uncertainty and irrational fear) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and hopelessness) and required extensive staff

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assistance with transfers and dressing. The care plan lacked documentation staff provided restorative exercises or services for the resident.

The medical record lacked documentation staff provided the resident with a restorative program to maintain or improve activities of daily living function.

On 3/21/19 at 7:48 AM, observation revealed the resident propelled his/her wheelchair to the dining room.

On 3/20/19 at 9:07 AM, Nurse G stated the facility had no (RA) Restorative Aide and the (CNA) Certified Nurse Aides had not provided restorative exercises or services for the resident.

On 3/20/19 at 1:29 PM, Nurse Aide M stated the facility had no Restorative Aide and the CNAs had not provided restorative exercises or services for the resident.

On 3/21/19 at 9:02 AM, Administrative Nurse D stated the facility had no restorative program to provide exercises and services to maintain or improve the resident's ADL function.

The (RAI) Resident Assessment Instrument 3.0 Manual recorded a dressing and grooming restorative program should be individualized to maintain the resident's self-performance in dressing, bathing, washing, and other personal hygiene. The RAI manual recorded an (RN) Registered Nurse or (LPN) Licensed Practical Nurse must supervise the resident's restorative nursing program, and complete a periodic evaluation of the restorative program in the resident's medical record.

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The facility's Restorative Nursing Services Policy, dated 10/28/18, recorded restorative services should be individualized to maintain the resident's strength, safety and ADL function, and the restorative services should be recorded on the resident's care plan. The restorative policy directed nursing staff to supervise the restorative program and complete periodic evaluations to monitor restorative services and the resident's status.

The facility failed to provide a restorative program to maintain or improve activities of daily living function for Resident #14, placing the resident at risk for a decline in ADL function.

- Resident #17's quarterly (MDS) Minimum Data Set, dated 2/09/19, recorded the resident had a (BIMS) Brief interview for Mental Status score of 14 (cognitively intact), required extensive staff assistance with transfers and walking. The MDS recorded the resident received restorative services for bed mobility, transfers, and walking 7 days a week.

The 3/13/19 care plan recorded the resident frequently complained of back and knee pain, and required extensive staff assistance with a walker for transfers and ambulation. The care plan lacked documentation staff provided restorative exercises or services for the resident.

The medical record lacked documentation staff provided the resident with a restorative program to maintain or improve activity of daily living function.

On 3/20/19 at 2:10 PM, observation revealed the

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resident transferred independently to his/her walker, and ambulated independently with a walker in his/her room.

On 3/20/19 at 9:07 AM, Nurse G stated the facility had no (RA) Restorative Aide and the (CNA) Certified Nurse Aides had not provided restorative exercises or services for the resident.

On 3/20/19 at 1:29 PM, Nurse Aide M stated the facility had no Restorative Aide and the CNAs had not provided restorative exercises or services for the resident.

On 3/21/19 at 9:02 AM, Administrative Nurse D stated the facility had no restorative program to provide exercises and services to maintain or improve the resident's ADL function.

The (RAI) Resident Assessment Instrument 3.0 Manual recorded a dressing and grooming restorative program should be individualized to maintain the resident's self-performance in dressing, bathing, washing, and other personal hygiene. The RAI manual recorded an (RN) Registered Nurse or (LPN) Licensed Practical Nurse must supervise the resident's restorative nursing program, and complete a periodic evaluation of the restorative program in the resident's medical record.

The facility's Restorative Nursing Services Policy, dated 10/28/18, recorded restorative services should be individualized to maintain the resident's strength, safety and ADL function, and the restorative services should be recorded on the resident's care plan. The restorative policy directed nursing staff to supervise the restorative program and complete periodic evaluations to

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F 676	Continued From page 19 monitor restorative services and the resident's status. The facility failed to provide a restorative program to maintain or improve activities of daily living function for Resident #17, placing the resident at risk for a decline in ADL function.	F 676		
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 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	F 758		

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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 had a census of 28 residents. The sample included 13 residents. Based on observation, record review and interview, the facility failed to ensure appropriate monitoring for use of psychotropic medication for 2 of 5 sampled residents. (#25, #23)

Findings included:

- Resident #25's physician order sheet, dated 2/6/19, documented diagnoses of pain, long term use of anticoagulant (a medication that helps to prevent blood clots), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and chronic heart failure.

The 14-day (MDS) Minimum Data Set assessment, dated 3/12/19, recorded the resident

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was independent with decision making as assessed by staff, exhibited no behaviors, and received minimal assistance of 1 staff for activities of daily living. The MDS further documented the resident received antianxiety, antidepressant, anticoagulant, antibiotic (medication used to treat infection), and diuretic (medication to promote the formation and excretion of urine) medications.

The psychotropic (CAA) Care Area Assessment, dated 6/12/18, documented the resident received Xanax (antianxiety medication) at bedtime, for COPD (Chronic Obstructive Pulmonary Disease, a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The 12/3/18 care plan recorded the resident receives antianxiety medication for COPD and directed staff to monitor the resident for drug effectiveness, adverse consequences, mood, and response to medication.

The 6/4/18 physician's order directed staff to administer Xanax, 1 mg (milligram) by mouth, daily at bedtime, for anxiety.

The medical record lacked a monitoring system specific to the use of Xanax antianxiety medication which included effectiveness, adverse side affects, and response to the medication.

The medical record documented the resident had been discharged to the hospital on 3/15/19.

On 3/20/19 at 2:02 PM, Administrative Nurse D verified the facility had no monitoring system for the resident's use of xanax antianxiety medication

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as care planned.

The facility's Medication Monitoring and Management policy, dated 10/28/18, documented the interdisciplinary team reviewed the resident's medication regimen for effectiveness, and actual or potential medication related problems, on an ongoing basis. The medication monitoring is to optimize the therapeutic benefit of therapy, minimize or prevent potential adverse consequences, and for appropriate, effective and safe medication use.

The facility failed to implement a monitoring system for Resident #25's use of Xanax, placing the resident at risk for adverse side effects.

- Resident #23's physician order sheet, dated 3/7/19, documented diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, psychosis (any major mental disorder characterized by a gross impairment in reality testing) not due to substance or known physiological (a branch of biology that deals with the normal functions of living) condition, and insomnia (inability to sleep).

The quarterly (MDS) Minimum Data Set assessment, dated 3/5/19, recorded the resident had moderately impaired cognition with fluctuating inattention behavior, and required extensive assistance of 1 staff for activities of

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daily living. The MDS further documented the resident received an antipsychotic medication on a routine basis.

The psychotropic drug use (CAA) Care Area Assessment, dated 12/13/18, documented the resident had a history of depression and anxiety, became anxious, had behaviors, and complained of severe stomach pain when the physician attempted a psychotropic medication reduction.

The care plan, dated 3/13/19, recorded the resident at risk for adverse consequences related to receiving antidepressant and antipsychotic medications. The care plan directed staff to assess and record the effectiveness of drug therapy and observe for mood and behavior changes.

The 1/21/16 physician order directed staff to administer Lexapro (antidepressant medication) 10 mg (milligram) by mouth, daily for major depressive disorder, and on 8/15/17 the physician ordered Zyprexa (antipsychotic medication) 2.5 mg, by mouth, daily at bedtime for depressive disorder.

The medical record lacked a monitoring system specific to the use of antidepressant and antianxiety medication, related to effectiveness, mood, and response to the medication.

On 3/19/19 at 9:33 AM, observation revealed staff assisted the resident to dress and groom, and transferred him/her to a recliner.

On 3/20/19 at 2:02 PM, Administrative Nurse D, verified the facility had no monitoring system for the use of antidepressant and antianxiety

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F 758	Continued From page 24 medication for the resident as care planned. The facility's Medication Monitoring and Management policy, dated 10/28/18, documented the interdisciplinary team reviewed the resident's medication regimen for effectiveness, and actual or potential medication related problems, on an ongoing basis. The medication monitoring is to optimize the therapeutic benefit of therapy, minimize or prevent potential adverse consequences, and for appropriate, effective and safe medication use. The facility failed to implement a monitoring system for Resident #23's use of Lexapro and Zyprexa, placing the resident at risk for adverse side effects.	F 758		