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	175457	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY OPERATOR, LLC	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #96937 and #97229. A revised copy of the 2567 was sent to the provider on 3/25/16.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 19 residents. Based on record review and interview, the facility failed to thoroughly document a resident's physical status	F 155		

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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and/or initiate (CPR) Cardiopulmonary Resuscitation for the 1 of 27 residents with a full code status. (#57)

Findings included:

- Resident #57's 14 day Medicare (MDS) Minimum Data Set assessment, dated 1/5/16, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 5 which indicated severely impaired cognition. The assessment revealed the resident dependent upon 2 staff for bed mobility, transfers, dressing, and toileting. The assessment further revealed the resident had unclear speech, sometimes understood others and responded adequately to simple, direct communication.

The 1/3/16 (CAA) Care Area Assessment for activities of daily living stated the resident made his/her own decisions but had his/her daughter and granddaughter listed as the emergency contacts.

The 12/23/15 care plan revealed the resident a full code and directed staff to attempt CPR if his/her heart or breathing stopped.

The 1/9/16 at 1:26 PM, nurse's note stated the staff checked on the resident at 6:00 AM, 7:30 AM, 9:00 AM, and he/she was resting quietly and had refused breakfast. The note further stated, at 10:15 AM, Medication Aide W checked on the resident, and he/she noted the resident with no respirations. The note stated the charge nurse went to the nurse's station to see if the resident

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was a full code status (requiring CPR), and started to go back to the resident's room to initiate CPR, while he/she contacted the physician to see if he/she should initiate CPR. The note further stated the physician directed the staff not to perform CPR at that time. The nurse's note revealed no further documentation or description of the resident when found by staff with no respirations.

On 3/8/16 at 7:24 AM, Administrative Nurse A stated staff should have initiated CPR right away since the resident was a full code.

On 3/8/16 at 10:10 AM, Medication Aide W stated he/she had knocked on the resident's door, did not get an answer, walked in and saw the resident did not look right. Medication Aide W stated, he/she went and notified the charge nurse, then continued with his/her medication pass.

The 9/15 facility's Cardiopulmonary Resuscitation and Basic Life Support Policy stated, if an individual (resident, visitor, or staff) is found unresponsive and not breathing normally, a licensed staff person who is certified in CPR/BLS shall initiate CPR unless it is known that a do not resuscitate (DNR) order that specifically prohibits CPR for that individual or there are obvious signs of irreversible death unless prohibited by state guidelines. The policy further stated staff should document the condition which the resident was found, the sequence of resuscitation involving approximate times, the resident's response to the resuscitation efforts, the time the EMS (Emergency Medical Services) took over, the time

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F 155	Continued From page 3 of death or time the response team transported the resident, and report the event to the medical director, administrator, and director of nursing. The facility failed to thoroughly document the condition of the resident including obvious signs of irreversible death, or initiate CPR for Resident #57 per the residents wishes and as specified in the plan of care and physician's order.	F 155		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

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The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 43 residents. The sample included 19 residents. Based on record review and interview, the facility failed to seek physician involvement for 1 of 1 residents with an acute change of status. Resident #57 developed abdominal distention (abdominal swelling) and hypoactive (reduced) bowel sounds two days in a row.

Findings included:

- The 1/4/16 (POS) Physician Order Sheet, indicated the resident had diagnoses of constipation (a condition in which there is difficulty in emptying the bowels, usually associated with hardened feces), and femur fracture (broken hip).

The 14 day Medicare (MDS) Minimum Data Set assessment, dated 1/5/16, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 5 which indicated severely impaired cognition. The assessment revealed the resident dependent upon 2 staff members for bed mobility, transfers, dressing, and toileting. The assessment further revealed the resident was always incontinent of bowel.

The 1/3/16 (CAA) Care Area Assessment for activities of daily living stated the resident had a problem with constipation, which required a trip to

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the (ER) Emergency Room on 12/31/15.

The 12/23/15 care plan stated the resident was occasionally constipated and directed staff to administer medications per the physician orders, monitor the resident for abdominal pain and distention, and assess the resident's bowel sounds as needed.

The 12/23/15 physician's order directed staff to administer (MOM) Milk of Magnesium, (a laxative) 30 (ml) milliliters, by mouth, daily, and follow the facility bowel protocol.

The facility failed to provide a bowel movement record sheet for the month of December 2015.

The 12/31/15 at 11:58 PM, nurse's note stated the resident complained of pain in his/her chest, and staff received an order from the physician to transport the resident to the (ER) Emergency Room.

The 12/31/15 Emergency Room Report revealed the Emergency physician evaluated the resident for constipation and abdominal pain. The report directed staff to use all as needed medications for constipation, as well as increase the resident's fluids. The report further directed staff to administer Reglan, (a medication for stomach problems) 10 (mg) milligrams, by mouth, 4 times daily, for abdominal pain, nausea and vomiting. The report further directed staff to administer a soap suds enema (a mixture of soap and water injected into the colon used to stimulate a bowel

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movement) if the the resident did not have a normal stool by noon on 1/1/16.

The 1/1/16 at 3:53 AM, nurse's note stated the resident returned from the ER and continued to yell out. The note stated the staff administered Norco, (a narcotic pain medication) 7.5 mg, by mouth, every 6 hours, as needed for pain and Ativan, (an antianxiety medication) 0.5 mg, by mouth, every 4 hours, as needed for anxiety.

The 1/2/16 at 4:46 PM, nurse's note stated staff administered a Biscodyl suppository, (laxative inserted into the rectum) 10 mg, with small results and he/she refused MOM. The note further stated the staff notified the physician and received orders to discontinue the MOM, and start Miralax, (a laxative) 17 grams, up to 4 times daily, as needed.

The 1/2/16 at 11:44 PM, nurse's note stated the resident had a small amount of black stool in his/her incontinent briefs and staff administered a soap suds enema to the resident with 2 quarter sized formed brown pieces of stool as a result. The note further stated the staff had administered 3 doses of Miralax during the shift. The note stated the resident's abdomen was distended and had hypoactive bowel sounds in all 4 quadrants. Review of the medical record revealed the staff did not notify the physician of the resident's continued distended abdomen and hypoactive bowel sounds.

The 1/3/16 at 4:52 PM, nurse's note stated the resident had hypoactive bowel sounds with

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constipation. The note further stated the staff administered a suppository with small results and the resident ate 10% of his/her meals during the shift. The note stated the resident would be added to the list to see the nurse practitioner on his/her next visit.

The 1/4/16 at 4:31 PM, nurse's note stated the nurse practitioner assessed the resident, and he/she directed staff to administer Colace, (a stool softener) 100 mg, by mouth, twice a day and increase the Miralax to twice daily and as needed. (two days after the resident's abdomen was distended and he/she had hypoactive bowel sounds)

The 1/8/16 at 3:12 AM, nurse's note stated the resident had 1 bowel movement during the shift, and staff encouraged fluids.

On 3/8/16 at 7:24 AM, Administrative Nurse A stated staff should have notified the physician regarding the resident's distended abdomen and hypoactive bowel sounds.

On 3/8/16 at 10:15 AM, Licensed Nurse W verified he/she did not contact the physician when the staff assessed the resident with a distended abdomen, and hypoactive bowel sounds.

The September 2012 facility Change in a Residents Condition or Status Policy stated the facility shall promptly notify the resident's attending physician of changes in the resident's medical/mental condition or status.

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F 157	Continued From page 8 The facility failed to notify the physician, in a timely manner, for Resident #57 who developed a distended abdomen, and hypoactive bowel sounds.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 19 residents. Based on observation, record review, and interview the facility failed to maintain an environment that promotes dignity for 2 of 19 residents. (#45 and #22) Findings included: - Resident #45's significant change (MDS) Minimum Data Set, dated 2/11/16, revealed the resident had a (BIMS) Brief Interview for Mental Status score of 6 which indicates severe cognitive impairment. The MDS further documented the resident had no behaviors, and required staff assistance with (ADLs) Activities of Daily Living except for eating, which he/she required minimal staff assistance. The assessment revealed the resident had impairment on both sides of his/her upper and lower extremities, and received antipsychotic and antidepressant medications. The care plan, dated 2/15/16, revealed the	F 241		

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resident required assistance of staff for completion of his/her ADLs. The care plan revealed the resident needed extensive assist of one staff for eating and personal hygiene

The ADL (CAA) Care Area Assessment, dated 2/11/16 revealed the resident mumbles, has unclear speech, and is sometimes understood by others. The CAA stated the resident is dependent on 2 staff for all ADLs except eating, which requires minimal assistance.

On 3/2/16 at 3:34 PM, observation revealed Resident #45, seated in his/her wheelchair, with his/her eyes closed. Observation revealed the resident's mouth open with an approximately 6 inch long line of drool/saliva coming out of the left corner of his/her mouth hanging down to his/her shirt. The wet spot on his/her shirt, measures approximately 3 inches wide x 6 inches long.

On 3/2/16 at 4:34 PM observation revealed the resident seated in his/her wheelchair, with his/her eyes closed and head tilted to the left. Further observation revealed a 6 inch string of continuous saliva/drool from his/her bottom lip on the left side to his/her mid-chest, and with the same T-shirt with the wet spot on.

On 3/3/16 at 10:32 AM, observation revealed the resident seated in his/her wheelchair, in his/her room, head leaning to the left and approximately 5 inch long string of drool/saliva hanging down to his/her shirt.

On 3/3/16 at 10:47 AM, observation revealed the resident seated in his/her
wheelchair in his/her room, leaning to the left with drool/saliva coming out of his/her mouth.

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On 3/3/16 at 2:24 PM, Administrative Nurse L verified the resident drools a lot, often has a wet shirt, and staff should change the resident's clothing if it is wet.

The facility's 8/2009 Dignity Policy indicated the residents shall be treated with dignity and respect at all times."Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

The facility failed to promote care in a manner to maintain and enhance dignity and respect for Resident #45.

- Resident #22's quarterly (MDS) Minimum Data Set assessment, dated 12/21/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15, indicating intact cognition. The MDS indicated the resident required staff supervision with bed mobility, transfer, walk in room, corridor, and locomotion off and on unit. The MDS indicated the resident required limited staff assistance with dressing, and supervision with set up help for eating.

The 2/25/16 care plan instructed the staff to provide the resident supervision, and set up assistance with eating.

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F 241	Continued From page 11 On 3/1/16 at 12:31 PM, observation revealed the resident took a drink of his/her coffee, choked, started coughing, spit some of his/her coffee down the front of his/her shirt, into his/her coffee cup, and on the floor. Continued observation revealed Administrative Staff N walked to the resident's table but did not offer the resident another cup of coffee or assist the resident in cleaning the coffee off his/her shirt. Further observation revealed the resident continued drinking the same coffee. On 3/8/16 at 3:40 PM, Administrative Nurse A stated he/she would expect staff to intervene and assist the resident, when he/she choked on his/her coffee, and spit up in his/her coffee cup. The facility's August 2009 Quality of life-Dignity policy stated residents shall be treated with dignity and respect at all times and "treated with dignity"meant the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Although some of the residents may be cognitively impaired, most reasonable people in our society would find this experience to be very demeaning. The facility failed to promote care in a manner that maintained or enhanced Resident #22's dignity, by not assisting the resident when he/she choked, coughed, spit, into his/her coffee cup, and continued to drink the coffee.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility	F 244		

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must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 43 residents. The sample included 19 residents. Based on observation, record review, and interview the facility failed to act upon the grievances of residents by not replacing a shower mat in 1 of 3 shower rooms, as expressed by residents in 2 of the last 12 resident council minutes.
Findings included:

- Review of the Resident Council minutes from March 2015-February 2016 revealed the residents requested a new shower mat in September 2015, and again in February 2016.

On 3/2/16 at 11:40 PM, observation revealed the shower room on the Center Hall had a bathmat on the shower floor, approximately 30 inches long by 12 inches wide. Further observation revealed the shower mat tan in color with 75% of the surface area covered in a black colored substance of dots scattered throughout the mat.

On 3/8/16 at 10:30 AM, Social Service Staff H verified the Resident Council brought up concerns about the shower mat more than once, but staff had not replaced the shower mat. Social Service staff H verified the staff did not follow up on the concern.

On 3/8/16 at 3:45 PM, Administrative Staff G

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F 244	Continued From page 13 stated he/she was aware the shower mat had been brought up in Resident Council and the shower mat had not yet been replaced. Administrative G stated there had been a miscommunication and a shower mat had been purchased in December 2015 but the new shower mat was placed in a different shower room and he/she was unaware there was a need for more than one shower mat. The facility's undated summary of federal and state residents' rights stated the resident has the right to receive services with reasonable accommodation of individual needs and preferences. The summary further stated the facility must provide a safe, clean, comfortable and home-like environment. The facility failed to act upon the concerns of the residents, by not providing a new bathmat for the Central Hall shower room, as requested twice since September 2015, during resident council meetings.	F 244		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 19 residents. Based on observation and interview the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable	F 253		

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environment on 3 of 3 halls for the 43 residents who reside in the facility.

Findings included:

- On 3/1/16 at 7:40 AM, observations during initial tour revealed the following:

Resident #32's room entrance door had an area approximately 12 inch by ½ inch wide, with the wood peeling off, approximately 16 inches from the bottom of the door.

Resident #62's room entrance door had an area approximately ½ inch by ½ inch squares across the middle of the door that was rough and sticky.

Resident #35's room entrance door had 3 round areas approximately ¼ inch in diameter with the wood peeling off and on the lower right side of the door an area approximately 16 inches from the base of the door ¼ inches in diameter with the top layer of wood peeling off. The bottom of the sink in the resident's room had a brownish stain approximately 3-4 inch in diameter around the drain and white powdery build up around the sink handles.

Resident #38's room entrance door had numerous scrapes and scratches ranging from the size of a dot to a 2 inch line on the lower left side.

Resident #60's room entrance door had a scratch across the width of the door approximately ½ inch wide just below the handle.

Resident #25's room entrance door had a scratch across the lower left side of the door, halfway

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across the width of the door approximately ¼ inch wide.

The 2 doors by the handicap sign in the center hallway had a scratch across the width of the door approximately ½ inch wide just below the handle.

The heater vent by the ambulance entrance door had a 1 inch area with peeling paint, a 2 inch by 1 inch area on the top front of the door with peeling paint and a 1 inch x ½ inch area across the bottom left side with peeling paint.

The wall outside the MDS coordinator's office had numerous large areas with unmatched paint. Outside the door across from the MDS coordinator's office had an area approximately 6 inches by 2 inches with chipped tile and an area on the baseboard outside the same door had an area with an approximately 4 inch scratch on the baseboard.

The railing outside the main dining room had 2 lines on the brick wall from the floor to the ceiling approximately 3/4 inch wide.

The wall outside the isolation cart storage room had a hole in the plaster approximately 2 inches in diameter, approximately 2 feet from the bottom of the floor.

In the west hall the baseboard from Resident #43's room to the exit door had several scrapes in the paint approximately 1/4 inch wide.

Resident #11's bathroom had a brown stain approximately 12 inches in front of the stool around to the back, an area to the left of the soap

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F 253	Continued From page 16 dispenser approximately 3 inches by 1 inch wide with peeling paint and an area to the right of the soap dispenser approximately 2 inches by 2 inches with peeling paint. Resident #43's room had an area approximately 3 inches long by ½ inch wide on the wall to the right of the bed's headboard with peeling paint. Resident #48's room entrance door had a gouge across the door ½ inch wide. The wall by the window had a scrape in the paint approximately 3 inches long by ½ inch wide and 2 penny size gouges in the wall under the wall light. The heat register in the room had rust under and around it and several spots approximately the size of a quarter with peeling paint. The wall by the bed had a purple stained area approximately 6 inches in diameter. On 3/8/16 at 9:05 AM, during the environmental tour, Maintenance Supervisor E verified the above findings. Upon request, the facility failed to provide a Facility Maintenance Policy. The facility failed to provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable environment for the 43 residents who reside in the facility on 3 of 3 halls.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 43 residents. The sample included 19 residents. Based on observation, record review and interview, the facility failed to thoroughly assess and seek physician involvement for 1 of 1 residents with an acute change of status. Resident #57 developed abdominal distention (abdominal swelling) and hypoactive (reduced) bowel sounds two days in a row.

Findings included:

- The 1/4/16 (POS) Physician Order Sheet, indicated Resident #57 had diagnoses of constipation (a condition in which there is difficulty in emptying the bowels, usually associated with hardened feces), and femur fracture (broken hip).

The 14 day Medicare (MDS) Minimum Data Set assessment, dated 1/5/16, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 5 which indicated severely impaired cognition. The assessment revealed the resident dependent upon 2 staff members for bed mobility, transfers, dressing, and toileting. The assessment further revealed the resident always incontinent of bowel.

The 1/3/16 (CAA) Care Area Assessment for activities of daily living stated the resident had a problem with constipation, which required a trip to

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the (ER) Emergency Room on 12/31/15.

The 12/23/15 care plan stated the resident was occasionally constipated and directed staff to administer medications per the physician orders, monitor the resident for abdominal pain and distention, and assess the resident's bowel sounds as needed.

The 12/23/15 physician's order directed staff to administer (MOM) Milk of Magnesium, (a laxative) 30 (ml) milliliters, by mouth, daily, and follow the facility bowel protocol.

The facility failed to provide a bowel movement record sheet for the month of December 2015.

The 12/31/15 at 11:58 PM, nurse's note stated the resident complained of pain in his/her chest, and staff received an order from the physician to transport the resident to the (ER) Emergency Room.

The 12/31/15 Emergency Room Report revealed the Emergency Room physician evaluated the resident for constipation and abdominal pain. The report directed staff to use all as needed medications for constipation, as well as increase the resident's fluids. The report further directed staff to administer Reglan, (a medication for stomach problems) 10 (mg) milligrams, by mouth, 4 times daily, for abdominal pain, nausea, and vomiting. The report further directed staff to administer a soap suds enema (a mixture of soap and water injected into the colon used to

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stimulate a bowel movement) if the the resident did not have a normal stool by noon on 1/1/16.

The 1/1/16 at 3:53 AM, nurse's note started the resident returned from the ER and continued to yell out. The note stated the staff administered Norco, (a narcotic pain medication) 7.5 mg, by mouth, every 6 hours, as needed for pain and Ativan, (an antianxiety medication) 0.5 mg, by mouth, every 4 hours, as needed for anxiety.

The 1/2/16 at 4:46 PM, nurse's note stated staff administered a Biscodyl suppository, (laxative inserted into the rectum) 10 mg, with small results and he/she refused MOM. The note further stated the staff notified the physician and received orders to discontinue the MOM, and start Miralax, (a laxative) 17 grams, up to 4 times daily, as needed.

The 1/2/16 at 11:44 PM, nurse's note stated the resident had a small amount of black stool in his/her incontinent briefs and staff administered a soap suds enema to the resident with 2 quarter sized formed brown pieces of stool as a result. The note further stated the staff administered 3 doses of Miralax during the shift. The note stated the resident's abdomen was distended and had hypoactive bowel sounds in all 4 quadrants. Review of the medical record revealed the staff did not notify the physician of the resident's continued distended abdomen and hypoactive bowel sounds.

The 1/3/16 at 4:52 PM, nurse's note stated the resident had hypoactive bowel sounds with

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constipation. The note further stated the staff administered a suppository with small results and the resident ate 10% of his/her meals during the shift. The note stated the resident would be added to the list to see the nurse practitioner on his/her next visit.

The 1/4/16 at 4:31 PM, nurse's note stated the nurse practitioner assessed the resident, and he/she directed staff to administer Colace, (a stool softener) 100 mg, by mouth, twice a day and increase the Miralax to twice daily and as needed. (two days after the resident's abdomen was distended and he/she had hypoactive bowel sounds)

The 1/8/16 at 3:12 AM, nurse's note stated the resident had 1 bowel movement during the shift, and staff encouraged fluids.

On 3/8/16 at 7:24 AM, Administrative Nurse A stated staff should have notified the physician regarding the resident's distended abdomen and hypoactive bowel sounds.

On 3/8/16 at 10:15 AM, Licensed Nurse W verified he/she did not contact the physician when the staff assessed the resident with a distended abdomen, and hypoactive bowel sounds.

The October 2010 Resident Examination and Assessment Policy directed the staff to examine and assess the resident for any abnormalities in health status. The policy directed the staff to assess the resident and notify the physician if the resident had abdominal distension and hypoactive bowel sounds.

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F 309	Continued From page 21 The facility failed to thoroughly assess and seek physician involvement for Resident #57 when he/she had a distended abdomen and hypoactive bowel sounds.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 19 residents. Based on observation, record review, and interview the facility failed to: Ensure the electrical monitoring system on the door to the stairs, leading to the basement, remained activated to provide a safe environment for the 2 cognitively impaired, independently mobile residents who reside in main facility. To provide a safe environment for the 7 cognitively impaired, independently mobile residents who reside in the Special Care Unit. To identify causal factors and implement interventions to prevent falls for 1 of 6 residents reviewed for accidents. (#12) To ensure the resident environment remained as free of accident hazards as possible regarding water temperatures.	F 323		

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Findings included:

- On 3/1/16 at 11:00 AM, observation revealed the door by the dining room in the (SCU) Special Care Unit had an alarm box mounted on the right side of the door frame. Further observation revealed the string from the alarm box hanging down and not attached to anything. Observation revealed at the top of the door frame, a white hook where the string should be attached to the alarm box.

On 3/1/16 at 11:05 AM, Nurse Aide B verified the string should be attached to the white hook at all times.

On 3/3/16 at 9:15 AM, observation revealed the alarm box string hanging from the box and not attached to the white hook at the center of the door frame. Further observation revealed at 9:40 AM, Nurse Aide B reattached the string to the hook.

On 3/3/16 at 4:10 PM, observation revealed the alarm box string hanging from the box and not attached to the white hook.

On 3/3/16 at 4:30 PM, Nurse Aide C verified the alarm should be attached at the hook at all times.

On 3/8/16 at 7:41 AM, Administrative Nurse A stated, when someone goes through the door, the string detaches from the alarm box and a second staff member should reattach it. Administrative Nurse A stated, the door alarm should never be left unattached.

Upon request the facility failed to provide a policy regarding the patio door alarm.

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The facility failed to ensure the alarm box at the patio door remained activated at all times.

- On 3/1/16 at 7:40 AM during initial tour, observation revealed the stairway door on the north side of the center hall, that leads to stairs going down to the basement, was unlocked and easily opened without keying in a code on the keypad located next to the door.

On 3/1/16 at 5:30 PM, observation revealed the same door unlocked and the stairway accessible without keying in a code on the keypad located next to the door.

On 3/1/16 at 5:35 PM, Administrative Staff G stated the door is to be locked at all times and requires a code to be keyed into the keypad located next to the door before it will unlock. Administrative Staff G stated once the code was keyed into the keypad, the door will unlock and remain unlocked for 15 seconds prior to relocking automatically.

On 3/1/16 at 5:40 PM, Administrative Staff G demonstrated the unlocking and relocking of the stairway door using the keypad located next to the door. During the demonstration, one time, out of several, the door did not relock after 15 seconds and was able to be opened by Administrative Staff G without keying in the code on the keypad. Administrative Staff G verified the door did not relock automatically each time.

The facility's undated Door Inspections procedure directed maintenance directors to inspect all doors weekly. The procedure further indicated doors with alarms need to be inspected to ensure

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the door is locked and secure and directed staff to ensure the key pads are functioning, lit up, and the door releases when the code is entered.

The facility failed to ensure the environment was free of accident hazards for 2 independently mobile, cognitively impaired residents by not ensuring a door that leads to stairs going down to the basement remained locked at all times, unless the correct code is keyed into the keypad.

- Resident #12's annual (MDS) Minimum Data Set assessment, dated 2/9/16, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 3 (severe cognitive impairment). The resident required total dependence with 1 staff for walking in room and minimal assistance with 1 staff for locomotion on and off the unit. The assessment further revealed the resident's balance was not steady, only able to stabilize with staff assistance, used a wheelchair for mobility, occasionally incontinent of bowel, and frequently incontinent of bladder. The resident had 2 or more non injury falls, and his/her vision was adequate with glasses.

The 2/9/16 (ADL) Activities of Daily Living/Fall (CAA) Care Area Assessment revealed the resident required limited or extensive staff assistance, with all ADLs. The assessment further indicated the resident was unsteady, but able to stabilize with staff assistance. The assessment further revealed the resident had two non-injury falls since the last MDS. His/her fall risk assessment is completed quarterly and PRN, with latest score of 1, indicating high risk of falls. The assessment further revealed the resident frequently incontinent of bladder, occasionally incontinent of bowel and routinely assisted with

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toileting and/or incontinence care.

The 2/14/16 care plan indicated the resident was at risk for falls, had an unsteady gait, and had a history of falls. The care plan indicated the resident used a walker in his/her room, a wheelchair for distance, and instructed staff to remind the resident to lock his/her wheelchair brakes before standing. The care plan further instructed staff to assure the resident's floor was free of glare, liquids, and foreign objects. The care plan instructed staff to encourage the resident to slowly assume a standing position, use environmental devices, keep his/her bed in the lowest position with the brakes locked, and keep his/her call light and personal items within reach at all times. The care plan further instructed staff to ensure the resident wears proper, well-maintained footwear or non-skid socks. The 2/23/16 update indicted the resident had a fall and sustained a laceration to his/her forehead and bruises to the right hip and back. The care plan revealed the resident was not on a toileting program.

The facility's fall risk evaluations revealed the resident a high risk for falls on 10/8/15, 1/4/16, 2/9/16, and 2/10/16.

The resident's medical record revealed the following fall records:
On 5/31/15 at 10:08 PM - (CMA) Certified Medication Aide found the resident on the floor, no injury, and the resident stated he/she slid out of the wheelchair onto his/her buttocks.

On 6/25/15 at 9:30 AM - At approximately 9:30 AM, a (CNA) Certified Nurse Aide reported the resident was on the floor, the cushion was out of

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the wheelchair, and the resident stated he/she slid out of his/her wheelchair. No evidence of injury.

On 10/7/15 at 5:30 AM - a CNA reported the resident sitting on floor with his/her back against the bed and bare feet. No injury, and the resident stated, " I slipped off".

On 10/8/15 at 7:58 AM- at approximately 7:25 AM staff observed the resident sitting on floor with his/her back leaning on the bed. The resident stated that he/she slid on to the floor when reaching from the bed to the chair to get his/her compact disc player. The resident stated he/she did not hit his/her head and staff observed no injury.

On 11/14/15 at 8:30 AM - Nurse called to resident's room at 6:00 AM when beginning this shift. Upon entry into resident room, the resident was in his/her wheelchair with the help of 2 staff, gait belt, and night nurse. The night nurse obtained the initial vital signs and this nurse completed a neurological assessment with no deficits noted and no apparent injuries.

On 11/24/15 at 6:34 PM - A female resident alerted staff that Resident #12 was sitting on the floor. When staff arrived, the nurse noted the resident sitting in an upright position in front of the recliner, and his/her pants were wet and smelled of urine. The resident stated, "I was trying to walk around my room, slipped and couldn't get up, I need clean clothes on now". No injury observed.

On 1/31/15 at 5:10 PM - Staff observed the resident lying flat on the floor in front of the wheelchair yelling for help at 5:15 AM. The

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resident denied hitting his/her head and reported he/she slid out of the chair onto his/her "butt" because he/she wanted to get into his/her recliner The resident denied injury or pain, and was incontinent of urine. The staff had taken the resident to the toilet at 2:45 PM and the resident's shoes were on at the time. Staff assisted the resident off of floor, obtained VS (vital signs) and neurological checks (level of being alert and oriented, movement of extremities, and pupil reaction) started. ROM (Range of Motion) (movement around a joint) WNL (Within Normal Limits) and no observed injury.

On 2/3/16 at 5:30 AM - Upon entering resident's room to administer 6:00 AM medications, staff observed the resident sitting on the floor directly in front of the TV, with his/her back against the front side of his/her recliner, (LLE) left lower extremity, under the wheelchair and behind the left front tire, (RLE) right lower extremity extended out in front of him/her and bare feet. The resident denied hitting his/her head and stated, "I slipped out of my chair, now help me up". No observed injury.

On 2/23/16 at 11:34 AM - A loud thud alerted staff, who observed the resident on the floor on his/her right side with head next to trash can and feet toward the bathroom. The resident had a laceration to the middle of his/her forehead 5 (cm) centimeters x 0.6 cm. The resident stated he/she was using the bathroom and was going to walk to his/her recliner and fell. The nurse asked the resident what he/she hit his/her head on and the resident stated, on the trash can.

On 3/3/16 at 10:43 AM, observation revealed the resident asleep in his/her recliner, with his/her

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feet down. The resident is leaning against the back of his/her recliner slightly hunched over, and call light not in reach. The resident had tennis shoes on but no glasses.

On 3/3/16 at 11:32 AM, Nurse Aide J stated staff do all of the resident's ADLs, because he/she is unable to do any of them. Nurse Aide J stated the resident requires limited assist for transfers, but tries to get up and walk on his/her own, and needs frequent checks.

On 3/3/16 at 9:32 AM, Nurse K stated the resident attempts to walk on his/her own, but is not able to, which causes him/her to fall a lot, and he/she does not use the call light.

On 3/3/16 at 2:24 PM, Administrative Nurse L stated the resident likes to be independent, but is unsteady, and requires one person assistance for transfers. After the resident's last fall, staff increased the amount of care they give him/her, staff toilet the resident before and after meals, and now ask and check him/her every 2 hours. Administrative Nurse L stated the resident likes to move things around in his/her room, and staff are to be observant and assist if needed.

On 3/3/16 at 3:20 PM, Physician M stated the resident has a poor memory and is not very compliant with using his/her call light or waiting for assistance due to his/her gradual decline.

The facility's Fall Policy, dated 2/2014, indicated if a fall should occur (witness or un-witnessed), the staff will complete the Fall Investigative Worksheet as well as an Incident Report. The plan of care will be updated at the time with a review of current interventions.

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The facility failed to provide interventions as care planned, to ensure the safety of Resident #12, who had numerous falls.

- On 3/1/16 at 7:40 AM, observations, during initial tour, revealed the following:

The public bathroom sink beside the main entrance had a hot water temperature of 124.4 degrees.

The central shower room sink had a hot water temperature of 125 degrees and the shower had a hot water temperature of 124 degrees.

Room 202 sink had a hot water temperature of 123.2 degrees.

Room 206 sink had a hot water temperature of 128.5 degrees.

Room 208 sink had a hot water temperature of 121 degrees.

Room 211 sink had a hot water temperature of 127.4 degrees

Room 212 sink had a hot water temperature of 125.4 degrees.

On 3/1/16 at 9:00 AM, Maintenance Director E stated that the reading on the hot water tank read 120 degrees and the output reading also read 120 degrees.

On 3/1/16 at 9:21 AM, Maintenance Director E

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stated he/she adjusted the gauge on the hot water tank, the water temperature now reads 110 degrees. The gauge was lowered to 115 degrees from 120 degrees. Maintenance Director E stated the water temperatures have never been hot before, water temperature usually reads between 107-109 degrees.

On 3/1/16 at 9:39 AM, the central shower sink hot water temperature was 106 degrees, the shower hot water temperature was 104.

On 3/1/16 at 9:39 AM, the public bathroom, by the main entrance, sink hot water temperature was 102 degrees.

On 3/2/16 at 9:50 AM, Maintenance Director E checked the temperatures in the central shower room. The sink had a hot water temperature of 117.4 degrees and the shower had a hot water temperature of 117.5 degrees.

On 3/2/16 at 9:51 AM, Maintenance Director E stated he/she thought the hot water temperatures were supposed to be between 100-110 degrees.

Random hot water temperature checks in the facility revealed the following:
3/1/16 - ranged between 100-108 degrees
3/2/16 - ranged between 102-110 degrees
3/3/16 - ranged between 106-110 degrees
3/8/16 - ranged between 106-110 degrees

The facility failed to ensure the resident environment remained as free of accidents hazards as possible regarding water temperatures in the facility that affected residents on 2 of 3 halls.

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F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 19 residents of which 1 resident reviewed for nutrition. Based on observation, record review, and interview the facility failed to identify, seek physician involvement and implement interventions to prevent significant weight loss for 1 of 1 residents. (#45) Findings included: - The 2/1/16 (POS) Physician Order Sheet revealed Resident #45 had the following diagnoses: Muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), bipolar disease (a major mental illness that causes people to have episodes of severe high and low moods), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), type II diabetes mellitus (a chronic condition that	F 325		

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affects the way the body processes blood sugar), major depressive disorder (major mood disorder), gastroesophageal reflux disease (backflow of stomach contents to the esophagus), dysphagia (difficulty in swallowing).

The 2/11/16 significant change (MDS) Minimum Data Set assessment revealed the resident had a (BIMS) Brief Interview for Mental Status score of 6 (severe cognitive impairment), totally dependent on 1-2 person assist for all (ADLs) Activities of Daily Living except eating, which required minimal assistance from 1 staff. The medical record further stated the resident had range of motion (measurement of movement around a joint) impairment of his/her upper and lower extremities on both sides, and endentulous (no teeth). The assessment revealed the resident had no problems chewing, 69 inches tall and weighed 188 pounds.

The 2/15/16 care plan directed staff to notify the physician and the resident's family of significant weight change, weigh the resident monthly and PRN (as needed).The care plan directed staff to educate the resident regarding the importance of not skipping meals or snacks, provide HS snacks, and a regular mechanical soft diet.

The meal intake medical record revealed the following:
December 2015:
Breakfast: refused everyday except 12/15/15 - ate 75%, 5 days with no documentation that the staff offered a meal.
Lunch: 50-100%, 5 days with no documentation
Dinner: 100% daily, refused 1 day, 15 days with no documentation

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January 2016:
Breakfast: refused everyday except 1 day 1/13/16 - ate 75%, 3 days with no documentation that the staff offered a meal
Lunch: 25-100%, 3 days with no documentation
Dinner: 100%, 16 days with no documentation

February 2016:
Breakfast: refused everyday except 1 day 2/6/16 - ate 100%, 5 days with no documentation that the staff offered a meal.
Lunch: 50-100%, 5 days with no documentation
Dinner: 50-100%, 19 days with no documentation

March 1-8, 2016:
Breakfast: refused everyday except 3/3/16 - ate 75%, no documentation 1 day that the staff offered a meal.
Lunch: 75-100%, refused 3 days, no documentation 1 day
Dinner: 50-100%, no documentation 4 days

The medical record revealed the following weights:

12/7/2015 188.8
1/4/2016 187.6
2/1/2016 188.4
3/1/2016 187.4

The 10/2/15 (RD) Registered Dietician note directed staff to continue to provide the same diet regimen.

On 3/8/16 at 7:45 AM, observation revealed the resident asleep in his/her bed while staff served breakfast to the other residents in the dining room.

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On 3/8/16 at 10:24 AM, observation revealed the CMA W (Certified Medication Aid) in the resident's room to administer medication, but the resident continued to sleep. CMA attempted to talk to the resident and wake him/her, but was unable to arouse him/her, even after raising the head of the bed.

On 3/8/16 at 11:16 AM, observation revealed the resident asleep in his/her bed while staff served lunch to the other residents in the dining room.

On 3/8/16 at 3:12 PM, observation revealed Nurse Aides S and T transferred the resident to his/her wheelchair with a Hoyer lift (a total body lift used to transfer residents). Continued observation revealed Nurse Aide T wheeled the resident to the scale in the dining room. After adjusting the scale to zero, staff placed the resident on the scale in his/her wheelchair (with a lift pad in the seat). The resident weighed 223.4 pounds in his/her wheel chair. The staff weighed the wheelchair, with the lift pad, at 52.6 pounds. The resident's weight without the wheelchair was 170.8 pounds. (16.6 pounds less than 1 week prior)

On 3/8/16 at 4:34 PM, observation revealed Administrative Nurse A and a nurse aide, transferred the resident out of bed to weigh him/her, again. The weight of the resident in his/her wheelchair (with lift pad) was 223.2 pounds. The wheelchair with just the lift pad in it weighed 52.4 pounds. The resident's weight without the wheelchair was 170.8 pounds as verified by Administrative Nurse A.

On 3/3/16 at 3:20 PM, Physician M verified the

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resident received a lot of medications. Physician M further stated that he/she is very adamant about reducing medications if not needed so the resident is not overmedicated and has reduced one medication. Physician M stated, "I will admit he/she is snockered" and indicated he/she was reducing his/her medications very slowly because of his/her history of violence.

On 3/8/16 at 11:47 AM, Nurse Aide J stated that since the resident didn't get up for breakfast or lunch, staff bring him/her a protein shake later and try to get him/her awake to drink it.

On 3/8/16 at 3:52 PM, Administrative Nurse V stated staff weigh residents monthly, the first day of the month, then weekly if they have concerns or weight losses .

On 3/8/16 at 4:05 PM, Administrative Nurse A stated staff weigh residents who have weight loss and newly admitted residents, weekly. Administrative Nurse A stated the facility had standing orders for nutritional shakes but the physician had not ordered any supplements for the resident.

Review of the facility's Standing Order Policy, dated 10/6/15, revealed no documentation regarding supplements.

On 3/8/16 at 4:53 PM, Staff Nurse I stated the facility had no documentation of the staff administering protein shakes to the resident.

On 3/10/16 at 1:22 PM, Physician M stated if the resident wasn't eating his/her meals, then it would make sense to weigh him/her more often, such as every 1-2 weeks.

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F 325	Continued From page 36 On 3/10/16 at 1:32 PM, (RD) Registered Dietician Z stated that he/she was not aware of the resident not eating some of his/her meals. The resident's weight today was 172.2 pounds, which is down 15.2 pounds from his/her last documented weight on 3/1/16. Registered Dietician Z stated staff reported that they couldn't figure out what was going on with the resident, and that he/she has not been eating quite as well as he/she had been. The RD stated he/she plans to leave an order for staff to provide a mighty shake (protein supplement) if the resident eats less than 50% of his/her meals. RD stated the resident needs 1-2 mighty shakes daily even though his/her BMI is above normal, and staff need to keep him/her awake and make sure he/she drinks the shake. The facility's Nutrition Policy, dated March 2012, revealed nursing personnel will evaluate food and fluid intake for residents with, or at risk for, significant nutritional problems. Nursing staff will assess and document the amounts eaten as indicated for individuals with or at risk for, impaired nutrition. The facility failed to thoroughly assess and complete root cause analysis in order to implement interventions to prevent significant weight loss for Resident #45, when documentation revealed the resident missed multiple meals because of being asleep, and had swallowing difficulty.	F 325		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION	F 327		

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The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 43 residents. The sample included 19 residents. Based on observation, record review, and interview the facility failed to accurately monitor fluid intake, as directed by the physician order, for 1 of 1 residents reviewed for hydration.(#37)

Findings included:

- The significant change (MDS) Minimum Data Set assessment, dated 1/5/16, indicated the resident had a (BIMS) Brief Interview of Mental Status score of 11 indicating the resident had moderately impaired cognition. The MDS indicated the resident required supervision with eating and extensive staff assistance with (ADLs) Activities of Daily Living.

The 1/5/16 care plan indicated the resident received a 1500 (ml) milliliters/24 hours fluid restriction related to his/her renal failure and dialysis. The care plan instructed staff to monitor and record his/her fluid intake.

The 6/9/15 physician order instructed staff to provide the resident with a fluid restriction of 1500 ml/24 hours.

The dialysis center communication sheet revealed a lack of documentation of fluid intake, while the resident was at dialysis, from 6/9/15

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until 3/2/16.

Review of the nurse aide ADL book, where the aides document residents' bathing, bowel movements, ADL assistance the residents require, and hydration record, revealed no documentation regarding this resident's fluid restriction.

Review of the (MAR) Medication Administration Record for the west hall charge nurse revealed lack of fluid intake documentation on the following dates:
1/12/16 day and evening shift.
1/28/16 day and evening shift.
1/30/16 night shift.
2/27/16 night shift.
2/20/16 day and evening shift.

On 3/2/16 at 4:23 PM, observation revealed the resident sitting in a wheelchair at a table near the nurse's station, and independently drinking a cup of coffee.

On 3/8/16 at 8:50 AM, Nurse Aide P stated the facility did not have any residents on a fluid restriction.

On 3/8/16 at 9:04 AM, Nurse Aide J stated the resident was on a fluid restriction and he/she documented the resident's intake of fluid at meals, but not in his/her room.

On 3/8/16 at 10:08 AM, Nurse I stated he/she records the resident's fluid intake each time he/she gives the resident fluids, including the resident's intake of fluids from meals, totals up the resident's fluid intake at the end of his/her shift, and records the amount in the purple 3 ring

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binder at the nurse's station. Nurse I stated the resident's fluid intake is not separated into amounts to be given throughout the day but is allocated 1500 ml/24 hours. Nurse I stated he/she assumes the resident did not receive fluids at dialysis, unless the dialysis center staff call and tell him/her the resident received fluids.

On 3/8/16 at 11:18 AM, Dietary Aide U stated the resident received an 8 (oz) ounce glass of water and 1 cup of coffee with meals, and if he/she asks for another glass of water he/she will tell the resident he/she is on a fluid restriction and cannot have anymore at that time. Dietary Aide U stated he/she does not have a specific amount of fluid the resident can have at meals, just knows he/she can have an 8 oz. glass of water and 1 cup of coffee.

On 3/8/16 at 3:40 PM, Administrative Nurse A stated the aides get an updated pocket care plan for each resident every day, and they should know which residents are on a fluid restriction. Administrative Nurse A stated the nurse is responsible for tracking and recording the resident's fluid restriction intake and he/she verified lack of documentation of fluid intake on 1/12/16 day or evening shift, 1/28/16 day and evening shift, 1/30/16 night shift, 2/27/16 night shift, and 2/20/16 day and evening shift.

On 3/8/16 at 4:09 PM, Dietary Staff Q stated he/she sends the resident a sack lunch, without any fluids, on the days he/she goes to dialysis. Dietary Staff Q stated the resident receives fluids at the dialysis center.

On 3/8/16 at 5:00 PM, Nurse Aide R stated he/she had no knowledge of a resident on the

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F 327	Continued From page 40 west hall being on a fluid restriction and if a resident was receiving a fluid restriction diet, on the center or west hall, he/she would document the fluid intake in the ADL book. The facility's October 2010 Encouraging and Restricting Fluids policy instructed staff to be accurate when recording the resident's fluid intake and be sure an intake and output record is maintained in the resident's room. The facility failed to accurately monitor Resident #37's fluid restriction intake.	F 327		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 43 residents. The sample included 19 residents of which 7 residents were reviewed for unnecessary drug use. Based on observation, record review and interview, the facility failed to adequately assess and monitor 5 of 7 sampled residents for unnecessary medications for:
Resident #45 for lack of implementation of physician orders timely
Resident #57 for lack of documentation for effectiveness of (PRN) as needed medication,
Resident #27 for lack of monitoring side effects, including bowel movements, and behaviors
Resident #35 for lack of monitoring and documentation of side effects and behaiors for the use of antipsychotic and antidepressant medication.
Resident #1 for lack of monitoring and documentation of side effects and behaiors for the use of antipsychotic and antidepressant medication.

Findings included:

- The 2/1/16 Physician's Order Sheet revealed Resident #45 had the following diagnoses: muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion), bipolar disease (a major mental illness that causes people to have episodes of severe high and low moods), absence of left leg below knee, anxiety (a mental or emotional reaction characterized by apprehension,

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uncertainty and irrational fear), major depressive disorder (major mood disorder), and long term drug therapy.
The significant change (MDS) Minimum Data Set, dated 2/11/16, revealed the resident had a (BIMS) Brief Interview for Mental Status score of 6 which indicates severe cognitive impairment. The MDS indicated the resident had inattention (failure to carefully think about, listen to, or watch someone or something), disorganized thinking (inability to put thoughts into logical order), and psychomotor retardation behaviors (the slowing-down of thought and a reduction of physical movements) present. His/Her mood score was 4 which indicated the resident had no signs of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The MDS further documented the resident had no behaviors, and required staff assistance with (ADLs) Activities of Daily Living except for eating, which he/she required minimal staff assistance. The MDS further revealed the resident received antipsychotic and antidepressant medications.

The 2/11/16 Psychotropic Drug Use (CAA) Care Area Assessment indicated the resident had diagnoses of dementia, anxiety, depression, and bipolar disease.

The 2/15/16 care plan instructed staff to administer to the resident medications for the diagnoses of agitation (extreme restlessness, as manifested in depression and other mental disorders) and depression. The care plan instructed staff to assess the resident's mood, behavior and response to medications daily. The care plan further instructed staff to monitor the resident for sedation (a state of calm or sleep).

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The 9/15/15 Physician Order directed staff to administer the following medications:
Depakote (mood stabilizer), 500 mg, (milligrams), 2 tablets, (BID) twice a day, to the resident for bipolar disorder. (Side effects include: confusion, delusions, mental depression, sleepiness, and unusual tiredness)
Remeron (a medication to treat abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), 45 mg, daily, at bedtime, for major depressive disorder (major mood disorder). (Side effects include: drowsiness, vison changes, dry mouth, and weight gain)
Zyprexa (a medication to treat any major mental disorder characterized by a gross impairment in reality testing), 20 mg, daily, at bedtime, for bipolar disorder. (Side effects include: drowsiness, dizziness, contipation, and weight gain)
Norco (a narcotic pain medication), 7.5/325 mg, (milligram) every 4 hours as needed, for pain. (Side effects include: drowsiness, constipation, blurred vison, and dry mouth)
The 9/22/15 at 5:53 PM nurse's behavioral note indicated the resident finished his/her meal, wanted to leave the dining room, requested the nurse propel him/her and the nurse told the resident to push himself/herself. The note indicated the resident hit and cussed at the nurse, and the nurse left the resident to propel himself/herself.
The 9/22/15 at 7:02 PM nurse's behavioral note indicated another resident reported Resident #45 grabbed a hold of his/her chair, refused to let him/her pass, and hit him/her. The note indicated the resident told the CMA (Certified Medication Aide) of the incident, and the CMA asked

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Resident #45 if he/she was having pain. The resident stated yes, and the CMA administered to the resident, Norco (a narcotic pain medication) 7.5/325 mg (milligrams) PRN (as needed).
The 9/24/15 3:28 PM nurse's behavioral note indicated the resident was resistive to cares this shift, and slapped at staff. The note indicated the staff asked the resident if he/she had pain, and staff administered to the resident, PRN Norco.
The 9/25/15 at 12:16 AM, nurse's behavioral note revealed the resident was resistive with cares and combative toward staff. Staff asked if resident was in pain and the resident would not answer, staff offered a PRN pain medication, but the resident refused, and staff will continue to monitor.
The 9/26/15 at 2:52 AM, nurse's behavioral note revealed the resident was verbally aggressive to the nurse this evening.
The 9/29/15 at 7:13 PM, nurse's note revealed lab personnel was here today, and the resident refused them to obtain a blood draw including a valporic acid level (measuring the medication Depakote - level in the resident's blood).
The September 2015 (MAR) Medication Administration Record revealed that Norco was administered to the resident on: 9/16, 9/18, 9/20, 9/21, and 9/24.
The 10/17/15 Psychiatrist Note indicated the resident was evaluated in his/her room, but was sleeping and did not talk with the provider. Staff report the resident was quite irritable when awake, but not violent and not a major management problem.
The October 2015 MAR revealed staff administered Norco, to the resident on 10/12/15.
The 11/12/15 at 11:10 AM behavior nurse's note revealed the resident was verbally aggressive towards staff when staff tried to shave the

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resident, because he/she had chose not to allow staff to shave him/her for 4 days.
The 11/21/15 Psychiatrist Note indicated the resident's mood blunted and flat, however he/she denied any feeling of depression. Staff reported the resident was irritable, but aggression had decreased. The psychiatrist directed the staff to continue the resident's current medications and obtain a valproic acid and liver function test - if not already completed.
The November 2015 MAR revealed staff administered Norco to the resident on 11/8, 11/9, 11/11, 11/16, 11/19, 11/21, 11/22, 11/23 and 11/27.
The December 2015 MAR revealed staff administered Norco to the resident on 12/9, 12/14, 12/15, 12/19, 12/23, 12/26, and 12/28.
The 1/23/16 Psychiatrist Note indicated the resident was sleeping in the day room but woke briefly to talk to the provider, and denied any issues with mood. The note described the resident as somnolent (sleepy, drowsy), and quickly fell back to sleep after talking with the provider. Staff report no major concerns with the resident's behavior/mood and he/she continued to refuse lab. Plan to monitor mood and continue to attempt to obtain lab. May consider decrease in Depakote if mood continues to appear sedated and lab cannot be obtained.
The January 2016 MAR revealed staff administered Norco to the resident on 1/14, and 1/16
The February 2016 MAR revealed staff administered Norco to the resident on 2/1, 2/10, 214, 2/19, 2/23, and 2/24.
The March 2016 MAR revealed staff administered Norco to the resident on 3/1.
On 3/2/16 at 3:34 PM, observation revealed the resident sitting in his/her wheelchair, with eyes

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closed and his/her mouth open. Further observation revealed a string of drool/saliva, approximately 6 inches long, coming out of the corner of his/her mouth and hanging down to his/her shirt.
On 3/2/16 at 4:34 PM, observation revealed the resident sitting in his/her wheelchair, with his/her eyes closed and head tilted to the left. Further observation revealed a continuous string of drool/saliva, approximately 5 inches long, from his/her bottom lip to his/her mid-chest, with a wet spot on his/her T-shirt.
On 3/3/16 at 10:32 AM, observation revealed the resident sitting in a wheelchair in his/her room with eyes closed, and head leaning to the left. Further observation revealed drool/saliva hanging down from his/her mouth to his/her shirt.
On 3/8/16 at 7:45 AM, observation revealed the resident asleep in his/her bed while staff served breakfast to the other residents in the dining room.
On 3/8/16 at 10:24 AM, observation revealed the CMA W (Certified Medication Aid) in the resident's room to administer medication, but the resident continued to sleep. CMA attempted to talk to the resident and wake him/her, but was unable to arouse him/her, even after raising the head of the bed.
On 3/8/16 at 11:16 AM, observation revealed the resident asleep in his/her bed while staff served lunch to the other residents in the dining room.
On 3/3/16 at 9:23 AM, Staff Nurse K stated the resident slept all the time, even after discontinuing one of his/her medications, Nuedexta.
On 3/3/16 at 11:32 AM, Nurse Aide J stated the resident has been a lot more tired, his/her condition has declined, and he/she used to be more conscious of his/her drooling.

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On 3/3/16 at 2:24 PM, Administrative Nurse L stated the physician had started to take him/her off of some medications, but wants to be very careful because of his/her history of hitting people, and his/her mental disability.

On 3/10/16 at 2:10 PM Nurse Practitioner AA verified the resident is sedated which is a problem. Nurse Practitioner AA stated that he/she wrote an order to start the resident on Lamictal (mood stabilizer) when he/she saw the resident, on 2/20/16, but the facility called today and told him/her the medication had not been ordered or started. Nurse Practitioner AA also stated that he/she had reduced the Depakote by 500 mg so it was down to 1,500 mg daily from 2,000 mg daily, which caused the resident's sedation, (review of the medical record revealed no reduction of the Depakote dose). Nurse Practitioner AA stated he/she was unable to check the resident's Depakote level because of his/her refusing lab draws and before he/she started the Depakote, staff reported that the resident was really aggressive. Nurse Practitioner AA stated he/she was not sure if the aggression is an anxiety issue or pain related.

The facility's Psychotropic Medication Use Policy, dated September 2012, stated that side effects shall be monitored and reported to the physician per notification protocol. Gradual dose reductions will be conducted per CMS guidelines. The community shall elicit the Physician response and request documentation on the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences.

The facility failed to adequately assess/monitor for adverse effects of medications and implement physician orders to decrease some medications in a timely manner for Resident #45.

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- Resident #1's (POS) Physician Order Sheet, dated 1/4/16, indicated the resident had diagnoses of schizophrenia (a mental illness causing delusions), bipolar disorder (cycles of depression and elation of mood), anxiety (a feeling of worry, nervousness, and unease), depression (a feeling of sadness and difficulty thinking), dementia with behavior disturbances (a disorder that impairs memory, coordination and leads to behaviors), and extrapyramidal movement disorder (drug induced movement disorder)

The quarterly (MDS) Minimum Data Set assessment, dated 12/23/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 12 which indicated moderately impaired cognition. The assessment revealed the resident required supervision with all activities of daily living except for personal hygiene which required limited assistance of 1 staff member. The assessment further revealed the resident did not have any behaviors including, rejection of care, and wandering, received antipsychotic, and antidepressant medication.

The 3/6/15 (CAA) Care Area Assessment for psychotropic drug use indicated the resident had disorganized thinking, fluctuating inattention and did not have any behaviors.

The 6/24/15 care plan stated the resident could become verbally or physically abusive, inappropriately disruptive and at times chooses to resist cares. The care plan directed staff assess his/her behavior, response to medication daily, and monitor for side effects.

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The 11/20/15 and 12/2/15 physician's order directed the staff to administer, Ativan, (an antianxiety medication) 1(mg) milligram, by mouth, every 6 hours, as needed for anxiety. (decreased on 1/22/16)

The 2/1/16 physician's order included the following medications:

Risperidal, (an antipsychotic medication)1mg, by mouth, at bedtime, initiated on 5/20/15.
Risperdal,1 mg, by mouth, in the morning, initiated 5/2/15.
Ativan, 0.5 mg, by mouth, twice a day, initiated on 1/22/16.
Seroquel, (an antipsychotic medication) 50 mg, by mouth, three times daily, initiated on 5/20/16.

The 4/23/15 physician's order directed staff to monitor the resident's antipsychotic medication for side effects every shift, and monitor the resident's behavior, aggression, and increased anxiety every shift.

The November 2015 Antipsychotic Side Effect Monitoring tool revealed missing documentation for the following days:

Dayshift-28, 29
Evening-28, 29, 30
Night-27

The November 2015 Psychoactive Monitoring Record for behavior of hallucinations for the use of Risperdal revealed missing documentation for the following days:

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F 329	Continued From page 50 Dayshift-28, 29, 30 Evening-28, 29, 30 Night-27 The November 2015 Psychoactive Monitoring Record for behavior of agitation and increased anxiety for the use of Ativan revealed missing documentation for the following days: Dayshift-28, 29 Evening-28, 29, 30 Night-27 The November 2015 Psychoactive Monitoring Record for behavior of aggression for the use of Seroquel revealed missing documentation for the following days: Dayshift-28, 29 Evening-28, 29, 30 Night-27 The December 2015 Psychoactive Monitoring Record for behavior of agitation and increased anxiety for the use of Ativan revealed missing documentation for the following days: Dayshift-28, 29, 30 Evening-28, 29, 30 Night-24, 27 The December 2015 Psychoactive Monitoring Record for behavior of aggression for the use of Seroquel revealed missing documentation for the following days:	F 329		

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F 329	Continued From page 51 Evening-7 The January 2016 Antipsychotic Side Effect Monitoring tool revealed missing documentation for the following days: Dayshift-28 Evening-28 Night-3, 29 The January 2016 Psychoactive Monitoring Record for behavior of hallucinations for the use of Risperdol revealed missing documentation for the following days: Dayshift-28 Evening-28 Night-3, 29 The January 2016 Psychoactive Monitoring Record for behavior of agitation and increased anxiety for the use of Ativan revealed missing documentation for the following days: Dayshift-28 Evening-28 Night-3, 29 The January 2016 Psychoactive Monitoring Record for behavior of aggression for the use of Seroquel revealed missing documentation for the following days: Dayshift-28 Evening-28 Night-3, 29	F 329		

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The February 2016 Antipsychotic Side Effect Monitoring tool revealed missing documentation for the following days:

Dayshift-23, 25, 27, 28, 29
Evening-23, 25, 27, 28, 29
Night-23, 25, 27, 28, 29

The February 2016 Psychoactive Monitoring Record for behavior of hallucinations for the use of Risperdol revealed missing documentation for the following days:

Dayshift-19, 25, 28, 29
Evening-19, 25, 28, 29

February 2016 Psychoactive Monitoring Record for behavior of agitation and increased anxiety for the use of Ativan revealed missing documentation for the following days:

Dayshift-19, 25, 28, 29
Evening-19, 25, 28, 29

February 2016 Psychoactive Monitoring Record for behavior of aggression for the use of Seroquel revealed missing documentation for the following days:

Dayshift-19, 25, 28, 29
Evening-19, 25, 28, 29

On 3/3/16 at 3:00 PM, observation revealed the resident ambulating independently in the commons area of the SCU.

On 3/3/16 at 3:27 PM, Nurse Aide BB stated the

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resident gets upsets and uses bad language but can be redirected by staff.

On 3/8/16 at 7:18 AM, Administrative Nurse A stated the resident did not have a lot of behaviors and was easily redirectable. Administrative Nurse A stated staff should assess the resident for medication side effects and verified the lack of documentation.

The 9/12/16 facility Antipsychotic Medication Use Policy stated medication side effects shall be monitored and reported to the physician.

The facility failed to assess, monitor, and document Resident #1's behaviors.

- Resident #57's 14 day (MDS) Minimum Data Set assessment, dated 1/5/16, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 5 which indicated severely impaired cognition. The assessment further revealed the resident was dependent upon 2 staff members for bed mobility, transfer, dressing, and toileting. The assessment further revealed the resident received antianxiety and pain medication.

The 1/3/16 (CAA) Care Area Assessment for pain indicated the resident required scheduled and as needed pain medication as well as antianxiety medication that the pharmacist reviewed monthly.

The 1/11/16 care plan directed the staff to assess the resident's pain daily and to record and report effectiveness of pain interventions and any adverse reactions. The care plan further stated to administer the resident's anxiolytic (a medication that inhibits anxiety) medication, and

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assess the response to the medication daily.

The 1/5/16 physician's orders included the following (PRN) as needed medication for pain and anxiety:
Lorazapam, (an anitianxiety medication) 0.5 (mg) milligrams, by mouth, every 4 hours, as needed for agitation, initiated on 12/23/15.
Hydrocodone, (pain medication) 7.5-325 mg, 1 by mouth, every 6 hours, as needed for pain, initiated on 12/23/15.

The January 2016 (MAR) Medication Administration Record revealed staff failed to obtain follow-up results for effectiveness after administering Lorazapam to the resident on the following days:

1/1/16-10:00 AM and 5:00 PM
1/2/16-10:30 AM
1/3/16-7:00 PM
1/6/16-8:00 AM
1/8/16-2:30 AM, 7:00 AM, 1:00 PM
1/9/16-10:00 AM

The January 2016 MAR revealed that staff failed to obtain follow-up results for effectiveness after administering Hydrocodone to the resident for pain:

1/1/16-10:30 AM
1/2/16-10:30 AM
1/3/16-2:30 AM
1/5/16-4:15 AM
1/6/16-8:00 AM
1/9/16-10:00 AM

On 3//16 at 7:24 AM, Administrative Nurse A stated staff should follow-up for effectiveness of

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medication on the MAR.

Upon request a policy for documentation for the effectiveness of as needed medications was not provided.

The facility failed to monitor the effectiveness of as needed medication for pain and agitation after being administered to Resident #57.

- Resident #27's diagnoses from the 2/1/16 physician's order sheet included: unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing due to an unknown cause) not due to a substance or known physiological condition, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), Unspecified dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, major depressive disorder recurrent (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness lasting more than two weeks in duration), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder.

The significant change (MDS) Minimum Data Set assessment, dated 1/8/16, indicated the resident had severely impaired cognition with inattention, disorganized thinking, altered level of consciousness, and psychomotor retardation (a slowing down of thought and reduction in physical movements) continuously present. The assessment further indicated the resident dependent upon 2 staff members for bed mobility,

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transfers, dressing, toileting, bathing, and received antipsychotic and antidepressant medications daily.

The 1/8/16 (CAA) Care Area Assessment for psychotropic (medications that affect a person's mental state) medications stated the consulting pharmacist reviewed the resident's medications monthly.

The 1/24/16 care plan stated the resident takes antipsychotic (medications used to treat psychosis), antianxiety (medications used to treat anxiety), antidepressant (medications used to treat depression,) and mood stabilizer medications. Instructions in the care plan directed staff to administer medications as ordered by the physician, assess the resident's behaviors and responses to the medications daily, and complete (AIMS) abnormal involuntary movement scale assessment quarterly and as needed. Further instructions directed staff to monitor for sedation, anticholinergic (a class of medications that may cause dry mouth, blurred vision, constipation, drowsiness, sedation, hallucinations, memory impairment, confusion, and difficulty urinating) and extrapyramidal (movement disorders as a result of taking certain medications) symptoms. The care plan further stated the pharmacy consultant will review the resident's medications monthly and will recommend gradual dose reductions of psychotropic medications. The care plan indicated the resident takes medications that have black box warnings, including Olanzapine (Zyprexa), which is not approved for treatment of behavioral symptoms in older adult patients with dementia-related psychosis.

The 1/18/16 physician's order directed staff to

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administer Zyprexa, 20 (mg) milligrams, by mouth, daily at bedtime related to dementia with behavioral disturbance. The 10/28/15 physician's order directed staff to administer Gabapentin, 300 mg, by mouth, twice daily, related to senile dementia with delusional features.

Further review of the medical record revealed the resident did not have a bowel movement on 12/7/15, 12/8/15, 12/9/15, 12/10/15, 12/11/15, and 12/12/15 (6 consecutive days). Review of the (MAR) Medication Administration Record revealed the resident did not receive any additional as needed medications to stimulate a bowel movement and review of nursing notes did not reflect an assessment of the resident's gastrointestinal system or bowel sounds. Further review of documentation submitted by the facility on 3/10/15 at 2:35 PM, revealed the resident had a bowel movement on 12/9/15, documented on the facility's Unit Report Sheet, which is not part of the medical record.

Additional record review revealed the resident did not have a bowel movement on 12/29/15, 12/30/25, 12/31/15 and 1/1/16 (4 consecutive days). Review of the MAR revealed the resident did not receive any additional as needed medications to stimulate a bowel movement and review of the nursing notes did not reflect an assessment of the resident's gastrointestinal system or bowel sounds.

Review of the January 2016 behavior monitoring and side effects monitoring lacked documentation and monitoring on 1/20/16, 1/22/16, 1/27/16, and 1/28/16 on first and second shifts, 1/23/16 and 1/24/16 on first shift, and 1/29/16 on 3rd shift.

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On 3/2/16 at 4:30 PM, observation revealed the resident, seated in a wheelchair, with the back of the chair reclined, and his/her feet in an elevated position. Observation revealed the resident had a calm facial expression, eyes open, and no restlessness or movement of his/her hands, feet or body.

On 3/3/16 at 8:57 AM, observation revealed the resident with his/her eyes open, lying in bed on his/her back, with the bed lowered to the floor and a mattress on the floor next to the bed.

On 3/8/16 at 7:55 AM, Nurse Aide J stated the resident's muscles were stiff when staff provided cares, but the resident was not combative towards staff or other residents. Nurse Aide J further stated the staff track resident bowel movements in a book at the nurse's station and nurse aides notify the charge nurse if a resident has gone three days without a bowel movement.

On 3/8/16 at 11:21 AM, Licensed Nurse I stated the nurse aides chart bowel movements and the facility used a three day bowel protocol, which stated that if a resident hasn't had a bowel movement in three days nursing staff identified there was an issue. Licensed Nurse I further stated after the staff identify an issue the nurse initiates the physician's standing orders for constipation and notifies the physician.

On 3/8/16 at 4:00 PM, Administrative Staff G stated the medical director was in the process of reviewing all residents' medications and diagnoses to ensure that all medications had an appropriate diagnosis. He/she further stated the medical director had not yet reviewed the resident's medications for appropriate diagnoses.

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On 3/8/16 at 5:35 PM, Administrative Nurse A stated the expectation for nursing staff is to initiate the bowel protocol if a resident has not had a bowel movement in 3 days and to administer as needed laxatives to stimulate bowel movements. Administrative Nurse A further stated the resident's gabapentin order may have been for nerve pain, but he/she was unsure.

On 3/14/16 at 11:05 AM, Administrative Nurse A verified the facility's system for tracking bowel movements was inconsistent and there were too many chances for staff to make an error while tracking bowel movements.

The facility's 9/2012 Antipsychotic Medication Use policy stated residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective, and will not be used for discipline or convenience of the staff. The policy further stated physician orders will include the diagnosis for the specified drug, and side effects shall be monitored and reported to the physician per notification protocol.

Upon request of the facility's bowel protocol, the facility provided an undated statement that indicated it is the practice of the facility to monitor resident's bowel movements and the community will follow resident's primary physician's standing orders.

The physician's standing orders, signed 10/6/15, indicated for constipation nursing staff shall initiate docusate sodium, 100 (mg), milligrams twice a day, as needed, if docusate sodium inadequate, add Miralax 17 (g) grams daily. If still

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inadequate results, Milk of Magnesia, 30 (cc), cubic centimeters, daily and if still inadequate results, use Magnesium Citrate 1 bottle.

The (FDA) Food and Drug Administration states Zyprexa is a prescription medication used to treat schizophrenia, bipolar I disorder and resistant depression that does not get better after using 2 other antidepressant medications. The FDA states Gabapentin is a medication used to control seizures, treat burning, stabbing pain or aches that affects the nerves after a person has an attack of shingles (acute, painful inflammation of nerve cell bodies), and the extended release form of the medication is used to treat restless leg syndrome (disorder characterized by an unpleasant tickling or twitching sensation in the leg muscles).

The facility failed to monitor side effects and behaviors, to have an effective system in place to monitor bowel movements, and to provide appropriate diagnoses for Zyprexa and Gabapentin for Resident #27.

Resident #35's annual (MDS) Minimum Data Set assessment, dated 2/15/16, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 14, indicating intact cognition. The assessment further revealed the resident required set up assistance and supervision for all activities of daily living, with the exception of being dependent on 1 staff for bathing and he/she received daily antipsychotic and antidepressant medications.

The 2/29/16 (CAA) Care Area Assessment for

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psychotropic medications stated the consulting pharmacist reviewed the resident's medications monthly and made gradual dose reductions as appropriate.

The 2/17/16 care plan stated the resident took antipsychotic and antidepressant medications for the diagnoses of senile psychosis (depressive, paranoid delusions, hallucinations or similar mental disorders due to the degeneration of the brain due to age) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness). The care plan directed staff to administer medications as ordered by the physician, and assess the resident's mood, behavior and response to medications daily.

The 6/23/15 physician's order directed staff to administer Zoloft, 25 (mg) milligrams, by mouth daily for depression. The 8/14/15 physician's order directed staff to administer Seroquel, 100 mg, by mouth three times daily for senile psychosis.

Review of the December 2015 side effects and behavior monitoring record lacked documentation on 12/14/15, 12/15/15, and 12/22/15 on 1st and 2nd shifts and on 12/31/15 for 3rd shift.

Review of the January 2016 side effects and behavior monitoring record lacked documentation on 1/2/16 and 1/3/16 on 3rd shift and 1/23/16 and 1/24/16 for 1st and 2nd shifts.

Review of the February 2016 side effects and behavior monitoring record lacked documentation on 2/29/16 on 1st and 2nd shifts.

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F 329	Continued From page 62 On 3/3/16 at 9:11 AM, observation revealed the resident seated in his/her wheelchair in the center hallway, dressed appropriately for the weather, and well-groomed. The resident self-propelled in the wheelchair and observed to have a blank facial expression on his/her face. On 3/8/16 at 7:18 AM, Administrative Nurse A stated the expectation for staff is to monitor and document on behaviors and side effects daily on each shift. On 3/8/16 at 11:21 AM, Licensed Nurse I stated the resident was stable on his/her medications right now and staff monitors for abnormal behaviors and side effects to medications on each shift. The facility's 9/2012 Antipsychotic Medication Use policy stated residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective and will not be used for discipline or convenience of the staff. The policy further stated physician orders will include the diagnosis for the specified drug and side effects shall be monitored and reported to the physician per notification protocol. The facility failed to monitor and document for side effects and abnormal behaviors for resident #35, who receives antipsychotic and antidepressant medications daily.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive	F 364		

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value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 43 residents. The sample included 19 residents. Based on observation, record review and interview, the facility failed to provide food served at the proper temperature for 9 of 9 residents who reside in the (SCU) Special Care Unit.

Findings included:

- On 3/3/16 at 11:50 AM, observation revealed in the SCU, Dietary Staff E checked the food temperatures of the noon meal and obtained the following:

Stuffing-121 degrees
Fish-110 degrees
Mixed vegetables-119 degrees
Pork chop-104 degrees

On 3/3/16 at 12:08 PM, observation revealed Dietary Staff E in the SCU after returning from the kitchen with another plate of food with the following temperatures:

Fish-138 degrees
Mixed vegetables-138 degrees
Stuffing-140 degrees

On 3/3/16 at 12:10 PM, Dietary Staff E stated the food would be reheated and brought up to the proper temperature.

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On 3/8/16 at 11:45 AM, observation revealed Dietary Staff F pushed the unheated silver food cart into the SCU with 9 food trays inside. Further observation revealed the food trays being served to the residents without food temperatures taken.

On 3/8/16 at 11:50 AM, observation revealed Dietary Staff E checked the temperature of 1 remaining food tray in the silver cart and revealed the bowl of beans at 110 degrees and the chicken strips at 120 degrees. Further observation revealed Dietary Staff E told the SCU staff to collect the trays because the food needed reheated and was too cold.

On 3/3/16 at 11:50 AM, Nurse Aide B stated staff does not take temperatures of the food after the dietary staff delivers the food to the SCU.

On 3/3/16 at 11:55 AM, Administrative Staff G verified the staff in the SCU do not take food temperatures.

On 3/8/16 at 11:45 AM, Nurse Aide D stated, he/she had never taken food temperatures in the SCU.

On 3/8/16 at 11:50 AM, Dietary Staff E stated the dietary staff are not to deliver all 9 trays at one time and are only to start with 4 trays so the food will not get cold.

The August 2011 facility Food Preparation and Service Policy stated the danger zone for food temperatures is between 41 degrees and 135 degrees which foods in this temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illnesses. The policy directed food to be cooked at the

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F 364	Continued From page 65 following temperatures: Poultry and stuffed foods-165 degrees Fish and other meats-145 degrees Fresh, frozen or canned fruits or vegetables-135 degrees The policy stated mechanically altered hot foods prepared for a modified consistency diet must stay above 135 degrees during preparation or they must be reheated to 165 degrees for at least 15 seconds. The facility failed to serve food to the 9 residents in the SCU at the proper temperature.	F 364		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 19 residents of which 3 were reviewed for dental. Based on observation, record review, and interview, the facility failed to obtain dental services to meet the needs for 1 of 3 sampled residents. (#55)	F 412		

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Findings included:

- Resident #55's quarterly (MDS) Minimum Data Set assessment, dated 1/2/16, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 3, indicating severely impaired cognition. The assessment revealed the resident required supervision with set up assistance for bed mobility, transfers, walking, eating, and limited assistance of 1 staff for dressing, toilet use and personal hygiene. The assessment further revealed the resident did not have any swallowing disorders, but did have mouth, facial pain, and discomfort or difficulty with chewing.

The dental (CAA) Care Area Assessment, dated 10/7/15, stated the resident received a regular diet with regular texture and regular consistency fluids. The CAA further stated the resident had no problems with chewing or swallowing, had poor dentition with cavities and broken teeth, and will be referred to the facility's dental services after insurance verification.

The 1/16/16 care plan indicated the resident had poor dentition and directed staff to inspect his/her mouth quarterly, and as needed for oral health, to observe for signs of difficulty chewing, and to remind, supervise, and/or assist the resident with brushing his/her teeth each morning and evening. The care plan further directed staff to provide the resident, and his/her family, available community resources for dental exams.

The 10/1/15 physician's order directed staff to obtain an appointment with a dentist for the resident.

The 10/8/15 social services note stated the

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physician wrote orders for the resident to have a dental appointment and the resident's family was aware the resident needed a dental appointment. The note further stated the family was waiting to see if the resident was approved for insurance so he/she could enroll in the facility's dental services which travels to the facility on a regular basis.

The 10/15/15 social services note indicated the social services designee provided the resident with hearing, dental, and vision appointments as needed.

The 12/4/15 social services note indicated the resident stated his/her vision, hearing, and dental issues were good and the social services designee was working to get the resident on the facility dental program.

The 1/2/16 Oral/Nutritional quarterly assessment indicated the resident had obvious or likely cavities or broken natural teeth.

The 1/14/16 social services note indicated the resident stated he/she had no problems with his/her vision or dental needs.

Review of the medical record revealed the resident had not been examined by a dentist since his/her admission to the facility in September 2015, although the physician directed the staff to have the resident see a dentist on 10/1/15.

On 3/2/16 at 8:59 AM, observation revealed the resident had tooth decay, with brown and black discolored teeth and missing teeth in the front part of his/her mouth on the upper and lower areas. The resident denied oral pain at the time of

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the observation.

On 3/3/16 at 8:54 AM, observation revealed the resident walked independently to the dining room and ate 100% of the breakfast meal of scrambled eggs, toast, cereal, and sausage without difficulty chewing or swallowing.

On 3/3/16 at 2:00 PM, Administrative Nurse L verified the resident had not been examined by a dentist since his/her admission to the facility.

On 3/3/16 at 3:15 PM, Social Services Staff H stated the resident did not have the dental plan for the dental services that comes to the facility on a routine basis. He/she further stated the dental plan was a financial liability the resident's family was not paying for at this time.

On 3/8/16 at 5:28 PM, Administrative Nurse A stated oral assessments were to be completed quarterly, and as needed, and he/she would expect staff to ensure the resident was examined by a dentist per the physician's orders. Administrative Nurse A stated the resident's family would not pay for the resident to see a dentist.

The facility's October 2012 Availability of Dental Services policy stated dental services will be provided to meet the needs of each resident. The social worker will assist in making dental appointments and transportation to assure that appointments can be made in a timely manner.

The facility failed to obtain dental services for Resident #55, who had obvious cavities or tooth decay and received an order from the physician on 10/1/15 to be examined by a dentist.

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PEABODY OPERATOR, LLC	407 N LOCUST STREET PEABODY, KS 66866

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F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 43 residents. The sample included 19 residents of which 7 were reviewed for unnecessary medications. Based on observation, record review and interview, the facility's pharmacy consultant failed to identify irregularities for 2 of 7 residents reviewed for unnnecessary medications.

The facility's pharmacy consultant failed to identify and address the facility's failure to adequately assess and monitor psychotropic medication use for Resident #45.

The facility's pharmacy consultant failed to identify and address the lack of appropriate diagnoses for medications for Resident #27.

- Resident #45's significant change (MDS) Minimum Data Set, dated 2/11/16, revealed the resident had a (BIMS) Brief Interview for Mental Status score of 6 which indicates severe cognitive impairment. The MDS indicated the resident had inattention (failure to carefully think about, listen

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to, or watch someone or something), disorganized thinking (inability to put thoughts into logical order), and psychomotor retardation behaviors (the slowing-down of thought and a reduction of physical movements) present. His/Her mood score was 4 which indicated the resident had no signs of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The MDS further documented the resident had no behaviors, and required staff assistance with (ADLs) Activities of Daily Living except for eating, which he/she required minimal staff assistance. The MDS further revealed the resident received antipsychotic and antidepressant medications.

The 2/11/16 Psychotropic Drug Use (CAA) Care Area Assessment indicated the resident had diagnoses of dementia, anxiety, depression, and bipolar disease.

The 2/15/16 care plan instructed staff to administer to the resident medications for the diagnoses of agitation (extreme restlessness, as manifested in depression and other mental disorders) and depression. The care plan instructed staff to assess the resident's mood, behavior and response to medications daily. The care plan further instructed staff to monitor the resident for sedation (a state of calm or sleep).

The 9/15/15 Physician Order directed staff to administer the following medications:

Depakote (mood stabilizer), 500 mg, (milligrams), 2 tablets, (BID) twice a day, to the resident for bipolar disorder. (Side effects include: confusion, delusions, mental depression, sleepiness, and

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unusual tiredness)

Remeron (a medication to treat abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), 45 mg, daily, at bedtime, for major depressive disorder (major mood disorder). (Side effects include: drowsiness, vison changes, dry mouth, and weight gain)

Zyprexa (a medication to treat any major mental disorder characterized by a gross impairment in reality testing), 20 mg, daily, at bedtime, for bipolar disorder. (Side effects include: drowsiness, dizziness, contipation, and weight gain)

Norco (a narcotic pain medication), 7.5/325 mg, (milligram) every 4 hours as needed, for pain. (Side effects include: drowsiness, constipation, blurred vison, and dry mouth).

The 9/22/15 at 5:53 PM nurse's behavioral note indicated the resident finished his/her meal, wanted to leave the dining room, requested the nurse propel him/her and the nurse told the resident to push himself/herself. The note indicated the resident hit and cussed at the nurse, and the nurse left the resident to propel himself/herself.

The 9/22/15 at 7:02 PM nurse's behavioral note indicated another resident reported Resident #45 grabbed a hold of his/her chair, refused to let him/her pass, and hit him/her. The note indicated the resident told the CMA (Certified Medication Aide) of the incident, and the CMA asked Resident #45 if he/she was having pain. The resident stated yes, and the CMA administered to

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the resident, Norco (a narcotic pain medication) 7.5/325 mg (milligrams) PRN (as needed).

The 9/24/15 3:28 PM nurse's behavioral note indicated the resident was resistive to cares this shift, and slapped at staff. The note indicated the staff asked the resident if he/she had pain, and staff administered to the resident, PRN Norco.

The 9/25/15 at 12:16 AM, nurse's behavioral note revealed the resident was resistive with cares and combative toward staff. Staff asked if resident was in pain and the resident would not answer, staff offered a PRN pain medication, but the resident refused, and staff will continue to monitor.

The 9/26/15 at 2:52 AM, nurse's behavioral note revealed the resident was verbally aggressive to the nurse this evening.

The 9/29/15 at 7:13 PM, nurse's note revealed lab personnel was here today, and the resident refused them to obtain a blood draw including a valporic acid level (measuring the medication Depakote - level in the resident's blood).

The September 2015 (MAR) Medication Administration Record revealed that Norco was administered to the resident on: 9/16, 9/18, 9/20, 9/21, and 9/24.

The 10/17/15 Psychiatrist Note indicated the resident was evaluated in his/her room, but was sleeping and did not talk with the provider. Staff report the resident was quite irritable when awake, but not violent and not a major management problem.

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The October 2015 MAR revealed staff administered Norco, to the resident on 10/12/15.

The 11/12/15 at 11:10 AM behavior nurse's note revealed the resident was verbally aggressive towards staff when staff tried to shave the resident, because he/she had chose not to allow staff to shave him/her for 4 days.

The 11/21/15 Psychiatrist Note indicated the resident's mood blunted and flat, however he/she denied any feeling of depression. Staff reported the resident was irritable, but aggression had decreased. The psychiatrist directed the staff to continue the resident's current medications and obtain a valproic acid and liver function test - if not already completed.

The November 2015 MAR revealed staff administered Norco to the resident on 11/8, 11/9, 11/11, 11/16, 11/19, 11/21, 11/22, 11/23 and 11/27.

The December 2015 MAR revealed staff administered Norco to the resident on 12/9, 12/14, 12/15, 12/19, 12/23, 12/26, and 12/28.

The 1/23/16 Psychiatrist Note indicated the resident was sleeping in the day room but woke briefly to talk to the provider, and denied any issues with mood. The note described the resident as somnolent (sleepy, drowsy), and quickly fell back to sleep after talking with the provider. Staff report no major concerns with the resident's behavior/mood and he/she continued to refuse lab. Plan to monitor mood and continue to attempt to obtain lab. May consider decrease in Depakote if mood continues to appear sedated and lab cannot be obtained.

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The January 2016 MAR revealed staff administered Norco to the resident on 1/14, and 1/16

The February 2016 MAR revealed staff administered Norco to the resident on 2/1, 2/10, 214, 2/19, 2/23, and 2/24.

The March 2016 MAR revealed staff administered Norco to the resident on 3/1.

The Pharmacy Consults on 9/21/15, 10/26/15, 11/20/15, 12/30/15, 1/26/16, and 2/22/16 indicated, medication review, no irregularies noted.

On 3/2/16 at 3:34 PM, observation revealed the resident sitting in his/her wheelchair, with eyes closed and his/her mouth open. Further observation revealed a string of drool/saliva, approximately 6 inches long, coming out of the corner of his/her mouth and hanging down to his/her shirt.

On 3/2/16 at 4:34 PM, observation revealed the resident sitting in his/her wheelchair, with his/her eyes closed and head tilted to the left. Further observation revealed a continuous string of drool/saliva, approximately 5 inches long, from his/her bottom lip to his/her mid-chest, with a wet spot on his/her T-shirt.

On 3/3/16 at 10:32 AM, observation revealed the resident sitting in a wheelchair in his/her room with eyes closed, and head leaning to the left. Further observation revealed drool/saliva hanging down from his/her mouth to his/her shirt.

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On 3/8/16 at 7:45 AM, observation revealed the resident asleep in his/her bed while staff served breakfast to the other residents in the dining room.

On 3/8/16 at 10:24 AM, observation revealed the CMA W (Certified Medication Aid) in the resident's room to administer medication, but the resident continued to sleep. CMA attempted to talk to the resident and wake him/her, but was unable to arouse him/her, even after raising the head of the bed.

On 3/8/16 at 11:16 AM, observation revealed the resident asleep in his/her bed while staff served lunch to the other residents in the dining room.

On 3/3/16 at 9:23 AM, Staff Nurse K stated the resident slept all the time, even after discontinuing one of his/her medications, Nuedexta.

On 3/3/16 at 11:32 AM, Nurse Aide J stated the resident has been a lot more tired, his/her condition has declined, and he/she used to be more conscious of his/her drooling.

On 3/3/16 at 2:24 PM, Administrative Nurse L stated the physician had started to take him/her off of some medications, but wants to be very careful because of his/her history of hitting people, and his/her mental disability.

On 3/3/16 at 3:20 PM, Physician M verified the resident received a lot of medications. Physician M further stated that he/she is very adamant about reducing medications if not needed so the resident is not overmedicated and has reduced one medication. Physician M stated, "I will admit

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he/she is snockered" and indicated he/she was reducing his/her medications very slowly because of his/her history of violence.

On 3/10/16 at 2:10 PM Nurse Practitioner AA verified the resident is sedated which is a problem. Nurse Practitioner AA stated that he/she wrote an order to start the resident on Lamictal (mood stabilizer) when he/she saw the resident, on 2/20/16, but the facility called today and told him/her the medication had not been ordered or started. Nurse Practitioner AA also stated that he/she had reduced the Depakote by 500 mg so it was down to 1,500 mg daily from 2,000 mg daily, which caused the resident's sedation, (review of the medical record revealed no reduction of the Depakote dose). Nurse Practitioner AA stated he/she was unable to check the resident's Depakote level because of his/her refusing lab draws and before he/she started the Depakote, staff reported that the resident was really aggressive. Nurse Practitioner AA stated he/she was not sure if the aggression is an anxiety issue or pain related.

The facility's Psychotropic Medication Use Policy, dated September 2012, stated that side effects shall be monitored and reported to the physician per notification protocol. Gradual dose reductions will be conducted per CMS guidelines. The community shall elicit the Physician response and request documentation on the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences.

The facility's Pharmacy Services Overview Policy, dated April 2007, stated the pharmacy will collaborate with the staff and practitioners to address and resolve medication related needs or

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problems. Recommend current resources to help staff to understand and identify medications and related information such as contraindications, adverse consequences, and appropriate monitoring.

The facility's pharmacy consultant failed to assess and monitor psychotropic medication use for Resident #45 and identify correct medication diagnoses for Resident #27.

- Resident #27's diagnoses from the 2/1/16 physician's order sheet included: unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing due to an unknown cause) not due to a substance or known physiological condition, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), Unspecified dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, major depressive disorder recurrent (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness lasting more than two weeks in duration), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder.

The significant change (MDS) Minimum Data Set assessment, dated 1/8/16, indicated the resident had severely impaired cognition with inattention, disorganized thinking, altered level of consciousness, and psychomotor retardation (a slowing down of thought and reduction in physical movements) continuously present. The assessment further indicated the resident

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dependent upon 2 staff members for bed mobility, transfers, dressing, toileting, bathing, and received antipsychotic and antidepressant medications daily.

The 1/8/16 (CAA) Care Area Assessment for psychotropic (medications that affect a person's mental state) medications stated the consulting pharmacist reviewed the resident's medications monthly.

The 1/24/16 care plan stated the resident takes antipsychotic (medications used to treat psychosis), antianxiety (medications used to treat anxiety), antidepressant (medications used to treat depression,) and mood stabilizer medications. Instructions in the care plan directed staff to administer medications as ordered by the physician, assess the resident's behaviors and responses to the medications daily, and complete (AIMS) abnormal involuntary movement scale assessment quarterly and as needed. Further instructions directed staff to monitor for sedation, anticholinergic (a class of medications that may cause dry mouth, blurred vision, constipation, drowsiness, sedation, hallucinations, memory impairment, confusion, and difficulty urinating) and extrapyramidal (movement disorders as a result of taking certain medications) symptoms. The care plan further stated the pharmacy consultant will review the resident's medications monthly and will recommend gradual dose reductions of psychotropic medications. The care plan indicated the resident takes medications that have black box warnings, including Olanzapine (Zyprexa), which is not approved for treatment of behavioral symptoms in older adult patients with dementia-related psychosis.

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The 1/18/16 physician's order directed staff to administer Zyprexa, 20 (mg) milligrams, by mouth, daily at bedtime related to dementia with behavioral disturbance. The 10/28/15 physician's order directed staff to administer Gabapentin, 300 mg, by mouth, twice daily, related to senile dementia with delusional features.

Review of the Pharmacy Consultation records for 11/20/15, 12/30/15, 1/26/16, and 2/22/16 revealed no concerns for the resident regarding appropriate diagnoses for Zyprexa and Gabapentin.

On 3/2/16 at 4:30 PM, observation revealed the resident, seated in a wheelchair, with the back of the chair reclined, and his/her feet in an elevated position. Observation revealed the resident had a calm facial expression, eyes open, and no restlessness or movement of his/her hands, feet or body.

On 3/3/16 at 8:57 AM, observation revealed the resident with his/her eyes open, lying in bed on his/her back, with the bed lowered to the floor and a mattress on the floor next to the bed.

On 3/8/16 at 7:55 AM, Nurse Aide J stated the resident's muscles were stiff when staff provided cares, but the resident was not combative towards staff or other residents.

On 3/8/16 at 11:21 AM, Licensed Nurse I stated the resident does not strike out or hit staff, but at times, he/she will hold onto staff and not let go.

On 3/8/16 at 4:00 PM, Administrative Staff G stated the medical director was in the process of reviewing all residents' medications and

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diagnoses to ensure that all medications had an appropriate diagnosis. He/she further stated the medical director had not yet reviewed the resident's medications for appropriate diagnoses.

On 3/8/16 at 5:35 PM, Administrative Nurse A stated stated the resident's gabapentin order may have been for nerve pain, but he/she was unsure.

The facility's 4/2007 Pharmacy Services Overview policy stated the facility shall contract with a licensed pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements.

The facility's 9/2012 Antipsychotic Medication Use policy stated residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective, and will not be used for discipline or convenience of the staff. The policy further stated physician orders will include the diagnosis for the specified drug, and side effects shall be monitored and reported to the physician per notification protocol.

The (FDA) Food and Drug Administration states Zyprexa is a prescription medication used to treat schizophrenia, bipolar I disorder and resistant depression that does not get better after using 2 other antidepressant medications. The FDA states Gabapentin is a medication used to control seizures, treat burning, stabbing pain or aches that affects the nerves after a person has an attack of shingles (acute, painful inflammation of nerve cell bodies), and the extended release form of the medication is used to treat restless leg

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F 428	Continued From page 81 syndrome (disorder characterized by an unpleasant tickling or twitching sensation in the leg muscles). The facility's consultant pharmacist failed to identify and address with the facility and primary physician lack of appropriate diagnoses for Zyprexa and Gabapentin for Resident #27.	F 428		