



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

FILE COPY

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 3050 0001 2125

November 26, 2014

Richard T. Strong, Administrator
Meridian Center Genesis Healthcare
1351 West Pine Avenue
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Strong:

On **November 20, 2014**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **October 22, 2014**. However, based on our on-site follow-up revisit conducted **November 20, 2014**, we found that your facility is not in substantial compliance with the following participation requirements:

F329 -- S/S: D -- 42 CFR §483.25(l) -- Drug regimen is free from unnecessary drugs

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each federal and state tag in column X5 Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 9, 2014**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

As noted in the letter of **September 18, 2014**, following the **Complaint Investigation** survey of **September 4, 2014**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **March 4, 2015**, if substantial compliance is not achieved by that time. The CMS letter dated October 2, 2014, outlined the following remedies:

Denial of Payment for New Admissions, effective October 17, 2014
A 'per instance' civil money penalty of **\$3500.00**.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Richard T. Strong, Administrator
November 26, 2014
Page 3 of 3

If you believe the deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **December 9, 2014**. If your request for informal dispute resolution is received after **December 9, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the on-site follow-up revisit. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/20/2014
NAME OF PROVIDER OR SUPPLIER MERIDIAN CENTER GENESIS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642		
(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 deficiencies were cited during a complaint follow-up investigation at your facility. The survey team included: Arnold Rosling, RN, BSN QIDP Michael Case, LSW, QIDP The survey team entered and exited the facility on 11/20/14. Survey Definitions: ASAP = As Soon As Possible BFS = Bureau of Facility Standards BID = Two times a day BMI = Behavior Monitoring and Interventions cm = Centimeters CNA = Certified Nurse Aide DON/DNS = Director of Nursing d/t = Due to IDT = Interdisciplinary Team IM = Intramuscular IPN = interdisciplinary Progress Notes MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set assessment PRN = As needed	{F 000}			
{F 329}	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	{F 329}	"This Plan of Correction is prepared and submitted as required by law. By submitting this plan of correction Meridian Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." <i>4/17/2014</i> <i>12/9/14</i>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



ADMINISTRATOR 12-9-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 329}	<p>Continued From page 1 combinations of the reasons above.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure drugs used to control behavior considered to be maladaptive were adequately indicated and appropriately monitored for 3 of 3 residents (#s 6, 8 and 9) reviewed who received behavior modifying drugs. This failure had the potential for harm if residents received drugs not needed to treat a specific medical condition, or experienced adverse side effects of those drugs. Findings included:</p> <p>1. Resident #8 was admitted to the facility on 7/16/14 with diagnoses which included non-Alzheimer's dementia.</p> <p>The most recent quarterly MDS assessment, dated 10/14/14 documented: - Severely impaired</p>	{F 329}	<p><u>F329</u></p> <p><u>Resident's effected</u></p> <p>Resident's # 8, 6, and 9 were assessed for any adverse effects related to administration of psychotropic medication by a licensed nurse; # 8 on 11/25/2014, #6 on 11/26/2014, & #9 on 12/02/2014 with no adverse effects noted.</p>	

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{F 329}	<p>Continued From page 2</p> <p>- Memory problems, delirium</p> <p>Resident #8's Medication Review Report (MRR - Physician's Orders), dated 10/30/14, stated she was to received Lorazepam (generic for Ativan, an anxiolytic drug) 1 mg by mouth every 4 hours as needed for palliative care related to dementia, unspecified, with behavioral disturbance.</p> <p>Resident #8's comprehensive care plan included a focus area that stated "Exhibits behaviors of agitation [as exhibited by] yelling out, hitting, biting, kicking, wandering and non compliance..." The goal stated "Reduce incidents of agitated behavior." Interventions included:</p> <ul style="list-style-type: none"> - Give medication as prescribed by MD - Remove resident from public area when behavior is disruptive/unacceptable - 1:1 supervision <p>The comprehensive care plan also included a focus area that stated "Use of antipsychotic [medication related to] hallucinations..." The goal stated "Improve [resident's] mental well being despite failed non-pharm interventions" and "[decrease] episodes of hallucinations." Interventions included:</p> <ul style="list-style-type: none"> - Behavior tracking - Continue with non-pharmacological interventions <p>Resident #8's record documented Lorazepam 1 mg was administered without sufficient indications. Examples included, but were not limited to, the following:</p> <p>a. Resident #8's MAR for November 2014 stated "LORazepam Tablet 1 MG Given 1 mg by mouth</p>	{F 329}	<p>Resident #6, #9, & #8's behavior management plan, psychotropic medication regimen, including the assessment, behavior monitoring-sheet, and the plan of care were reviewed by the interdisciplinary team (IDT) on or before 12/09/2014. The physician was updated with results of review on or before 12/09/2014, and orders were clarified and plan of care was updated by licensed nurse on or before 12/09/2014.</p> <p><u>Other residents with the potential to be effected.</u></p> <p>A review of residents who require psychotropic medication was completed by IDT on or before 12/09/2014. Resident assessments, indications for use, behavior monitoring flow sheets, physician's orders, and plan of care were updated by the IDT members as indicated on or before 12/09/2014.</p> <p>A review of residents on PRN psychotropic medications was completed by the IDT on or before 12/09/14 to ensure that there are adequate indications for use of PRN medication, and that non-pharmacological interventions are appropriate/ effective. Behavior</p>	

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{F 329}	<p>Continued From page 3 every 4 hours as needed for [PRN] pallitive [sic] care related to Dementia, unspecified, with behavioral disturbance."</p> <p>No additional information related to parameters for the use of the PRN (symptoms/behavior exhibited, intensity of symptoms/behavior, duration of symptoms/behavior, impact of symptoms/behavior on the resident or others, etc.) could be found in the record.</p> <p>During an interview on 11/20/14 at 2:25 p.m., the DNS stated behaviors would be listed on the resident's behavior sheet and care plan, but information related to frequency, duration or intensity or behavior needed prior to the PRN being administered was not present. The DNS stated decisions related to administering the PRN were at the discretion of the nurse on duty.</p> <p>Resident #8's record did not include clear indications for the use of her PRN Lorazepam.</p> <p>b. Resident #8's MAR for November 2014 documented she received Lorazepam 1 mg on the following dates/times: 11/6/14 at 2:00 a.m. and 6:20 p.m.; 11/11/14 at 8:45 p.m.; 11/13/14 at 9:15 p.m.; 11/14/14 at 9:00 a.m. and 8:00 p.m.; 11/16/14 at 8:00 p.m.; 11/18/14 at 9:30 p.m.; and 11/19/14 at 5:00 p.m.</p> <p>Resident #8's PRN Sheet for November 2014 documented the drug was given for restlessness, anxiety and aggression on 11/6/14 at 2:00 a.m., increased anxiety on 11/6/14 at 6:20 p.m., increased agitation on 11/11/14 and 11/13/14, and for increased anxiety and agitation on 11/18/14. However, there was no additional information documenting the use of the drug was indicated</p>	{F 329}	<p>management plans/ behavior flow sheets will be updated by an IDT member on or before 12/09/14 as indicated by the review.</p> <p>Residents` who require psychotropic medications will be reviewed by the consultant pharmacist to ensure adequate indication for use on or before 12/09/2014.</p> <p><u>Systemic change and education</u></p> <p>Licensed nursing staff were re-educated by the Nurse Practice Educator on the behavior management policy including documentation and medication administration requirements for psychotropic administration on or before 12/09/2014.</p> <p>Licensed nurse staff and Certified Nursing Assistants were educated on or before 12/09/2014 by the Nurse Practice Educator on the CMS Hand in Hand Training for Nursing Homes modules 3, 4, and 6.</p> <p>A post-test competency was administered by the Nurse Practice Educator or designee will be completed by the licensed staff on or before 12/09/2014 related to the</p>		

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{F 329}	<p>Continued From page 4 (symptoms exhibited, intensity of symptoms, duration of symptoms, impact of symptoms on the resident or others, non-pharmacological interventions attempted and found non-effective, etc.).</p> <p>The PRN Sheet did not include documentation regarding the drug's administration on 11/14/14 at 9:00 a.m. and 8:00 p.m., 11/16/14 at 8:00 p.m., or 11/19/14 at 5:00 p.m.</p> <p>Additionally, Resident #8's BMI form for November 2014 was reviewed and found to be blank for the above dates.</p> <p>c. Resident #8's IPNs for November 2014 were reviewed. The IPNs, when compared with PRN documentation, did not contain information the use of the PRN drug was indicated, as follows:</p> <ul style="list-style-type: none"> - 11/8/14, time not indicated: "Patient yelling out one time." A subsequent entry, dated 11/8/14 at 9:30 p.m., stated "1:1 reported that Resident was assisted to floor." The MAR documented Lorazepam 1 mg was administered at 9:30 p.m. and the PRN Sheet documented the drug was given for "[increased] agitation/aggression [sic]." - 11/12/14 at 2:00 a.m.: "Ativan for [increased] agitation/anxiety [with] effectiveness noted." However, the BMI form was blank, and the MAR documented the drug was administered on 11/12/14 at 3:15 p.m. No additional information regarding behavioral symptoms was present in the record. - 11/13/14 at 11:30 p.m.: "resident medicated [with] PRN Ativan for [increased] agitation..." The MAR documented the drug was given on 	{F 329}	<p>center's behavior management program, including indications for use of psychotropic medications and administration and documentation of effectiveness of non-pharmacological interventions prior to PRN psychotropic medication use.</p> <p><u>Audit</u></p> <p>Beginning the week of 12/10/2014 the Director of Nursing or designee will review 5 residents who require psychotropic administration/ behavior management to validate that psychotropic medications have an indication for use, are administered as ordered and indicated, that non-pharmacological interventions are implemented per the resident's plan of care. These audits will be completed weekly X4 weeks and then monthly X2 months or until resolved. The Director of Nursing and/or unit managers will audit the records of those residents with new behaviors and/or orders for PRN psychoactive medications per the facility clinical management process to validate appropriate use and interventions. Residents receiving prn psychoactive medications and/or identified as having disruptive</p>	

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{F 329}	<p>Continued From page 5 11/13/14 at 9:30 p.m.</p> <p>- 11/15/14 at 10:30 p.m.: "[increased] agitation and restlessness noted. PRN ativan administered..." The MAR documented the drug was given 7/15/14 at 7:30 p.m.</p> <p>- 11/17/14 at 11:00 p.m.: "Medicated [at evening with] PRN Ativan for [increased] agitation/anxiety [with] effectiveness noted." The MAR documented the drug was given at 8:30 p.m.</p> <p>The BMI form was blank for the above dates, and there was no additional information regarding behavioral symptoms present in the record.</p> <p>Resident #8's IPN documentation did not provide sufficient information related to behavioral symptoms and their duration or intensity, or documentation non-pharmalogical interventions had been tried and found ineffective, to demonstrate the use of PRN Lorazepam was indicated.</p> <p>d. Resident #8's PRN use and behavioral documentation were reviewed for November 2014. The documentation did not support the use of the PRN drug, as follows:</p> <p>- 11/3/14: Resident #8's MAR documented Lorazepam 1 mg was administered at 1:30 p.m. The BMI form documented Resident #8 was "Hitting" two times during the day shift (6:00 a.m. - 2:00 p.m.) and staff intervened by "Removed patient from environment." The BMI documented the intervention "Improved" Resident #8's behavior. The PRN Sheet and IPN did not contain information regarding the use of the PRN or Resident #8's behavior.</p>	{F 329}	<p>behaviors will be reviewed at a minimum of annually, quarterly and as needed with change of condition to validate continued appropriateness of medication and non-pharmacological interventions by the facility IDT team. the results of these audits will be compiled by the Director of Nursing and will be presented to the QA/ PI committee for review and remedial intervention</p> <p>The Director of Nursing will be responsible for monitoring and follow-up.</p>	

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{F 329}	Continued From page 6 The record documented the PRN was utilized even though non-pharmacological interventions were documented as effective. - 11/4/14: The MAR documented Lorazepam 1 mg was administered at 1:00 p.m. and the PRN Sheet stated "[increased] Anxiety." However, the BMI sections documented "0" episodes of behavior for the night (10:00 p.m. - 6:00 a.m.) and evening (2:00 - 10:00 p.m.) shifts, and were blank for the day shift. The IPN did not contain information regarding the use of the PRN or Resident #8's behavior. The record documented the PRN was utilized for increased anxiety, but did not provide information as to how the anxiety was demonstrated or what non-pharmacological interventions were tried and found ineffective prior to the use of the PRN Lorazepam. - 11/5/14: The MAR documented Lorazepam 1 mg was administered at 10:15 a.m. and 7:15 p.m. and the PRN Sheet stated "[increased] Anxiety" for both entries. The IPN, dated 11/5/14 at 8:55 a.m., documented Resident #8 "Tapped Forehead on TV stand during Evening also punched CNA in head...patient was given PRN Ativan for agitation..." The IPN documentation did not correspond with the administration times for the drug on 11/4/14 or 11/5/14. Additionally, the BMI form documented Resident #8 was "Hitting" one time during the night shift and staff intervened by "Redirecting by engagement in alternative activity." The BMI	{F 329}			

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{F 329}	<p>Continued From page 7</p> <p>documented the intervention "Improved" Resident #8's behavior. The BMI also documented Resident #8 was "Pushing" two times during the day shift, and staff intervened by "Redirected by engagement in alternative activity," "Removed patient from environment," and "Listened to patient, attempted to calm." The BMI documented the intervention "Improved" Resident #8's behavior.</p> <p>The record documented the PRN was utilized for increased anxiety, but did not provide information as to how the behavior was exhibited, the intensity, or impact of the behavior on the resident or others to justify the use of the PRN Lorazepam. Additionally, the record documented the PRN was utilized even though non-pharmacological interventions were documented as effective.</p> <p>- 11/9/14: The MAR documented Lorazepam 1 mg was administered at 3:30 p.m. and 10:00 p.m. The PRN sheet stated "Anxiety" for the 3:30 p.m. dose and "Anxiety/Aggression" for the 10:00 p.m. dose. The IPN documented, on 11/9/14 at 5:00 p.m. "Increased agitation. PRN Ativan relieved [patient's] distress."</p> <p>The record documented the PRN was utilized for increased anxiety and aggression, but did not provide information as to how the behavior was exhibited, the intensity, or impact of the behavior on the resident or others to justify the use of the PRN Lorazepam.</p> <p>Additionally, the BMI documented Resident #8 was "Hitting" two times and "Pushing" three times during the day shift on 11/9/14. The BMI documented staff intervened by "Removed</p>	{F 329}			

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NAME OF PROVIDER OR SUPPLIER MERIDIAN CENTER GENESIS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642		
(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 329}	<p>Continued From page 8</p> <p>patient from environment" and "Escorted patient to room for reduced stimuli." The BMI documented the interventions "Improved" Resident #8's behavior.</p> <p>The record documented the PRN was utilized even though non-pharmacological interventions were documented as effective.</p> <p>During an interview on 11/20/14 at 3:45 p.m., the LSW was interviewed and stated there were no parameters related to duration or frequency of behavior to be exhibited prior to the use of PRN Lorazepam.</p> <p>During an interview on 11/20/14 at 4:50 p.m., the Regional Consultant stated the facility had looked at people on antidepressants (which was cited during the complaint survey of 9/4/14), but had not looked at PRN use when assessing monitoring and indicators for use.</p> <p>2. Resident #6 was admitted to the facility on 12/6/13 with diagnoses that included traumatic brain injury (TBI), anxiety disorder, and depression.</p> <p>The most recent quarterly MDS assessment, dated 10/12/14 documented:</p> <ul style="list-style-type: none"> - Severely impaired with a BIMS of 4 - Behavior not directed at others - Wandering <p>Resident #6's MRR, dated 10/28/14, stated he was to receive Lorazepam 0.5 mg one tabley by mouth as needed for TBI dementia with associated agitated features each evening PRN.</p> <p>Resident #6's comprehensive care plan included</p>	{F 329}			

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{F 329}	<p>Continued From page 9</p> <p>a focus area that stated "[History of] yelling out, hitting self, and/or other behavior as an alternative to communicating." The goal stated he "will have less than five episodes of yelling out/hitting self." Interventions included:</p> <ul style="list-style-type: none"> - Document any behavior observed - Check routinely related to any unmet need <p>The comprehensive care plan included a focus area that stated "Exhibits periods of depression with anxiety [as exhibited by] socially inappropriate yelling out [related to history of] brain injury." The goal stated "Staff will be able to redirect [Resident #6's] depressed/anxious mood with 1:1 interaction." Interventions included:</p> <ul style="list-style-type: none"> - Give item or task in an attempt to distract - Remove to a quiet area during episodes of socially inappropriate behavior - Give medication as prescribed <p>Resident #6's record documented Lorazepam 1 mg was administered without sufficient indications. Examples included, but were not limited to, the following:</p> <p>a. Resident #6's MAR for November 2014 stated "LORazepam Tablet 0.5 MG Given 1 tablet by mouth as needed for TBI dementia with associated agitated features [each evening] PRN."</p> <p>No additional information related to parameters for the use of the PRN (symptoms/behavior exhibited, intensity of symptoms/behavior, duration of symptoms/behavior, impact of symptoms/behavior on the resident or others, etc.) could be found in the record.</p>	{F 329}			

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{F 329}	Continued From page 10 During an interview on 11/20/14 at 2:25 p.m., the DNS stated behaviors would be listed on the resident's behavior sheet and care plan, but information related to frequency, duration or intensity or behavior needed prior to the PRN being administered was not present. The DNS stated decisions related to administering the PRN were at the discretion of the nurse on duty. Resident #6's record did not include clear indications for the use of his PRN Lorazepam. b. Resident #6's PRN use and behavioral documentation were reviewed from 10/22/14 - 11/19/14. During that time, the PRN Lorazepam was used 4 times. However, documentation did not support all uses of the PRN drug, as follows: - Resident #6's MAR documented he received Lorazepam 0.5 mg on 10/26/14 at 9:00 p.m. The PRN Sheet documented "Aggitation [sic]." However, Resident #6's BMI form did not document any maladaptive behaviors on 10/26/14. Additionally, his IPN documented, on 10/27/14 at 2:00 a.m., "Resident medicated [with] prn Ativan [times 1] before bedtime due to increased aggitation [sic]." - Resident #6's MAR documented he received Lorazepam 0.5 mg on 11/10/14 at 11:15 p.m. The PRN Sheet documented "Agitation." However, Resident #6's BMI form did not document any maladaptive behaviors on 11/10/14. Additionally, his IPN documented, on 11/10/14 at 3:00 p.m., "[no] behaviors noted." The next IPN entry, dated 11/11/14 at 10:30 a.m.,	{F 329}			

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{F 329}	<p>Continued From page 11 documented "No Behaviors noted or reported."</p> <p>The record documented the PRN was utilized for agitation on 10/26/14 and 11/10/14, but did not provide information as to how the behavior was exhibited, the duration or intensity, or the impact of the behavior on the resident or others that would justify the use of the PRN Lorazepam. Additionally, there was no documentation that non-pharmalogical interventions had been tried and found ineffective prior to the use of the PRN.</p> <p>During an interview on 11/20/14 at 3:45 p.m., the LSW was interviewed and stated there were no parameters related to duration or frequency of behavior to be exhibited prior to the use of PRN Lorazepam.</p> <p>During an interview on 11/20/14 at 4:50 p.m., the Regional Consultant stated the facility had looked at people on antidepressants, but had not looked at PRN use when assessing monitoring and indicators for use.</p> <p>3. Resident #9 was admitted to the facility on 9/01/07 and readmitted on 9/18/09 with diagnoses of anxiety state unspecified, mild cognitive state, depressive disorder not elsewhere classified.</p> <p>The most recent Quarterly MDS, dated 11/5/14, documented:</p> <ul style="list-style-type: none"> - Severe cognitive impairment, - Verbal behaviors toward others 4 to 6 days a week, and - Extensive assistance of one person required for bed mobility, locomotion, dressing, toileting, personal hygiene and bathing. 	{F 329}			

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{F 329}	<p>Continued From page 12</p> <p>Physician's Order dated 9/26/14 documented, "Lorazepam tablet 0.5 mg, give one tablet by mouth every 4 hours as needed for anxiety related to anxiety state unspecified."</p> <p>The resident's comprehensive care plan had a focus, dated 8/1/2014, that documented, "Resident exhibits behaviors of verbalized anxiety, verbal aggression, agitation as a manifestation of her Depression." The interventions were:</p> <ul style="list-style-type: none"> - Give medication as per physicians orders, - Observe and report any changes in mental status, and - Encourage loved ones to keep incontact/visit. <p>The resident's comprehensive care plan had an additional focus, dated 9/15/14, of, "Exhibits behavior of anxiety as evidenced by verbal/physical aggression towards others related to: end stage COPD, SOB.[chronic obstructive pulmonary disease, shortness of breath]" There was an addition of "Verbalized anxiety, verbal aggression, hitting, kicking, biting." The interventions were:</p> <ul style="list-style-type: none"> - Document behaviors, - Give medication as prescribed by MD, - Change environment, - Redirect with an activity, - Listen and attempt to calm, - Try to show her familiar items, and - Offer food/fluids/toilet. <p>Review of MARs revealed the following the resident received Lorazepam without any indicated need and/or ma as follows starting 10/22/14 through 11/17/14: *October 2014 MAR: 10/22/14 at 9:35 p.m. for anxiety; 10/23/14 at</p>	{F 329}			

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{F 329}	<p>Continued From page 13</p> <p>9:05 p.m. for anxiety; 10/26/14 at 7:10 p.m. anxiety; 10/27/14 at 8:30 p.m. no reason documented; 10/29/14 at 8:00 p.m. no reason documented; and 10/30/14 at 3:00 p.m. no reason documented.</p> <p>and BMIs</p> <p>*October 2014 BMI: The only entry was for 10/27/14. It documented the resident had two episodes of wandering, was redirected by engagement in alternative activity, the behavior was unchanged.</p> <p>*November 2014 MAR: 11/1/14 at 8:05 p.m. for increased anxiety; 11/2/14 at 7:40 p.m., for anxiety and 11:30 p.m., no reason documented; 11/3/14 at 8:10 p.m., for anxiety; 11/8/14 at 8:10 p.m. for anxiety ; 11/9/14 at 6:50 p.m., no reason documented; 11/10/14 at 6:00 p.m., no reason documented; 11/14/14, 11:30 p.m. for anxiety; 11/15/14 at 7:30 p.m. for anxiety; 11/16/14 at 7:30 p.m. for anxiety; and 11/17/14 at 7:25 p.m., for anxiety.</p> <p>*November 2014 BMI: On 11/4/14 the resident had three episodes of wandering, was redirected by engagement in alternative activity, the behavior improved. On 11/11/14 the resident was hitting, redirected by engagement in alternative activity, the behavior improved. The resident also had three episodes of wandering, was redirected by engagement in alternative activity, the behavior was unchanged. On 11/17/14 the resident was hitting, redirected by engagement in alternative activity, the behavior improved.</p> <p>The resident's care plan and behavior monitoring did not identify the parameters of "anxiety" and the resident received the medication without clear</p>	{F 329}			

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{F 329}	Continued From page 14 indications for its use. The Administrator and DON were informed on 11/20/14 at 5:00 pm. No further information was provided.	{F 329}			

Bureau of Facility Standards

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{C 000}	16.03.02 INITIAL COMMENTS The following deficiencies were cited during a complaint followup investigation at your facility. The survey team included: Arnold Rosling, RN, BSN QIDP Michael Case, QIDP, LSW The survey team entered the facility on 11/20/14 and exited the facility on 11/20/14.	{C 000}		
{C 788}	02.200.03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F329.	{C 788}	See F 329	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

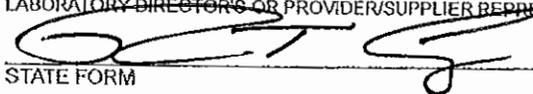
(X6) DATE

STATE FORM

6399

V17112

If continuation sheet 1 of 1



ADMINISTRATOR

12/9/14