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WESTCHESTER VILLAGE OF LENEXA	8505 PFLUMM ROAD LENEXA, KS 66215

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to complete an accurate Minimum Data Set (MDS) assessment sampled for Hospice Services (palliative end of life care provided by an outside agency) which affected 2 residents (#29 and #13). Findings included: - Resident #29 February 2019 electronic medical record (EMR) documented diagnoses that included: dysphagia (swallowing difficulty), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and dementia (progressive mental disorder characterized by failing memory, confusion). The Quarterly Minimum Data Set (MDS) assessment dated 4/29/18, documented a Brief Interview for Mental Status (BIMS) score of 00 which indicated severely impaired cognition. The MDS recorded that the resident was on Hospice yet did not indicate the resident had 6 months or less to live.	F 641		

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

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

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The Annual MDS assessment, dated 7/26/18, documented staff interview that noted resident had short and long-term memory problem. The MDS recorded that the resident was on Hospice yet did not indicate the resident had 6 months or less to live.

The Care Area Assessment (CAA), dated 7/26/18, for psychotropic medications indicated the resident received antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medication due to anxiety.

Review of the Hospice admitting orders, dated 10/18/17, indicated the resident had a life expectancy of 6 months or less if the terminal illness runs its normal course.

On 2/6/19 at 12:42 PM, administrative license nursing staff E stated that the MDS should indicate life expectancy of less than 6 months to live if the resident was on hospice and it was noted that the resident had less than 6 months to live. He/she further stated that a modified MDS would be submitted for the inaccurate MDS.

The facility policy stated that the facility would conduct a comprehensive assessment according to the Federal regulation and Medicare guidelines and the Resident Assessment Instrument.

The facility failed to develop an accurate MDS assessment which indicated 6 months or less to live for a resident on Hospice.

- Resident #13 February 2019 EMR documented diagnoses that included: sarcopenia (loss of

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F 641	Continued From page 2 muscle tissue as a natural part of the aging process), constipation (difficulty passing stool) and heart failure. The Significant Change MDS assessment, dated 9/25/18, documented a BIMS score of 14 which indicated intact cognition. The MDS recorded that the resident was on Hospice yet did not indicate the resident had 6 months or less to live. The CAA, dated 9/25/18, for cognition documented the resident was alert and orientated and able to make his/her own decisions. Review of the Hospice certification order, dated 10/18/17, indicated the resident has a life expectancy of 6 months or less if the terminal illness runs its normal course. On 2/6/19 at 12:42 PM, administrative license nursing staff E stated that it should indicate life expectancy less than 6 months to life on the MDS if the resident was on hospice and it was noted that the resident had less than 6 months to live. He/she further stated that a modified MDS would be submitted for the inaccurate MDS. The facility policy stated that the facility would conduct a comprehensive assessment according to the Federal regulation and Medicare guidelines and the Resident Assessment Instrument. The facility failed to develop an accurate MDS assessment which indicated 6 months or less to live for a resident on Hospice.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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F 656	Continued From page 3 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 4	F 656		

requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 33 residents. The sample included 12 residents. Based on observation, interview and record review, the facility failed to develop a care plan for 2 residents. Resident #13 who had constipation (difficulty passing stools) and Resident #28 who had a tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted).

Findings included:

- Resident #13's November 2018 electronic medical record (EMR) documented diagnoses that included: heart failure, sarcopenia (loss of muscle tissue as a natural part of the aging process) and constipation (difficulty passing stool).

The Significant Change Minimum Data Set (MDS) assessment, dated 9/25/18, documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS lacked documentation of constipation.

The Quarterly MDS assessment, dated 12/23/18, documented a BIMS score of 15 which indicated intact cognition. The MDS lacked documentation of Hospice.

The Pain Care Area Assessment (CAA), dated 9/25/18 documented the resident had generalized pain and took pain medication.

The care plan dated September 2018, lacked an

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F 656	Continued From page 5	F 656		

initial constipation care plan.

The resident's EMR documented orders for: Bisacodyl Suppository (medication to relieve constipation) 10 milligrams (mgs.) rectally every 72 hours if the resident had no bowel movement in 3 days dated 5/7/18; Bisacodyl suppository 10 mgs. rectally every 24 hours as needed for constipation dated 5/7/18; and Colace (medication to relieve constipation) 100 mgs. orally twice daily dated 1/16/19

Observation on 2/6/19 at 8:20 AM, resident was noted to be lying in bed on his/her right side with pillows under the residents' right side and in between his/her knees.

On 2/6/19 at 4:40 PM administrative nursing staff D verified the lack of a care plan for the resident's history of constipation. He/she stated a constipation care plan should be done.

The facility's policy dated 12/2016 directed staff review the healthcare practitioner's orders and implement a baseline care plan.

The facility failed to develop a care plan for resident #13 who had constipation.
- The Electronic Medical Record (EMR) for resident #28 listed diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion) and history of malignant neoplasm of the larynx (cancer of the voice box).

The admission Minimum Data Set (MDS) dated 1/20/19 documented the resident had a Brief Interview for Mental Status score of 5, which indicated moderate cognitive impairment. The

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F 656	Continued From page 6 resident required facility staff supervision to limited assistance with his/her Activities of Daily Living (ADLs). The resident received tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted) care. The cognitive Care Area Assessment (CAA) dated 1/20/19 documented the resident could engage in conversation with minimal answers. The resident's baseline care plan dated 1/12/19 lacked documentation for tracheostomy care. On 2/5/19 at 1:16 PM the resident sat in the dining room visiting with his/her child. An intact tracheotomy dressing was visible on the resident's neck. On 2/6/19 at 4:40 PM administrative nursing staff D verified the lack of a care plan for tracheostomy care needs. He/she stated a care plan should be done. The facility's Baseline Care Plan policy dated 2/2019 documented the facility staff would develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The facility failed to develop a comprehensive care plan with interventions to address the resident's tracheostomy care needs.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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F 657	Continued From page 7 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33. The sample included 12 residents. Based on record review, observation and interview, the facility failed to review and revise the care plan to direct care aimed at prevention future falls for resident #20. Findings included: Resident #20's electronic medical record dated February 2019 included diagnoses of malignant	F 657		

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neoplasm of prostate (a new growth of cancerous tissue of the prostate) and hypertension (elevated blood pressure).

The admission MDS (minimum data set) dated 10/01/18 documented the resident had a BIMS (brief interview for mental status) score of 1 which indicated severe cognitive impairment. The assessment recorded resident required extensive assist of one person for bed mobility, transfers, locomotion on and off the unit, dressing and personal hygiene and extensive assist of two persons for toilet use. The MDS recorded that resident was not steady during transfers moving from a seated to standing position, not steady during transfers and had functional limitation in the lower extremities. The resident had no falls since admission.

The quarterly MDS dated 12/27/18 revealed a BIMS of 03 which indicated severe cognitive impairment. He/she revealed the resident required extensive assistance of one person for bed mobility, transfers, dressing, personal hygiene and toilet use and limited assistance of one person for locomotion on and off the unit. The assessment revealed resident #20 was unsteady moving from a seated to standing position, moving off and on the toilet and surface to surface transfers. The resident had two non-injury falls and one injury fall since the prior assessment.

The fall care area assessment (CAA) dated 10/04/18 recorded that resident had a potential for falls due to requiring assistance from staff with actives of daily living (ADLs)

The electronic medical record (EMR) dated

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F 657	Continued From page 9 11/28/18 revealed the resident had an unwitnessed fall in his/her room with an injury to his/her forehead, bridge of nose and right knee. The care plan lacked an intervention to direct staff to prevent future falls. On 02/06/19 at 3:27 P.M. licensed staff G verbalized that the licensed staff add the intervention to the care plan within a 24-hour timeline. On 02/06/19 at 4:20 P.M. licensed staff D verbalized that licensed staff on duty add the care plan intervention at the time of the fall. The facility's Goals and Objectives, Care Plans policy dated September 2017 documented care plans are revised at least quarterly. The facility failed to revise the care plan with interventions for the prevention/protection from falls for resident #20 who sustained an injury form an unwitnessed fall.	F 657		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility identified a census of 39 residents.	F 684		

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The sample included 12 residents. Based on observation, interview and record review, the facility failed to manage bowels for 1 resident, resident #13 who had constipation (difficulty passing stools), and failed to perform neurological assessments, after unwitnessed falls for 3 (#20, #28, and #16) of 3 residents sampled for falls.

Findings included:

- Resident #13's November 2018 electronic medical record (EMR) documented diagnoses that included: heart failure, sarcopenia (loss of muscle tissue as a natural part of the aging process) and constipation (difficulty passing stool).

The Significant Change Minimum Data Set (MDS) assessment, dated 9/25/18, documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS lacked documentation of constipation.

The Quarterly MDS assessment, dated 12/23/18, documented a BIMS score of 15 which indicated intact cognition. The MDS lacked documentation of Hospice.

The Care Area Assessment (CAA), dated 9/25/18, for pain documented the resident had generalized pain and took pain medication.

The care plan, dated September 2018, lacked an initial constipation care plan.

Review of the documented bowel movements noted lack of a bowel movements during the following days:

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11/11/18 through 11/14/18 with no bowel movement for 4 days.
11/16/18 through 11/27/18 with no bowel movement for 12 days.
12/19/18 through 12/25/18 with no bowel movement for 6 days.
1/3/19 through 1/6/19 with no bowel movement for 4 days.

Review of the medication administration record (MAR) lacked medications given for constipation in November 2018. In December 2018, only one stool softener was administered on 12/26/18 and noted to be ineffective.

Review of the progress notes lacked documentation of bowel assessment or notification of physician of constipation.

Observation on 2/6/19 at 8:20 AM, resident was noted to be lying in bed on his/her right side with pillows under the residents' right side and in between his/her knees.

On 2/6/19 at 12:30 PM licensed nursing staff G stated that if a resident had not had a bowel movement in 2 days, he/she would check to see if there was an as needed stool softener, assess the bowel sounds, notify the physician, and document in the residents' chart. Licensed nursing staff G further revealed that an alert would trigger on the EMR if a resident has not had a bowel movement for 2 days to alert staff.

The facility's protocol, lacked a date, directed staff to assess the resident and administer as needed medications as appropriate if a resident has not had a bowel movement in 3 days and to notify the physician if the bowel protocol is

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ineffective.

The facility failed to manage bowels for resident #13, who had a diagnosis of constipation.

- The Electronic Medical Record (EMR) for resident #16 documented diagnoses of difficulty walking, need for personal care assistance, cognitive communication deficit, and ataxia (lack of muscle control or coordination of voluntary movements.

The admission Minimum Data Set (MDS) dated 12/7/18 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident required supervision to extensive assistance with his/her Activities of Daily Living (ADLs). The resident had no falls during the look back period.

The Care Area Assessment (CAA) for falls dated 12/7/18 documented the resident had a potential for falls due to weakness and the need for staff assistance for his/her ADLs.

The fall care plan revised 2/3/19 documented the resident was reeducated on the use of his/her call light when needing staff assistance with his/her surface to surface transfers and/or ADLs.

The ADL care plan dated 1/30/19 documented the resident required limited staff assistance with transfers as needed.

The fall risk assessment dated 12/1/18 documented the resident had a moderate risk of falling.

The nurse's progress note dated 2/3/19 at 1:44

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AM documented a nurse found the resident sitting on the floor beside his/her bed. The resident stated his/her legs gave way when getting up. The resident denied hitting his/her head.

The nurse's progress note dated 2/4/19 at 1: 05 AM documented the facility staff did not include neurological assessments (assessment of pupil size and reactivity to light, and hand grip strength which can help identify a possible brain injury) with the fall follow up checks.

The nurse's progress note dated 2/4/19 at 12:49 PM documented the facility staff did not include neurological assessments with the fall follow up checks.

On 2/6/19 at 8:30 AM the resident transferred him/herself from his/her wheelchair to his/her bed without difficulty.

On 2/6/19 at 8:30 AM the resident stated the staff asked him/her to call for transfers, but he/she doesn't always do so.

On 2/6/19 at 3:27 PM licensed staff G stated the nursing staff initiated neurological assessments with all unwitnessed falls.

On 2/6/19 at 4:10 PM administrative staff D stated the nursing staff initiated neurological assessments with unwitnessed falls unless the resident had intact cognition and knew how the fall had occurred.

The facility's fall protocol policy dated February 2018 documented the facility staff performed neurological assessments for 72 hours after an unwitnessed fall.

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The facility failed to perform neurological assessments, after an unwitnessed fall, to assess for a possible brain injury for this resident with impaired mobility.

- Resident #20's electronic medical record dated February 2019 included diagnoses of malignant neoplasm of prostate (a new growth of cancerous tissue of the prostate) and hypertension (elevated blood pressure).

The admission Minimum Data Set (MDS) dated 10/01/18 documented the resident had a Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment and no behaviors. The assessment recorded the resident required extensive assist of one person for bed mobility, transfers, locomotion on and off the unit, dressing and personal hygiene and extensive assist of two persons for toilet use. The resident was not steady during transfers, moving from a seated to standing position and not steady during transfers and functional limitation in the lower extremities. The resident had no falls since admission.

The quarterly MDS dated 12/27/18 revealed a BIMS score of 03 which indicated severe cognitive impairment. The resident required extensive assistance of one person for bed mobility, transfers, dressing, personal hygiene and toilet use and limited assistance of one person for locomotion on and off the unit.. The

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assessment revealed resident #20 was unsteady moving from a seated to standing position, moving off and on the toilet and surface to surface transfers. The resident had two non-injury falls and one injury fall since the present admission.

The Fall Care Area Assessment (CAA) dated 10/04/18 recorded that the resident was a potential for falls due to requiring assistance from staff with Activities of Daily Living (ADLs).

The Electronic Medical Record (EMR) dated 11/28/18 recorded that he/she had an unwitnessed fall in his/her room. The resident reported to facility licensed staff he/she didn't know where he/she was trying to go but knew he/she had fallen and that he/she had hit his/her head. Head to toe assessment was completed and neurological checks (checks for the level of consciousness) were started. The facility was unable to provide completed documentation of neurological check sheet.

On 02/06/19 at 3:27 P.M. licensed staff G stated that neurological checks are started for all unwitnessed falls.

On 02/06/19 at 4:10 P.M. licensed staff D stated that neurological checks are started after an unwitnessed fall and neurological checks would not be started if a resident was cognitively aware and denied hitting his/her head. Licensed staff D stated he/she did not know what the fall protocol policy stated.

The facility's fall protocol policy dated February 2018 documented the facility staff performed neurological assessments for 72 hours after an

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unwitnessed fall.

The facility failed to perform neurological assessments, after an unwitnessed fall, to assess for a possible brain injury for this resident with impaired mobility.

- The Electronic Medical Record (EMR) for resident #28 documented diagnoses of difficulty walking, repeated falls, muscle weakness, poor balance, and Parkinson's disease which involves of the central nervous systems and that affects movement and can cause involuntary muscle contractions that result in shaking.

The Admission Minimum Data Set (MDS) dated 01/20/19 revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated severe impaired cognition. The resident required supervision to limited assistance for Activities of Daily Living (ADL's). The resident was occasionally incontinent of urine and had a history of falls.

The Care Area Assessment (CAA) for falls dated 01/20/19 documented the resident was alert and oriented to self and had short and long term memory deficits. The resident had a potential for falls due to impaired balance during transition, incontinence, Parkinson's disease, diagnosis of depression and anxiety.

The fall care plan revised 2/1/19 instructed staff to frequently remind the resident to use the call lights for assistance.

The ADL care plan dated 1/12/19 documented the resident required limited staff assistance for ADL's and used both a walker and a wheelchair

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for mobility.

The fall risk assessment dated 01/09/19 revealed the resident was at high risk for falls.

The nurse's progress note dated 02/01/19 at 5:40 PM documented the resident was found on floor by staff, mild right hand pain, and was unable to tell staff what he/she was trying to do before the fall.

The nurse's incident noted dated 2/2/2019 04:14 AM revealed the resident continued on fall follow-up without neurological assessments (assessment of pupil size and reactivity to light, and hand grip strength which can help identify a possible brain injury).

The nurse's incident note dated 02/03/2019 at 02:38 AM revealed the resident continued on fall follow-up without neurological assessments.

The nurse's incident note dated 02/03/2019 at 12:55 PM revealed the resident continued on fall follow-up without neurological assessments due to a recent fall.

The nurse's incident note dated 02/04/2019 at 01:08 AM revealed the resident continued on fall follow-up without neurological assessments.

The nurse's incident note dated 02/04/2019 at 12:44 PM revealed the resident continued on fall follow-up with no neurological assessments.

An observation on 02/06/19 08:07 AM the resident stood at the sink with the water running without staff in attendance.

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F 684	Continued From page 18 An observation on 02/06/19 11:52 AM revealed the resident sitting in wheelchair in his/her room going through drawers in his/her dresser. An interview with resident #28 on 02/04/19 1:47 PM revealed he/she has fallen few times. An interview with licensed staff G on 02/06/19 at 3:34 PM revealed neurological assessments should be performed with fall follow-up assessments for unwitnessed falls. An interview with administrative staff D on 02/06/19 at 16:30 PM revealed the nursing staff initiated neurological assessments on residents when falls were unwitnessed, except when resident had intact cognition and could tell staff how the fall had occurred. The facility's fall protocol policy dated February 2018 documented the facility staff performed neurological assessments for 72 hours after an unwitnessed fall. The facility failed to perform neurological assessments, after an unwitnessed fall, to assess for a possible brain injury for this resident with impaired cognition and mobility.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		

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§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 33 residents. The sample included 12 residents. Based on interviews, observation, and record review the facility failed to act upon the pharmacist consultant recommendations for documentation of the administration of medications for 1 (#4) of 5 residents sampled for unnecessary medication

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use.

Findings included:

- The Electronic Medical Record (EMR) for resident #4 listed diagnoses of major depression disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), anxiety (Anxiety-mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and pain in an unspecified joint.

The admission Minimum Data Set (MDS) dated 8/11/18 documented a Brief Interview for Mental Status (BIMS) score of 9, which indicated a moderate cognitive impairment and a PHQ-9 (testing used to assess signs of depression) score of 0, which indicated mild depression. The resident received an antipsychotic (medication used to treat psychosis (any major mental disorder characterized by a gross impairment in reality testing), an anxiolytic (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), and an opioid (medications used to treat pain) 7 of 7 days in the look back period; and an antidepressant (medication used to treat depression) 6 of 7 days in the look back period.

The quarterly MDS dated 11/8/18 documented a BIMS score of 15, which indicated intact cognition and a PHQ-9 score of 0, which indicated no symptoms of depression. The resident received an antidepressant and an anxiolytic medication 7 of 7 days in the look back period.

The Care Area Assessment (CAA) for psychotropic medications (medications used to

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treat psychosis, depression, and anxiety) dated 8/11/18 documented the resident received medications for anxiety, depression, and psychosis.

The CAA for pain dated 8/11/18 documented the resident's pain medications relieved his/her pain.

The psychotropic medication care plan dated 7/31/18 documented the facility staff administered psychotropic medications as ordered by the physician, to the resident. The resident received psychotropic medications for anxiety and depression.

The pain management care plan dated 7/31/18 documented the facility staff administered pain medications as ordered by the physician, to the resident.

The EMR documented physician's orders for: Escitalopram (medication to treat depression) 20 milligrams (mgs.) by mouth every evening 7/31/18; Xanax (medication to treat anxiety) 0.5 mgs. by mouth twice daily for anxiety 10/17/18; and Tramadol (pain medication) 25 mgs. by mouth twice daily 1/7/19.

Review of the Medication Administration Records (MARs) August 2018 through February 6, 2019 lacked documentation for: Escitalopram 20mgs. 4 of 31 doses in August; 2 of 30 doses in September; 7 of 31 doses in October; 3 of 30 doses in November; and 1 of 31 doses in January; Xanax 0.5mgs. 2 of 15 doses in October,11 of 60 doses in November, and 3 of 62 doses in December; and Tramadol 50mg by mouth 50mgs. 5 of 49 doses in January.

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The November 2018 pharmacy Medication Regimen Review (MRR) documented lack of documentation on the MAR indicated medications were not given with no reason being documented for the omissions.

On 2/5/19 at 10:30 AM the resident actively participated in an activity game.

On 2/6/19 at 3:27 PM licensed staff G stated when medications were not given when scheduled the computer did highlight the missing dose.

On 2/6/19 at 3:43 PM direct care staff O stated when a medication if due the computer highlights the dose in yellow and when past due it becomes red. He/she always reviews every resident's medication administration record prior to leaving his/her shift to make sure the medications are given.

On 2/6/19 at 4:10 PM administrative staff D stated he/she expected staff to give medications as ordered by the physician. He/she did not audit of the MARs.

The facility's Documentation of Medication Administration policy dated April 2007 documented a nurse or certified medication aide shall document all medications administered to each resident on the resident's MAR. Administration of medication must be documented immediately after it is given.

The facility failed to administer medications ordered by the physician to this resident with depression, anxiety, and pain.

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		

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prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 33 residents. The sample included 12 residents. Based on interviews, observations, and record review the facility failed to administer psychotropic medications (medications used to treat psychosis, depression, and anxiety) necessary to clarify the rational for, the benefits of, and approach to monitoring for benefits and adverse consequences for 2 (#4 and #134) of 5 residents sampled for unnecessary medication use.

Findings included:

- The Electronic Medical Record (EMR) for resident #4 listed diagnoses of major depression disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and an anxiety (Anxiety- mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The admission Minimum Data Set (MDS) dated 8/11/18 documented a Brief Interview for Mental Status (BIMS) score of 9, which indicated a moderate cognitive impairment and a PHQ-9

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(testing used to assess signs of depression) score of 0, which indicated mild depression. The resident received an antipsychotic (medication used to treat psychosis-any major mental disorder characterized by a gross impairment in reality testing) and an anxiolytic (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) 7 of 7 days in the look back period; and an antidepressant (medication used to treat depression) 6 of 7 days in the look back period.

The quarterly MDS dated 11/8/18 documented a BIMS score of 15, which indicated intact cognition and a PHQ-9 score of 0, which indicated no symptoms of depression. The resident received an antidepressant and an anxiolytic medication 7 of 7 days in the look back period.

The Care Area Assessment (CAA) for psychotropic medications dated 8/11/18 documented the resident received medications for anxiety, depression, and psychosis.

The psychotropic medication care plan dated 7/31/18 documented the facility staff administered psychotropic medications as ordered by the physician, to the resident. The resident received psychotropic medications for anxiety and depression.

The EMR documented physician's orders for: Escitalopram (medication to treat depression) 20 milligrams (mgs.) by mouth every evening 7/31/18; Xanax (medication to treat anxiety) 0.5 mgs. by mouth twice daily for anxiety 10/17/18.

Review of the Medication Administration Records (MARs) August 2018 through February 6, 2019

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lacked documentation for: Escitalopram 20mgs. 4 of 31 doses in August; 2 of 30 doses in September; 7 of 31 doses in October; 3 of 30 doses in November; and 1 of 31 doses in January; Xanax 0.5mgs. 2 of 15 doses in October,11 of 60 doses in November, and 3 of 62 doses in December.

On 2/5/19 at 10:30 AM the resident actively participated in an activity game. His/her body posturing and facial expressions were relaxed

On 2/6/19 at 3:27 PM licensed staff G stated when medications were not given when scheduled the computer did highlight the missing dose.

On 2/6/19 at 3:43 PM direct care staff O stated when a medication if due the computer highlights the dose in yellow and when past due it becomes red. He/she always reviews every resident's medication administration record prior to leaving his/her shift to make sure the medications are given.

On 2/6/19 at 4:10 PM administrative staff D stated he/she expected staff to give medications as ordered by the physician. He/she did not audit of the MARs.

The facility's Documentation of Medication Administration policy dated April 2007 documented a nurse or certified medication aide shall document all medications administered to each resident on the resident's MAR. Administration of medication must be documented immediately after it is given.

The facility failed to administer psychotropic

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F 758	Continued From page 27 medications necessary to clarify the rational for, the benefits of, and approach to monitoring for benefits and adverse consequences for this resident with anxiety and depression.	F 758		