STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 standard Medicare/Medicaid recertification survey started on 03/11/18 and concluded on 03/14/18.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		4/18/18

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

Electronically Signed | 04/05/2018

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide care in a manner which maintained or enhanced resident dignity for 2 of 15 sampled residents (Resident #14 and #17) and one supplemental resident (Resident #11). Failure to knock on residents' doors prior to entering does not respect their privacy or personal space. Findings include: Review of the facility policy titled, "Dignity" occurred on 03/14/18. This policy, revised February 2017, stated, ". . . Respecting resident's private space and property. (Examples include . . . knocking on doors and requesting permission to enter . . ." - Observation on 03/11/2018 at 3:36 p.m., showed a Certified Nursing Assistant (CNA) (#2) entered Resident #17's room without knocking. The resident was in her room being transferred from her bed to her wheel chair with a full body mechanical lift. - Observation on 03/11/18 at 3:46 p.m., showed a CNA (#2) entered Resident #11's room without knocking and announcing herself. The resident	F 550	1. Residents #11,#14 and#17 are being assisted in a dignified manner by staff knocking and announcing themselves before entering the room. 2. The facility has identified that all residents of the facility have the potential to be affected by this practice. 3. On or before April 11, 2018, all staff will receive in-service education on resident dignity regarding respecting resident space and property. Process change: General orientation Dignity education will now be provided by Social Services/Social Service Designee with expectations of staff behavior in regards to resident rights, resident's private space, and resident's property. 4. An audit has been developed to monitor the process of respecting the resident dignity in relation to knocking on resident's door and announcing self to resident before entering room. Audits will be completed by DNS or	

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F 550	Continued From page 2 was in her room. - Observation on 03/12/18 at 9:39 a.m. showed a nursing staff member (#4) performed a dressing change for Resident #14. During the observation, a CNA (#3) opened the door and entered the room without knocking/announcing herself. During an interview on 03/13/18 at 4:32 p.m., an administrative nurse (#1) stated staff are expected to knock before entering residents' rooms.	F 550	designee 6x weekly for one month, 4x weekly for second month, weekly for third month, and 4x quarterly for 3 quarters. Audit summary reports will be provided to the Quality Assurance Committee for further recommendations and monitoring to ensure sustained compliance. 5. Compliance will occur on or before April 18th, 2018.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		4/18/18

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F 656	Continued From page 3 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 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policy, the facility failed to develop a comprehensive care plan for 1 of 12 sampled residents (Resident #23). Care planning drives the type of care and services that a resident receives and failure to develop a care plan that includes the care and services to be provided to the resident may negatively impact the resident's quality of life. Findings include: Review of the facility policy titled "Care Plan" occurred on 03/14/18. This policy, revised November 2016, stated, ". . . Each resident will have an individualized, person-centered, comprehensive plan of care . . . review of the physician's orders, any problems, needs and concerns identified will be addressed. . . ."	F 656	1. On 3/13/2018 resident #23 careplan was updated to reflect pain management, goals and interventions. 2. The facility has identified all residents who receive pain management have the potential to be affected by this practice. 3. On or before April 11, 2018, the care plan team will receive in-service education on proper Comprehensive Care Planning. Process change: Weekly IDT meeting will include in-depth Pain Management review and care plan updates. 4. An Audit tool has been developed to monitor proper care planning of resident	

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F 656	Continued From page 4 Review of Resident #23's medical record occurred on all days of survey. Diagnoses included Alzheimer's, osteoporosis, and pain. Resident #23's medication administration record (MAR), showed resident received oxycodone-acetaminophen tablet 5-325 milligram (mg) 0.5 tablet by mouth two times a day and acetaminophen (Tylenol) 650 mg two times a day. The Quarterly Minimum Data Set (MDS), dated 01/16/2018 identified Resident #23 as using non-pharmacological interventions for pain, having pain present almost constantly, pain that makes it hard to sleep, and identified pain as severe. Review of Resident #23's care plan occurred on 03/13/2018. The care plan failed to address the resident's pain and provide goals and interventions to manage Resident #23's pain. During an interview on 03/13/18 at 11:20 a.m., an administrative nurse (#1) stated, "yes, you are correct, this resident's care plan does not address the resident's pain."	F 656	pain management, goals and interventions related to pain and will be completed by DNS or designee weekly for one month, monthly x 2 months and quarterly for 3 quarters. Audit summary reports will be provided to the Quality Assurance Committee for further recommendations and monitoring to ensure sustained compliance. 5. Compliance will occur on or before April 18th, 2018.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, facility staff	F 658	1.(Part 1) Resident #35 dressing was correctly applied on 3/13/18.	4/18/18

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F 658	Continued From page 5 failed to follow professional standards for 2 of 2 residents observed receiving specialized nursing care (Resident #35 and #144). Failure to follow professional standards during a surgical dressing change (Resident #35) and administration of medications by feeding tube (Resident #144) may result in the residents experiencing adverse consequences. Findings include: Review of the facility policy titled "Wound Dressing Change" occurred on 03/14/18. The policy, revised October 2017, stated, ". . . Check physician's order . . . Perform beginning five . . . Put on gloves . . . Remove soiled dressing and discard in plastic bag . . . Remove gloves and discard in same plastic bag. Perform hand hygiene . . . Put on gloves . . . Cleanse the skin and wound thoroughly with normal saline . . . Position dressing over the wound . . . Place all disposable items in plastic bag with dressings, seal and discard according to procedure . . . Perform ending five . . . " Review of the facility policy titled "Nursing Services Policies and Procedures" occurred on 03/14/18. The policy, revised May 2016, stated, ". . . When the words "beginning five" and "ending five" are found in a procedure, it refers to the following steps that happen at the beginning and end of a procedure. Beginning Five . . . 5. Perform hand hygiene Ending Five . . . 1. Remove gloves if applicable . . . 2. Perform hand hygiene . . ." - Review of Resident #35's record occurred on all days of survey and identified the resident had a	F 658	1.(Part 2)Resident #144 had no adverse affects from failing to flush prior to medication administration and failing to flush between medications. Resident #144 has since been discharged back to her home and no longer resides in facility. The nurse involved in giving the medications was given education regarding proper administration of medications via tube. 2. (Part 1)The facility has identified that all residents who require wound dressing care have the potential to be affected by this practice. 2.(Part 2)The facility has identified that all residents who receive medication administration via tube have the potential to be affected by this practice. The facility currently has no residents who receive medications Via Tube. 3.(Part 1)On or before April 11, 2018 all nursing staff who provide wound care treatments will receive in-service education on proper wound care and dressing changes. Process Change: Wound Care will be implemented into our annual licensed nursing staff skills verification. 3.(Part 2)On or before April 11, 2018, all licensed nursing staff will receive in-service education on proper medication administration via tube.	

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F 658	Continued From page 6 surgical wound to the right lower leg and upper thigh secondary to a skin graft procedure. A surgeon's "Postoperative Instructions," dated 02/22/18, stated, ". . . Leave dressing in place on the thigh . . . If dressing comes off completely, replace with a dressing consisting of non-stick gauze (Xeroform or Adaptic), and antibiotic ointment (Silvadene or Polysporin), then cover with a large ABD dressing [a thick gauze dressing]." Observation on 03/11/18 4:50 p.m. showed Resident #35 resting in bed with no dressing present on the wound to his right thigh. A licensed nurse (#5) stated Resident #35 had skin grafted from his right thigh to his right calf and stated the resident had removed the dressing from his right thigh. This nurse left the room and another licensed nurse (#6) entered with dressing supplies, performed hand hygiene, and donned gloves. Without cleansing the wound or applying antibiotic ointment, the nurse (#6) placed an ABD over the wound and taped it in place. At that point, an administrative nurse (#8) entered and asked the nurse (#6) to come out to hall. The nurse (#6) removed her gloves and exited the room without performing hand hygiene. After several minutes, the nurse (#6) returned to the room and stated she should have placed a Xeroform dressing on wound. She then performed hand hygiene, donned gloves, removed the ABD, and applied Xeroform and a new ABD to wound. The nurse (#6) left the room without performing hand hygiene or bagging and removing the soiled dressings. Observation showed the waste basket nearly overflowing with	F 658	Process Change: Medication Administration via tube will be implemented into our annual licensed nursing staff skills verification. 4.(Part 1) An audit has been developed to monitor the professional standards of wound dressing changes. Audit will be completed by DNS or designees 2X weekly for one month, 1X weekly for 2nd and 3rd months, and quarterly for 3 quarters. Audit summary reports will be provided to the Quality Assurance committee for further recommendations and monitoring to ensure sustained compliance. 4.(Part 2) An audit has been developed to monitor the professional standards of medication administration via tube. In the event that there is a resident in the facility receiving medications via tube, the audit will include direct observation of the nurse giving the medications. If there is no resident in the facility receiving medications via tube, the audit will monitor nursing staff being able to verbally describe the steps in correct administration of medications via tube. The audit will be completed by DNS or designee and will be done once a week x 4 weeks, monthly x 2 months, and quarterly x 3 quarters. In the event that a resident is admitted and receiving medications via tube, the audit frequency will be increased as needed to ensure	

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F 658	Continued From page 7 soiled dressings/supplies. During an interview on 03/13/18 at 4:15 p.m. an administrative nurse (#1) confirmed the LPN (#6) should have performed hand hygiene prior to leaving the room and should have bagged and removed the soiled dressings and supplies after performing the dressing change. Review of the facility policy titled "Medication Administration Via Tube" occurred on 03/14/18. This policy, revised November 2013, stated, ". . . If tablets can be crushed, crush finely and mix with sterile water. . . . Administer each medication separately and flush the tubing between each medication. Flush with 5 ml [milliliters] of sterile water after each individual medication is given. . . . Flush tube with 30 ml (cc [cubic centimeters]) of sterile water before and after administering each medication pass. . . ." - Observation of medication pass occurred on 03/12/18 at 10:10 a.m. A licensed nurse (#4) crushed the following medications for Resident #144: Lisinopril (for blood pressure) 20 milligrams (mg), Allopurinol (for gout) 100 mg, Amlodipine (for blood pressure) 5 mg, and aspirin (for blood pressure) 81 mg. The nurse failed to flush the tubing before administering the first medication. The nurse then poured water into the syringe and added the crushed medication to the water. The resident asked, "Aren't you supposed to mix that with water? So it doesn't clog the tube?" The nurse stated, "Oh, I thought it would dissolve better," and used the plunger of the syringe to push the medication through the tubing. The nurse then mixed the other medications with water prior to adding them to the syringe, but	F 658	that all nurses are following the correct procedure. Audit summary reports will be provided to the Quality Assurance committee for further recommendations and monitoring to ensure sustained compliance. 5. Compliance will occur on or before April 18th 2018.	

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F 658	Continued From page 8 failed to flush between each medication. During an interview on 03/13/18 at 4:29 p.m., an administrative nurse (#1) stated staff are expected to flush between medications, and before and after each medication administration.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and family and staff interview, the facility failed to assist with activities of daily living (ADLs) for 1 of 6 sampled residents (Resident #34) who required staff assistance for grooming. Failure to provide assistance to residents who cannot perform the task independently may result in decreased self-esteem and poor grooming. Findings include: Review of the facility policy titled "Hair Care" occurred on 03/14/18. This policy, revised October 2017, stated, ". . . Style hair as resident desires. . . . " Review of Resident #34's medical record occurred on all days of survey. Diagnoses included rheumatoid arthritis. The resident's current Minimum Data Set (MDS), dated 01/29/18, identified extensive assistance from one person for personal hygiene.	F 677	1. Resident #34 is receiving assistance from staff with ADLs per resident's care plan. 2. The facility has identified that all residents in the facility who require staff assistance with ADLs has the potential to be effected by this practice. 3. On or before 04/11/2018, all nursing staff who provide residents with ADL assistance will receive in-service training in regards to resident dignity, activities of daily living, and hair care. Process Change: Reinforcement of caregivers expectations that all residents who require ADL assistance will receive necessary ADL services including grooming and personal hygiene. 4. An audit tool has been developed to monitor compliance of ADL care provided	4/18/18

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F 677	Continued From page 9 Observations throughout the survey showed Resident #34's hair looked disheveled and unkempt. During an interview on 03/11/18, a family member stated, "Look at her hair. They can't even fix her hair?" The family member further stated the resident took pride in her appearance and always had her hair fixed. Observation identified Resident #34 received a bath on 03/12/18, but staff failed to curl/style her hair. During an interview on 03/13/18 at 4:30 p.m., an administrative nurse (#1) identified staff could fix residents' hair after they receive a bath.	F 677	to dependent residents, and will be completed by Social Service Director or designee 6X weekly for 1 month, 4X weekly for 2nd month, 2x weekly for 3rd month, and 2X quarterly for 3 quarters. Audit summary reports will be provided to the Quality Assurance Committee for further recommendations and monitoring to ensure sustained compliance. 5. Compliance will occur on or before April 18th 2018.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of operating instructions, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 3 sampled residents (Resident #20) observed during transfers utilizing a sit to stand lift. Failure to follow specific transfer instructions for Resident #20 placed the resident at risk of an	F 689	1. Resident #20 is now being transferred with Sit-to-Stand Lift according to care plan. 2. The facility has identified that all residents who require transfer assistance with the use of the Sit-to-Stand Lift and wear heel booties have the potential to be	4/23/18

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F 689	Continued From page 10 accident and/or injury. Findings include: Review of the facility's "Operating Instructions" for the EZ Way Sit to Stand Lift occurred on 03/14/18. The instructions, dated 11/04/11, stated ". . . Safety . . . Follow any specific lift/transfer instructions for the resident. . . ." Review of Resident #20's record occurred on March 12-14, 2018 and identified diagnoses including osteoarthritis, osteoporosis, and history of falls. An admission Minimum Data Set, dated 01/04/18, identified the resident required extensive assistance of one staff member for transfers. The current care plan stated, "TRANSFER: Assist of 1 with sit to stand . . ." A physician's order, dated 12/28/17, stated, "Heel Booties on at all times except with transfers . . ." Observation on 03/12/18 at 8:41 a.m. showed Resident #20 seated in her wheel chair with heel boots on both feet. A Certified Nursing Assistant (CNA) (#7) prepared to transfer Resident #20 utilizing a sit to stand lift. The CNA positioned Resident #20's feet on the foot rest without removing her heel boots. Observation showed the resident did not stand upright in the lift and the sling rode up to her axillae during the transfer. During an interview on 03/13/18 at 4:30 p.m., an administrative nurse (#1) stated staff can access a resident's care plan on a kiosk in hall. She stated staff should check the kiosk prior to caring for the resident for the first time and should follow the care plan.	F 689	affected by this practice. 3. All nursing staff will attend in-service education on or before 4/11/2018 regarding Sit-to-Stand operating instructions and resident kardex review on the kiosks. Process Change: Reinforcement of nursing staff accessing resident kardex/transfer section prior to transfers. 4. An audit tool has been developed to monitor compliance of staff performing safe operation of Sit-to-Stand Lift, transferring according to resident's care plan, and demonstration of use of the Kardex for review of care planned transfer information. This audit will be completed by Rehab Coordinator RN or designee 4X a week for 1 month, 3X a week for 2nd month, 1X a week for 3rd month, and 2X quarterly for 3 quarters. Audit summary reports will be provided to the Quality Assurance Committee for further recommendations and monitoring to ensure sustained compliance. 5. Compliance will occur on or before April 18th 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

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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. §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	F 756		4/18/18

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

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F 756	Continued From page 12 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure staff acted on the pharmacist's recommendations for dose reductions of psychotropic medications for 1 of 5 residents selected for unnecessary medication review (Resident #8). Failure to attempt a dose reduction for psychotropic medications, without a clinical rational for continuing the dose, may result in the resident receiving an unnecessary medication and experiencing adverse consequences from the medication. Findings include: Review of Resident #8's medical record occurred on March 13-14, 2018. Physician's orders included the following psychotropic medications: * Seroquel (antipsychotic) 100 milligrams (mg) daily for major depressive disorder - initiated on 06/20/16 * Lorazepam (antianxiety) 0.5 mg daily for anxiety state - initiated on 06/14/16 Review of the Consultant Pharmacist's Medication Reviews for Resident #8 identified the following: * 03/07/17: Lorazepam - "Resident has been using this medication for over one year. . . ." The physician responded by accepting the recommendation and wrote: "Will Discuss [with] pt [patient]." The record identified, on 03/30/17, the physician ordered a psychiatric consult. The record lacked evidence the resident received the ordered	F 756	1. Regarding Resident #8, on 3-19-2018 physician was contacted regarding the gradual dose reduction recommended by the pharmacist. 2. The facility has identified that all residents who receive psychotropic medications have the potential to be affected by this practice. 3. On or before April 11, 2018, all members of the Care Plan Team and all nurses will receive in-service education on the rational and procedure for gradual dose reduction of psychotropic Process Change: Dose reduction recommendations will be reviewed weekly in IDT meetings to ensure proper physician follow-up. 4. Audits will be done to ensure physician follow-up for all psychotropic medication reduction recommendations. Audits will be completed by DNS or designee weekly x one month, monthly x 2 months, quarterly x 3 quarters. Audit summary reports will be provided to the Quality Assurance Committee for further recommendations and monitoring to ensure sustained compliance. 5. Compliance will occur on or before	

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	355100	A. BUILDING _____ B. WING _____	03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

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F 756	Continued From page 13 consult and the Lorazepam dose remained unchanged. * On 06/29/17: Seroquel - "Patient has taken current dose of the above antipsychotic medication since 6/16 [June 2016] . . ." The physician responded by rejecting the recommendation and wrote: "Will reassess on rounds." A physician's progress note, dated 07/06/17, stated, "Physician order sheet reviewed and signed. We will continue with her present management. . . ." The physician failed to document the clinical rationale for not attempting a dose reduction for the Seroquel.	F 756	April 18th 2018.	