| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on 05/18/15 and completed on 05/21/15, the sample included three (3) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey. | F 000 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident interview, and staff interview, the facility failed to | F 280 | 1) The Dietary Manager visited with resident #2 and established a goal weight. A supplement was started on 5-15-15 for resident #7, The plan for resident #5 is to start using a standing lift for transfers when long periods of weight bearing is necessary.<br>2) A policy for a planned weight loss will be developed by 6-15-15. The dietary Manager will be responsible for inputting the weights in the medical record for all the residents. Any changes made to the care plan will be posted in the CNA charting rooms for 2 weeks. CNA's will review and sign care plans quarterly. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Bonnie Dahlgren | Administrator | 06-16-15 |

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 280 | Continued From page 1<br>revise care plans to include the residents' current needs and status for 3 of 12 sampled residents regarding weight loss (Resident #2 and #7), and assistance needed during transfers (Resident #5). Failure to update the care plans to include the residents' current needs limited staff's ability to communicate care needs and ensure continuity of care for each resident.<br><br>Findings include:<br><br>- Review of Resident #2's record occurred on all days of the survey.<br><br>Review of Resident #2's significant change MDS (Minimum Data Set) assessment, dated 11/09/14, identified the resident with intact cognition and weighed 161 pounds and had no identified weight loss.<br><br>The resident's most recent quarterly MDS assessment dated, 05/02/15, revealed the resident weighed 138 pounds, and the resident lost 5% or more in the last month or 10% in the last 6 months and was not on a physician prescribed weight loss regimen.<br><br>Review of Resident #2's current care plan identified, "Alteration in nutrition related to diagnosis of hyperlipidemia, vitamin deficiency and poor appetite at times. Has complaints of upset stomach at times . . ." The care plan failed to address the resident's weight loss or weight loss goals.<br><br>During an interview on 05/20/15 at 2:52 p.m., Resident #2 reported she had always been overweight, but wanted to try to lose some to be more comfortable. Resident #2 reported she | F 280 | 3. If there is a discrepancy in a weight, the dietary manager will instruct the CNA's to reweigh the resident. Any changes made to the care plan will be posted in the CNA charting room. CNA's will review and sign care plans quarterly. The DON or designee will maintain a file with posted changes in the office for 1 year.<br>4. At the weekly Skin, Weight, Bowel, and bladder meeting, the Dietary Manger will do a 7 month look back on any resident designated at risk for weight loss or unplanned weight loss and then the dietary manager will review the weight losses with the QA coordinator on a monthly basis for 4 months and randomly thereafter. QA and the DON will meet monthly to review all collected changes to the care plan.<br>5. CNA's will be notified of care plan posting changes at the CNA meeting on 6-17-15. | 6-25-15 |

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| F 280 | Continued From page 2 | F 280 | | |

stopped eating her midnight snack and started losing the weight, and reported she was surprised that it had such results. Resident #2 reported she has lost about 30 pounds, and weighed 138 pounds this morning. The resident also reported she had a personal weight loss goal of getting down to 126 pounds.

During an interview on 05/21/15 at 9:45 a.m., an administrative nursing staff member (#4) stated the resident's weight loss and desire for weight loss should have been included in the care plan.

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included anemia and edema. A quarterly MDS, dated 04/24/15, identified intact cognition, supervision with meals after set up help only, and a non-prescribed weight loss. A physician's order, dated 4/29/15, identified a "regular diet with certain food pureed as she requests."

Resident #7's current care plan stated, "Problem: Resident has pedal edema, . . . Resident is prescribed FUROSEMIDE [a diuretic] (d/c'd [discontinued] 5/12/14) . . . Problem: Resident has difficulty swallowing . . .Weigh resident monthly and PRN [as needed]. Record results. Determine food preferences, Dietary service to evaluate and follow up quarterly and as deemed necessary . . . Record resident's oral intake . . . EATS ALL MEALS IN HER ROOM PER RESIDENT REQUEST. RESIDENT HAS REQUESTED HER MEALS BE GROUND FOR EASIER CHEWING AND SWALLOWING . . ."

The facility failed to review and revise the care plan to address Resident #7's weight loss of 25 pounds over six months.

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| F 280 | Continued From page 3<br><br>- Review of Resident #5's medical record occurred on all days of survey.<br><br>Observation on 05/19/15 at 9:35 a.m., showed a CNA (#8) used a sit-to-stand mechanical lift to transfer Resident #5 from her wheelchair onto the toilet and then from the toilet to the recliner in the resident's room.<br><br>Observation occurred on 05/19/15 at 3:30 p.m., showed two CNAs (#9) and (#10) used a sit-to-stand mechanical lift to transfer Resident #5 from her bed into the bathroom and onto the toilet; then from the toilet to her wheelchair.<br><br>Review of Resident #5's current care plan stated, ". . . Problem: Alteration in mobility related to weakness and confusion, Approaches: . . . Resident is to be transferred with stand pivot transfer and with assist of 2 CNA [certified nurse aide] with gaitbelt . . . May transfer with assist of one staff when alert . . . " The care plan did not include the use of a stand lift.<br><br>During an interview on 05/21/15 at 11:10 a.m., an administrative nurse (#5) reviewed Resident #5's care plan and stated, "no it doesn't say anything about a stand lift." | F 280 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | F 323 | | |

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| F 323 | Continued From page 4<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of the facility policy, record review, and staff interview, the facility failed to ensure each resident's environment remained as free from accident hazards as is possible for 1 of 4 sampled residents (Resident #3) who experienced falls. The failure to follow the planned interventions to prevent falls, and failure to complete a thorough investigation after each fall limits the facility's ability to determine the most appropriate interventions to prevent additional falls.<br><br>Findings include:<br><br>Review of the facility's policy titled, "Falls Policy and Procedure" occurred on 05/21/15. The policy identified, "Purpose/Objective: [Facility] maintains the responsibility to provide an assessment and accurate account of a residents fall and assess the resident for injury. . . . Documentation Procedure: 1) Document event in the nurses notes. Be sure charting is as thorough as possible. Include: . . . b. Physical/mental condition before and after fall. c. Anything pertinent that may have contributed to the fall. . . . ii. When toileted last iii. Adequate footwear iv. Resident not using assistive device (walker, cane, ect [sic]) v. Were there any liquids on the floor? . . . 5) Interventions will be implemented on each fall individually if required and will be care planned. Such as but not limited to: a. PT/OT [physical therapy/occupational therapy] b. Change in toileting schedule c. Least restrictive devices . . ." | F 323 | 1) The DON and/or designee will meet with the nursing staff on 6-17-15. New safety and fall risk assessments were completed for Resident #3. Appropriate revisions were made to the care plans to reflect all current safety interventions. The revised assessments and care plans were reviewed with staff involved in the care of each resident.<br>2) The nursing management team reviewed the MDS Assessments for all residents who have been identified as having a potential risk for falls. Fall and safety risk assessments are complete and interventions currently in place are appropriate. | |

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| F 323 | Continued From page 5<br>Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, depressive disorder, closed rib fracture, and insomnia. The record identified the resident experienced six falls from 06/01/14 to 04/27/15.<br><br>Review of Resident #3's significant change Minimum Data Set (MDS), dated 02/13/15, identified moderate cognitive impairment, required extensive assistance of two or more staff for transfers, walking in his room, and personal hygiene and experienced one fall with an injury since the last assessment.<br><br>Review of Resident #3's quarterly MDS, dated 05/06/15, identified cognition intact, required extensive assistance of one staff for transfers and personal hygiene, supervision of one staff for walking in his room and toilet use, and experienced one fall with a major injury since the prior assessment.<br><br>Review of the resident's comprehensive care plan identified, ". . . Alteration in mobility due to R) [right] sided CVA [cerebrovascular accident] with L) [left] sided hemiplegia [paralysis of one side of the body] and discomfort at times . . . " with approaches which directed staff to encourage the resident to reposition every 1 to 1 1/2 hours and help as needed per 1-2 staff, encourage the resident's ambulation with a walker, gaitbelt and assist of 1-2 staff PRN [as needed]. ". . . Therapy has deemed him unsafe but he continues to walk independently with walker and family is in agreement with resident. . . ." The care plan's approaches also identified the resident tended to walk on his tippy toes on the left foot and needed reminding to put his whole foot down on the floor | F 323 | 3. All Licensed Nursing staff will be in serviced on the facility policy for Accidents and Supervision by 6-17-15. All incident reports will be reviewed daily during the business week by the nursing management team to ensure appropriate implementation of safety interventions including updating the plan of care have been accomplished.<br>4. Nursing management will review each incident report upon occurrence to ensure appropriate interventions are implemented and updated plan of care is complete. The Director of Nursing Services(DNS), or designee, will complete random weekly chart audits for six (6) consecutive weeks and review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of resident falls/accidents and that care plans have been updated to reflect these interventions. Audited records will be reviewed by the DNS/QA Coordinator until such time consistent substantial compliance has been achieved.<br>5. | 06-25-15 |

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when ambulating, ". . . Resident impulsive at times will not use walker . . . Resident a fall risk . . ." The care plan identified the problem of pressure ulcer risk with approaches for staff to encourage the resident to repositioned every two to three hours and help as needed per one staff (which conflicts with the repositioning directions above). The care plan also identified a problem of impaired thought processes related to CVA. With approaches to, . . . "Keep resident environment free of clutter and safety hazards . . ."

Review of an investigation for a fall the resident experienced on 02/12/15 at 1:15 a.m. referred to the following nursing note: ". . . Resident is on floor of the bathroom on his buttucks [sic]. Resident reported that he was at the sink and turned around to use the toilet when he lost his balance and fell on the floor. . . . Resident noted to have a skin tear to left forearm. . ." The investigation form included "Additional Comments and/or Steps Taken to Prevent Recurrence" which remained blank. The investigation did not include whether the resident had his walker at the time of the fall, whether he had appropriate footwear on at the time of the fall, if the floor was free of clutter, or the last time staff checked on the resident prior to the fall to ensure any needs were met.

Review of an investigation for a fall the resident experienced between 04/22/15 and 04/23/15 at an unknown time revealed, "Resident states he tripped & fell onto bed hitting his rib on siderail - He originally stated 'Last Night' then 'maybe yesterday'. CNA [certified nurse aide] states he was fine this a.m. He then states 'it was today'. No trauma noted to ribs or chest." The investigation form included "Additional Comments

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and/or Steps Taken to Prevent Recurrence" revealed, "Family does not want PT - had PT in February" The investigation did not include any assessment regarding the continued need for the side rail or the safety related to having it on the resident's bed.

Review of an investigation for a fall the resident experienced on 04/27/15 at 3:45 a.m. identified, "Resident was found sitting on floor. He states he slid out of bed to the floor because he could not get up. . . .", and identified the bed in low position with 1/4 rails raised. The investigation form included "Additional Comments and/or Steps Taken to Prevent Recurrence" did not state what type of footwear the resident wore at the time of the fall, whether his walker was within reach at the time of the fall, if the floor was free of clutter, or whether staff assessed the safety of the side rail on the bed, or mattress after the resident experienced the fall.

Review of a nurse's note about the fall dated 04/27/15 at 3:51 a.m. included, ". . . Res [resident] stated that his rib hurt from where he bumped them on his side rail a few days ago and would possibly like a clinic appointment in a.m."

Review of a Radiology Imaging report, dated 04/28/15, identified, "Acute segmental fracture lateral right 8th rib . . ."

Observation on 05/19/15 at 5:24 p.m. showed Resident #3 walked down the hall with a walker into his room and then into his bathroom. A CNA (#3) followed the resident to the bathroom door and asked him if he needed assistance. The resident responded, "no" as he pulled down his pants and sat on the toilet. After asking again and

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receiving the same response, the CNA (#3) shut the bathroom door, walked past 3 tissues on the floor in front of the recliner and left the room. At 5:35 p.m., the resident finished in the bathroom, left his walker in the restroom and walked out to the recliner in his room past the tissues on the floor, turned around and sat down in the recliner. The CNA failed to assist Resident #3 with transfers, toileting, and ambulation as identified on his most recent MDS.

On 05/21/15 at 9:45 a.m., an administrative nursing staff member (#4) stated CNAs need to check on the resident intermittently throughout the day however there was no set schedule for how often. The staff member stated it depended on the resident and it depended on the aide.

On 05/21/15 at 10:20 a.m., an administrative nursing staff member (#5) stated therapy determined the resident unsafe to ambulate independently but family wanted to continue to allow him to walk independently as he chose. The staff member (#5) stated she did not have any expectation for supervision while in the bathroom, or how often staff needed to check on the resident when he stayed in his room. The records showed three of the six falls the resident experienced occurred either in his room or bathroom. The staff member (#5) also stated she did not increase supervision for the resident after his falls, had not assessed the resident's footwear at the time of the falls, and stated she did not have any additional information regarding the investigations other than what was on the reports.

The facility failed to thoroughly investigate each fall to help determine causative factors, remove hazards from the resident's environment,

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| F 323 | Continued From page 9<br>implement interventions to limit the risk of falls, and evaluate the effectiveness of those interventions. | F 323 | | |
| F 325 SS=D | 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br><br>Based on a resident's comprehensive assessment, the facility must ensure that a resident -<br>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and<br>(2) Receives a therapeutic diet when there is a nutritional problem.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to implement and monitor interventions to prevent weight loss and maintain nutritional status for 3 of 5 sampled residents (Resident #1, #5, and #7) who experienced weight loss. Failure to initiate timely and effective interventions, and re-evaluate and modify the interventions as needed, resulted in significant weight loss for Resident #1 and severe weight loss for Resident #5, and #7.<br><br>Findings include:<br><br>Review of the facility policy titled "Weight Loss Policy" occurred on 05/21/15. This policy, dated March 2012 stated, " Objective: To identify significant weight loss of 5% in 30 days, 7.5% in | F 325 | 1. The Director of Nursing Services and Dietary Manager reassessed the nutritional status of Resident(s) #1, 5, 7. Revisions were made to the care plan(s) and revised interventions will be reviewed with staff involved in the care of each resident on 6-17-15. Resident #7 was started on a 4 oz. supplement 3 times a day on 5-18-15. A 5 lb. weight gain was noted in 11 days so the Dr. reduced the supplement to 2 times per day. Resident #5 has maintained a weight from 123-126 lbs. since 12/14. She is about average BMI. She continues to receive 4 oz. of supplement 3 times per day. Resident #1's supplement was increased from 4 oz. to 6 oz. 4 times per day on 6-1-15.<br>2. The facility has determined that all residents have the potential to be affected. | |

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| F 325 | Continued From page 10<br>90 days or 10% in 180 days or less to maintain acceptable parameters of nutritional status. Policy/Procedure: 1. Upon admission obtain baseline weights. 2. Resident weight will be obtained and recorded monthly. 3. If significant weight loss is noted it will be assessed and care planned at the time of detection. 4. Physician will be notified. 5. Family will be notified. 6. Dietician will be consulted as needed. 7. High calorie foods will be offered such as extra cream, gravies, butter as residents diet allows. 8. If no improvement is noted within 14 days, supplements will be give under order of physician."<br><br>- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included anemia and edema. A quarterly Minimum Data Set (MDS), dated 04/24/15, identified intact cognition, supervision with meals after set up, and not on prescribed weight loss regimen. A physician's order, dated 4/29/15, identified a "regular diet with certain food pureed as she requests."<br><br>Resident #7's current care plan stated, "Problem: Resident has pedal edema, . . . . Resident is prescribed FUROSEMIDE [a diuretic] (d/c'd [discontinued] 5/12/14) . . . Problem: Resident has difficulty swallowing . . .Weigh resident monthly and PRN [as needed]. Record results. Determine food preferences, Dietary service to evaluate and follow up quarterly and as deemed necessary . . . Record resident's oral intake . . . EATS ALL MEALS IN HER ROOM PER RESIDENT REQUEST. RESIDENT HAS REQUESTED HER MEALS BE GROUND FOR EASIER CHEWING AND SWALLOWING . . ." | F 325 | 3) An in-service education program was conducted by the Director of Nursing Services and the Dietary Manager with all direct care staff addressing nutritional interventions including weight documentation and monitoring.<br>4) The Dietary Manager will review each weight report to ensure appropriate measurements are recorded and complete and to monitor weight fluctuations. The Director of Nursing Services (DNS), or designee, will complete weekly chart audits for six (6) consecutive weeks and review all weight reports and residents with weight change to ensure that changes are identified and appropriate interventions have been put in place. Care plans will be reviewed for updated information to reflect these interventions. Audited records will be reviewed by the Quality Assurance Coordinator until such time consistent substantial compliance has been achieved as determined by the committee.<br>5) | 6-17-15<br><br>6-25-15 |

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| F 325 | Continued From page 11<br>A dietary progress note, dated 1/28/15, stated, ". . . current weight is 121# . . . she had a 7# weight loss. . . . She usually eats the same thing everyday. She eats 75-100% of most meals. . . ."<br><br>Review of Resident #7's "Doctor's Orders and Progress Notes showed the following:<br>12/08/2014, ". . . Physical Examination . . . Her weight is at 128 lbs [pounds]. . . She has no ankle edema. . . ."<br>02/12/2015, " . . . Weight is 120 lbs which is down 8 lbs from last time. . . ."<br>04/15/15, ". . . Physical Examination . . . Weight 114 lbs which is down 6 lbs from February . . . "<br><br>Review of Resident #7's weights over the last six months showed the following:<br>* 11/06/14 - 132 pounds<br>* 12/03/14 - 128 pounds<br>* 01/08/15 - 122 pounds<br>* 02/11/15 - 120 pounds - a severe weight loss of 9% in 3 months<br>* 03/04/15 - 119 pounds<br>* 04/01/15 - 115 pounds<br>* 05/13/15 - 107 pounds - a severe weight loss of 18% weight loss in 6 months<br><br>During an interview on 05/19/15 at 5:15 p.m., a dietary manager (#2) stated, in reference to Resident #7's weight loss over a six month period, "we should have done something sooner." Resident #7's medical record showed an order for a supplement, dated 05/18/15.<br><br>The facility staff failed to implement interventions for Resident #7's continued weight loss until it totaled 18% over a six month period.<br><br>- Review of Resident #5's medical record | F 325 | | |

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| F 325 | Continued From page 12<br>occurred on all days of survey and showed an admission date of 10/29/14. Diagnoses included hypertension and dementia. An admission MDS, dated 11/05/14, identified severely impaired cognition, extensive assist of one person for eating, and identified a weight loss. A quarterly MDS, dated 04/26/15, identified a weight loss.<br><br>Review of "Doctor's orders and Progress Notes" showed the following:<br>11/20/14, ". . . seen for a 30 day visit . . . Physical Examination . . . Weight 140 lbs . . . No edema . . . "<br>12/18/14, ". . . Weight 140 lbs [changed to 126 lbs] . . . No edema . . ."<br>During an interview on 05/21/15 at 9:10 a.m., a nurse manager (#1) stated that the weight of 140 lbs was an error and she informed the physician, then changed the weight to 126 lbs.<br><br>Review of Resident #5's nursing progress notes during the period from 11/01/14 to 11/17/14 showed the nursing staff documented "no edema noted" or "lower extremities are negative for edema" on 15 days.<br><br>Review of Resident #5's dietary notes stated the following:<br>11/13/14, ". . . current weight is 140# . . . She is on a regular soft diet and eats 25-50% of most meals . . . "<br>11/17/14, stated, ". . . had a 5% weight loss since her admit but it was an antisipated [sic] weight loss as she came from [hospital name] on IV [intravenous] fluids."<br>11/18/14, written by the dietician stated, "Nutritional status reviewed for admit assessment . . . intakes average 25-50% of meals. Resident has experienced a 5% weight loss since admit, | F 325 | | |

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resident had been on IV fluids while hospitalized prior to admit so weight loss was anticipated . . . Resident sits at a feeder table for meals and is assisted by staff. Would recommend resident receive a multivitamin supplement d/t [due to] low Hgb [hemoglobin] and Hct [hematocrit] levels. No other changes to plan of care at this time . . . "
12/26/14, "Residents meal intakes are very poor. She will not hold her head up to take in any foods offered to her. She will often refuse meals and alternative meals. . . . She is down 8# and/or 5% within a month due to this."
01/29/15, ". . . current weight is 123# . . . She has lost quite a bit of weight since admit but is also overweight and this is appropriate for her BMI [body mass index] levels still being high. . . .has been eating 25-50% give or take. She is on a supplement at snack times twice a day . . . "

Review of Resident #5's weights over the last six months showed the following:
* 11/01/14 - 140 pounds
* 12/06/14 - 128 pounds - a severe weight loss of 8% in one month
* 01/02/15 - 124 pounds
* 02/08/15 - 120 pounds - a severe weight loss of 14% in 3 months
* 03/06/15 - 120 pounds
* 04/03/15 - 120 pounds
* 05/01/15 - 123 pounds

Review of Resident #5's physician's orders showed the following:
11/06/14 - regular soft diet
01/16/15 - 4 ounce high calorie protein supplement at 2:30 p.m. and 8:00 p.m. This order occurred two months after dietary noted a 5% weight loss in one month.
02/18/15 - 4 ounce high calorie supplement with

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| F 325 | Continued From page 14<br>meals and 2:30 p.m.<br>04/20/15 - 4 ounce supplement three times a day<br><br>Resident #5's current care plan stated, ". . . Problem: Potential for alteration in nutrition related to dementia and diagnosis of diabetes mellitus, Goal: Resident will consume at least 50% of meals, Approaches: . . . Offer resident alternatives for meals when not eating well . . . REGULAR SOFT DIET, 4 OZ HIGH CALORIE HIGH PROTEIN SUPPLEMENT AT 9:30AM, 2:30PM AND 8PM . . . "<br><br>During an interview on 05/19/15 at 5:00 p.m., a dietary manager (#2) identified how she tracks residents' weights. The staff member stated, "I get an alert on my computer" regarding changes in resident weights, but that Resident #5's weights from 11/07/14 to 01/15/15 "were not entered into the computer" but in the weight book.<br><br>During an interview on 05/21/15 at 10:30 a.m., a physician (#7), stated, "the supplement slowed [Resident #5's] weight loss and that "could have been started sooner."<br><br>The facility staff failed to recognize the contributing factors leading to Resident #5's severe weight loss. The interdisciplinary team failed to identify and implement interventions until Resident #5 lost 14 pounds.<br><br>- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included congestive heart failure, anemia, and constipation. The current MDS, dated 04/14/15, identified short and long term memory problems, | F 325 | | |

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eats independently with set up help only, and no weight loss.

Resident #1's care plan stated, " . . . Problem: Alteration in nutrition related to personal dietary preferences. Goal: Resident will eat at least 50% of meals. . . Approaches: . . . Dietary services to evaluate Resident's current nutritional status quarterly or as deemed necessary . . . Weigh resident monthly and PRN [as needed]. Record results and report any loss/gain to physician and dietician . . . INFO Resident prefers toast as meals per her request . . . Resident requests supplements to be given with meals . . ."

Resident #1's physician's orders stated, " . . . 01/16/13 Regular diet . . . 01/16/13 High cal [calorie]/high protein supplements 4 oz [ounces] chocolate three times a day, with meals. High cal/high protein supplements 4 oz chocolate twice a day, with snacks . . ."

Resident #1's dietary notes stated the following:
* 10/13/14 "[Resident #1] current weight is 104# . . . She lost 6# this quarter. . . . She will often refuse her meals served and requests toast and jelly. She eats 75-100% of her meals. She is getting a 4oz supplement 4x [times] daily at all 3 meals and at 2:30 snacks. She was receiving a supplement at 8pm snack and she would throw it in the garbage. We asked her if she wanted us to stop the 8pm and she said yes. . . ."
* 04/15/15 "[Resident #1] weight is 99# . . . She had a recent weight loss due to her only eating around 25-50%. She is still drinking 75-100% of supplements that she gets with meals and 2:30 snacks. . . . "

Resident #1's dietary quarterly assessment,

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| F 325 | Continued From page 16<br>dated 04/15/15, identified a quarterly weight loss of 7%.<br><br>Review of Resident #1's weights showed the following weight loss:<br>* 10/28/14 - 109 pounds<br>* 12/02/14 - 108 pounds<br>* 12/30/14 - 107 pounds<br>* 01/27/15 - 106 pounds<br>* 02/24/15 - 104 pounds<br>* 03/31/15 - 102 pounds<br>* 04/28/15 - 98 pounds - a significant weight loss of 10% in 6 months<br><br>Observation on 05/19/15 showed Resident #1 consumed 100% of her 4 oz chocolate supplement at all meals and 2:30 p.m. snack.<br><br>During an interview on the morning of 05/20/15, a dietary manager (#2) stated Resident #1 is losing weight as she pushes food away, she likes her toast, and drinks her supplement provided four times a day. This dietary manager confirmed Resident #1 received her supplement four times a day, not five times a day, as ordered by the physician and failed to provided documentation of Resident #1's family being notified of the weight loss.<br><br>Staff failed to follow the physician order for Resident #1's supplement, consider an increase in the resident's supplement (receiving four ounces since 01/16/13), and notify the dietician and Resident #1's family of the weight loss. | F 325 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from | F 329 | | |

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| F 329 | Continued From page 17<br>unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and review of facility policy, the facility failed to ensure a medication regimen free from unnecessary medications for 3 of 8 sampled residents (Resident #8, #10, and #12) receiving psychopharmacological medications. Failure to attempt a gradual dose reduction (GDR), unless contraindicated, in an effort to reduce or discontinue antipsychotic or hypnotic use may result in residents receiving unnecessary medications and experiencing adverse drug effects related to their use. | F 329 | 1) The medication regimen for Resident 8, 10, & 12 was reviewed by the physician. The indication for the prescribed hypnotic drug was clearly documented by the physician in the medical record.<br><br>2) The facility has determined that all residents receiving antipsychotic drugs have the potential to be affected. A review of all medication orders for antipsychotic drugs, and indications for use, will be completed by 7-15-15.<br><br>3) All Licensed Nursing staff will be in serviced regarding the facility policy for Indications for Use of Antipsychotic Drugs. A copy of the regulations regarding unnecessary drugs and the facility's policy regarding use of antipsychotic drugs were provided to the physician as a resource. | 6-12-15 |

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| F 329 | Continued From page 18<br>Findings include:<br><br>The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For psychopharmacological medications (other than antipsychotics and sedatives/hypnotics), a tapering of the medication should be attempted annually, unless clinically contraindicated. For antipsychotics, a GDR must be attempted annually, unless clinically contraindicated. For sedatives/hypnotics, a GDR should be attempted quarterly unless clinically contraindicated.<br><br>Review of the facility policy titled "Use of Antipsychotic Medications" occurred on 05/21/15. This undated policy stated, ". . . Policy/Procedure: . . . 5. If no behaviors of concern are noted in 3 months time, there will be a trial dose reduction if physician feels this would be beneficial. . . . 7. The medication will be used at the lowest effective dose."<br><br>- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included insomnia. Medications included Ambien 5 milligrams (mg) at bedtime since admission on | F 329 | 4) The Director of Nursing Services (DNS), or designee, will complete random weekly audits for six (6) consecutive weeks of new antipsychotic medication orders to ensure that appropriate indications for use of any antipsychotic drugs are clearly documented in the medical record. Audit records will be reviewed by the QA Coordinator until such time consistent substantial compliance has been achieved as determined by the QA committee.<br><br>5) | 6-25-15 |

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| F 329 | Continued From page 19<br>09/06/13.<br><br>The quarterly Minimum Data Set (MDS), dated 03/03/15, identified Resident #8 had difficulty falling or staying asleep or sleeping too much half or more than half the days during the assessment period and felt tired or had little energy nearly every day during the assessment period. The care plan stated, "Alteration in Sleep pattern . . . Approaches: Provide quiet environment, encourage no caffeine, prescribed Zolpidem [Ambien]."<br><br>Resident #8's "Doctor's Orders and Progress Notes," dated 04/09/15, stated, ". . . also uses Ambien 5 mg at bedtime . . . Impression and Plan . . . Insomnia. Continue Ambien . . ."<br><br>The medical record showed Resident #8's physician changed the scheduled Ambien to as needed (PRN) 09/17/14 and changed it back to scheduled on 11/10/14. The facility failed to consider a GDR or indicate why it is clinically contraindicated quarterly as required.<br><br>- Review of Resident #10's medical record occurred on May 20-21, 2015. Diagnoses included insomnia. Medications included Ambien 10 mg every evening, initiated April 2014.<br><br>The quarterly MDS, dated 03/16/15, identified Resident #10 had difficulty falling or staying asleep or sleeping too much and felt tired or had little energy half or more than half the days during the assessment period. The care plan stated, "Alteration in sleep pattern . . . Approaches . . . Keep environment quiet and calm . . . Teach resident and family side effects of medication. Discourage caffeinated beverages before bed. | F 329 | | |

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Resident is prescribed Zolpidem . . ."

A telemedicine physician's visit with Resident #10, dated 01/21/15, stated, ". . . She sleeps well at night. Anxiety has been better. . . . PLAN: We will continue with the current medications. We will follow up in 3 months. . . ."

Resident #10's "Doctor's Orders and Progress Notes," dated 02/12/15, stated, "Impression and Plan: . . . Insomnia. Continue Ambien 10 mg QHS [every night] . . ."

Resident #10's "Consultant Pharmacist Resident Review," dated 02/25/15, stated, "Could we try a GDR on Zolpidem and go 5 mg nightly?" The response stated, "Refuses." The form did not identify who refused.

The facility failed to consider a GDR of Resident #10's Ambien or indicate why it is clinically contraindicated.

- Review of Resident #12's medical record occurred May 20-21, 2015. Diagnoses included dementia, anxiety, depression, and insomnia. Medications included trazadone (an antidepressant used to aide with sleep), 25 mg at bedtime, Seroquel (antipsychotic) 50 mg at bedtime, Buspirone (antianxiety) 5 mg in the morning and 15 mg at bedtime, Ativan (antianxiety) 0.5 mg every evening, and Cymbalta (antidepressant) 60 mg daily.

The quarterly MDS, dated 05/11/15, identified, during the assessment period, Resident #12 had difficulty falling or staying asleep nearly every day, felt tired or had little energy half or more than half the days, and exhibited no behaviors.

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Resident #12's care plan stated, "Problem/Need: . . . inadequate sleep patterns with difficulty falling or staying asleep . . . Discourage resident from caffeine . . . Schedule monthly psychiatric visits . . . Trazadone . . . every evening . . . Problem/Need: Alteration in mood related to diagnosis of depression, adjustment disorder with mixed anxiety and depressive mood . . . Schedule psychiatric visits . . . prescribed Ativan . . . Seroquel . . ."

Resident #12's psychiatry progress notes stated the following:
*04/16/14 - ". . . [name] reports that she is doing well . . . PLAN: We will continue with current medications. . . ."
*07/16/14 - ". . . [name] reports that she is doing well. Staff is also not reporting any complaints. She is more alert. . . . We will continue with current medications. . . ."
*10/15/14 - ". . . [name] reportedly is sleeping well. . . . We will continue with current medications. . . ."
*01/21/15 - ". . . [name] reportedly is sleeping well. . . . We will continue with current medications. . . ."

Resident #12's medical record showed the facility failed to attempt a GDR for Seroquel and failed to attempt a tapering of Cymbalta, Buspirone, Trazadone, Ativan.