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F 000	INITIAL COMMENTS An unannounced Medicare special focus survey was conducted 2/14/17 through 2/15/17. Corrections are required for compliance with the following Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 118 at the time of the survey. The survey sample consisted of 12 current resident reviews (Resident #1 through Resident #12).	F 000		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		2/28/17

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

Electronically Signed | 02/24/2017

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F 329	Continued From page 1 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (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; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure that 6 of 12 Residents in the sample survey was free from unnecessary medications, Resident #7, Resident #8, Resident #9, Resident #11, Resident #1 and Resident #4. The Findings Included: 1. For Resident #7 the facility staff failed to monitor for the use of two antidepressants drug use, Celexa and Remeron, to include specific behaviors, interventions, side effects and effectiveness. Resident #7 was a 90 year old female who was originally admitted on 2/11/16 and readmitted on 8/16/16. Admitting diagnoses included, but were not limited to: hypertension, major depression, anxiety, history of falls and dementia.	F 329	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. 1. Medications and behavior documentation for residents 7,8,9,11,1, and 4 have been reviewed and behavior monitoring ordered for every shift. All residents on psychoactives were reviewed on 2/14/17, and behavior monitoring orders changed to every shift. MD has reviewed 100% psychoactive medication orders to ensure medications are	

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F 329	Continued From page 2 The most current minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 11/14/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 12. The facility staff coded that Resident #7 required set up assistance (1/1) to extensive assistance (3/2) with Activities of Daily Living (ADL's). In Section N. medications the facility staff coded tat Resident #7 received 7 days on an antidepressant and 7 days on an antianxiety medication. On February 15, 2017 at 9:30 a.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced signed physician orders dated 1/18/17. Signed physician orders included, but were not limited to: "CeleXA Tablet (Citalopram Hydrobromide) Give 20 mg by mouth one time a day for depression. Remeron Tablet 15 MG (Mirtazapine) Give 1 tablet by mouth at bedtime related to ANXIETY DISORDER, UNSPECIFIED (F41.9); MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (F33.9)." (sic) Continued review of the clinical record produced the January and February 2017 Medication Administration Records (MAR's). Review of the January and February 2017 MAR's documented that the facility staff were administering the Celexa and Remeron as ordered by the physician. Continued review of the January and February 2017 MAR's also read: "ANTIDEPRESSANT/ANTIANXIETY MEDICATION-MONITOR FOR SEDATION/DROWSINESS, MUSCLE TREMORS, FAST/SLOW/IRREGULAR HEARTBEAT, AGITATION, HEADACHE,	F 329	necessary for optimal treatment. 2. All Residents using psychoactive medications are at risk. 3. SDC or designee will provide education to nursing staff on behavior monitoring and documentation of behaviors. 4. UM or designee will audit 5 residents weekly x 4 weeks then monthly x 3 months to ensure necessity of medications and correct documentation of behaviors . Above process will be reviewed monthly x 3 months with QA. 5. Date of Compliance 2/28/17	

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F 329	Continued From page 3 EXCESSIVE WEIGHT GAIN, ABNORMAL B/P (blood pressure), HALLUCINATIONS, SEVERE WEAKNESS, CONSTIPATION, DIFFICULT URINATION, BLURRED VISION, CONFUSION, PHOTOSENSITIVITY, SLURRED SPEECH, DIZZINESS. Document: "Y" if monitored and none if the above observed. "N" if monitored and any of the above was observed, select chart code "Other/See Nurses Notes" and progress note findings as needed. PRN (as needed)" "BEHAVIORS-MONITOR FOR THE FOLLOWING: HALLUCINATIONS. Document: "Y" if monitored and none if the above observed. "N" if monitored and any of the above was observed, select chart code "Other/See Nurses Notes" and progress note findings as needed. PRN (as needed)" (sic) The surveyor noted that there was no documentation on the January and February 2017 MAR's of the interventions, side effects, effectiveness and specific behaviors related to the antidepressant drug use, Celexa and Remeron, for Resident #7. Further review of the clinical record produced the nursing "Progress Notes." Review of the nursing progress notes did not reveal any monitoring of the antidepressant drug use, Celexa and Remeron, to include interventions, side effects, effectiveness and specific behaviors for Resident #7. Continued review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP identified the following "Focus, Goals and Interventions." "Focus The resident has depression r/t (related to) Dementia Goal The resident will remain free of s/s (signs and symptoms) of distress, symptoms of depression, anxiety or sad mood by/through review date	F 329		

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Interventions ...Monitor/document/report PRN (as needed) any risk for harm to self. Monitor/document/report PRN and s/s of depression, including: hopelessness, anxiety, sadness, insomnia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons." (sic)

On February 15, 2017 at 10:30 a.m. the surveyor notified the Director of Nursing (DON) that Resident #7 was receiving two antidepressants, Celexa and Remeron, and that specific behaviors of depression, interventions, side effects or effectiveness for the use of the antidepressants could not be located in the clinical record. The DON stated that the facility staff were monitoring Resident #7 and only charted if Resident #7 had behaviors. The surveyor notified the DON that the facility staff also needed to document interventions, side effects and effectiveness of the antidepressants. The surveyor requested to see the documentation regarding the monitoring of the specific behaviors, interventions, side effects and effectiveness. The DON stated that Resident #7 did not have any behaviors documented on the MAR's. The surveyor notified the DON that if no documentation was available then the facility could not validate that the monitoring was done. The surveyor informed the DON that if it's not documented, then you couldn't prove that it was done. The DON stated, "I know."

On February 15, 2017 at 2:30 p.m. the survey

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team met with the Administrator (Adm), DON, MDS Nurse and the Staff Development Coordinator. The surveyor notified the Administrative Team (AT) that Resident #7 was receiving two antidepressants, Celexa and Remeron. The surveyor notified the AT that review of the clinical record failed to produce documentation for monitoring for specific behaviors, interventions, side effects and effectiveness for the antidepressant drug use.

No additional information was provided as to why the facility staff failed to monitor Resident #7 for antidepressant drug use.

2. For Resident #8 the facility staff failed to monitor for the use of three antidepressants, Celexa, Remeron and Trazodone, to include interventions, side effects and effectiveness.

Resident #8 was a 79 year old female who was admitted on 12/14/16. Admitting diagnoses included, but were not limited to: nondisplaced fracture of the tibial spine, history of falls, osteoporosis, hypertension and asthma.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a 30 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 1/10/17. The facility staff coded that Resident #8 had a Cognitive Summary Score of 15 The facility staff also coded that Resident #8 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident # received 7 days of an antidepressant.

On February 15, 2017 at 11:30 a.m. the surveyor

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reviewed Resident #8's clinical record. Review of the clinical record produced signed physician orders dated 1/16/17. Signed physician orders included, but were not limited to: "Citalopram Hydrobromide (Celexa) Tablet 40 MG Give 1 tablet by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (F33.9), Mirtazapine (Remeron) Tablet 15 MG Give 1 tablet by mouth at bedtime related to MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (F33.9), TraZODone HCl Tablet 50 MG Give 1 tablet by mouth at bedtime for insomnia 1 pill PO (by mouth) daily." (sic)

Continue review of the clinical record produced the January and February 2017 Medication Administration Records (MAR's). The January and February 2017 MAR's documented that the facility staff were administering the Celexa, Remeron and Trazodone as ordered by the physician. Continued review of the January and February 2017 MAR's also read: "BEHAVIORS-MONITOR FOR THE FOLLOWING: (specify) ITCHING, PICKING AT SKIN, RESTLESSNESS (AGITATION), HITTING, INCREASE IN COMPLAINTS, BITING, KICKING, SPITTING, CUSSING, RACIAL SLURS, ELOPEMENT, STEALING, DELUSIONS, HALLUCINATIONS, PSYCHOSIS, AGRESSION, REFUSING CARE. Document: "Y" if monitored and none if the above observed. "N" if monitored and any of the above was observed, select chart code "Other/See Nurses Notes" and progress note findings as needed. PRN (as needed)." (sic) The surveyor noted that there was no documentation on the January and February 2017 MAR's of the interventions, side effects and effectiveness related to the antidepressant drug

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use, Celexa, Remeron and Trazodone for Resident #8.

Further review of the clinical record produced the nursing "Progress Notes." Review of the nursing progress notes did not reveal any monitoring of the antidepressant drug use, Celexa, Remeron and Trazodone, to include interventions, side effects and effectiveness for Resident #8.

Continued review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP identified the following "Focus, Goals and Interventions." "Focus The resident uses psychotropic medications r/t (related to) depression. Goal The resident will be/remain free of , gait disturbance, constipation/impaction or cognitive/behavioral impairment. Interventions-ANTIDEPRESSANT MEDICATION-MONITOR FOR SEDATION/DROWSINESS, MUSCLE TREMORS, FAST/SLOW/IRREGULAR HEARTBEAT, AGITATION, HEADACHE, EXCESSIVE WEIGHT GAIN, ABNORMAL B/P (blood pressure), HALLUCINATIONS, SEVERE WEAKNESS, CONSTIPATION, DIFFICULT URINATION, BLURRED VISION, CONFUSION/DELIRIUM, SKIN RASH/PHOTOSENSITIVITY, NERVOUSNESS/RESTLESSNESS. Monitor for side effects and effectiveness." (sic)

On February 15, 2017 at 1:10 p.m. the surveyor notified the Director of Nursing (DON) that Resident #8 was receiving three antidepressants, Celexa, Remeron and Trazodone, and that interventions, side effects or effectiveness for the use of the antidepressants could not be located in the clinical record. The DON stated that the facility staff were monitoring Resident #8 and only

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charted if Resident #8 had behaviors. The surveyor notified the DON that the facility staff also needed to document interventions, side effects and effectiveness of the antidepressants. The surveyor requested to see the documentation regarding the monitoring of the interventions, side effects and effectiveness. The DON stated that Resident #8 did not have any behaviors documented on the MAR's. The surveyor notified the DON that if no documentation was available then the facility could not validate that the monitoring was done. The surveyor informed the DON that if it's not documented it wasn't done. The DON shook her head up and down.

On February 15, 2017 at 2:30 p.m. the survey team met with the Administrator (Adm), DON, MDS Nurse and the Staff Development Coordinator. The surveyor notified the Administrative Team (AT) that Resident #8 was receiving three antidepressants, Celexa, Remeron and Trazodone. The surveyor notified the AT that review of the clinical record failed to produce documentation for monitoring for interventions, side effects and effectiveness for the antidepressant drug use.

No additional information was provided as to why the facility staff failed to monitor Resident #8 for antidepressant drug use.

3. For Resident #9 the facility staff failed to monitor for psychotropic, Zyprexa, and an antidepressant, Trazodone, drug use to include specific behaviors, interventions, side effects and effectiveness.

Resident #9 was a 62 year old male who was originally admitted on 10/4/14 and readmitted on

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1/9/17. Resident #9's most recent admission was from a psychiatric inpatient stay at a local hospital. Resident #9's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, Schizophrenia, hypothyroidism, major depression and liver disease.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 1/13/17. The facility staff coded that Resident #9 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #9 required set up assistance (1/1) to extensive assistance (3/2) with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #9 received 4 days of a psychotropic medication and 4 days of an antidepressant medication.

On February 14, 2017 at 3:30 p.m. the surveyor reviewed Resident #9's clinical record. Review of the clinical record produced signed physician orders dated 11/1/16. Signed physician orders included, but were not limited to: "OLANZapine Tablet (Zyprexa) Tablet 15 MG Give 2 tablets by mouth at bedtime related to SCHIZOPHRENIA, UNSPECIFIED (F20.9) TraZODone HCl Tablet 50 MG Give 0.5 tablet by mouth at bedtime related to MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED (32.9). "(sic)

Continue review of the clinical record produced the January and February 2017 Medication Administration Records (MAR's). The January and February 2017 MAR's documented that the facility staff were administering the Zyprexa and Trazodone as ordered by the physician. Continued review of the January and February

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F 329	Continued From page 10 2017 MAR's also read: "ANTIPSYCHOTIC/ANTIDEPRESSANT MEDICATION-MONITOR FOR DRY MOUTH, CONSTIPATION, BLURRED VISION, DISORIENTATION, DIFFICULTY URINATING, DARK URINE, YELLOW SKIN, N/V (nausea/vomiting), LETHARGY, DROOLING, EPS SYMPTOMS (TREMORS, DISTURBED GAIT, INVOLUNTARY MOVEMENT OF MOUTH OR TONGUE), ABNORMAL BP (blood pressure), PHOTOSENSITIVITY, HEADACHE, WEIGHT GAIN. Document: "Y" if monitored and none if the above observed. "N" if monitored and any of the above was observed, select chart code "Other/See Nurses Notes" and progress note findings as needed related to SCHIZOPHRENIA, UNSPECIFIED (F20.9); MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED (F32.9) PRN (as needed). BEHAVIORS-MONITOR FOR THE FOLLOWING: Resident resistive to care at times, taking oxygen on and off, refusing to go to doctors appointments, non compliant with signing in and out of facility, non compliant with wearing bifocal eyeglasses, keeping urinal on bed side table, refuses assessments/care, manually increasing/decreasing amount of liters on 02 (oxygen) tank, concentrator. Document: "Y" if monitored and none if the above observed. "N" if monitored and any of the above was observed, select chart code "Other/See Nurses Notes" and progress note findings as needed related to UNSPECIFIED SCHIZOPHRENIA UNSPECIFIED CONDITION (295.90); ANXIETY STATE, UNSPECIFIED (300.00), DEPRESSIVE DISORDER NOT ELSEWHERE CLASSIFIED (311); INSOMNIA UNSPECIFIED (780.52). PRN (as needed)." (sic) The surveyor noted that there was no documentation on the January and	F 329		

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February 2017 MAR's of the specific behaviors, interventions, side effects and effectiveness related to the psychotropic, Zyprexa, and antidepressant, Trazodone, drug use for Resident #9." (sic)

Further review of the clinical record produced the nursing "Progress Notes." Review of the nursing progress notes did not reveal any monitoring of the psychotropic, Zyprexa, and antidepressant drug use, Trazodone, to include specific behaviors, interventions, side effects and effectiveness for Resident #9.

Continued review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP identified the following "Focus, Goals and Interventions." "Focus Mood and Behaviors requiring psychotropic drug use. The resident Resident is resistive to care at times, taking oxygen on and off, refusing to go to doctors appointments, non compliant to signing in and out of facility, non compliance with wearing bifocal eyeglasses, keeping urinal on bed side table, refusing assessments/care, manually increasing/decreasing amount of liters on O2 tank and concentrator, refuses to have armband on his body r/t (related to) schizophrenia, anxiety and insomnia. Goal The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Interventions Educate the resident about risks, benefits and the side effects and/or toxic symptoms." (sic)

On February 15, 2017 at 7:30 a.m. the surveyor notified the Director of Nursing (DON) that

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F 329	Continued From page 12 Resident #9 had a recent psychiatric inpatient stay at a local hospital. The surveyor notified the DON that Resident #9 was receiving a psychotropic, Zyprexa, and an antidepressant, Trazodone, and that specific behaviors, interventions, side effects or effectiveness for the use of the psychotropic and antidepressant could not be located in the clinical record. The DON stated that the facility staff were monitoring Resident #9 and only charted if Resident #9 had behaviors. The surveyor notified the DON that Resident #9 had just been readmitted from a psychiatric inpatient stay and that changes were made in his medications. The surveyor notified the DON that monitoring should have been done to include specific behaviors, interventions, side effects and effectiveness. The DON stated that Resident #9 did not have any behaviors documented on the MAR's. The surveyor notified the DON that if no documentation was available then the facility could not validate that the monitoring was done. The surveyor informed the DON that if it's not documented it wasn't done. The DON did not respond to the surveyor statement. On February 15, 2017 at 2:30 p.m. the survey team met with the Administrator (Adm), DON, MDS Nurse and the Staff Development Coordinator. The surveyor notified the Administrative Team (AT) that Resident #9 was receiving a psychotropic, Zyprexa, and an antidepressant, Trazodone. The surveyor notified the AT that review of the clinical record failed to produce documentation for monitoring for specific behaviors, interventions, side effects and effectiveness for the psychotropic and antidepressant drug use.	F 329		

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F 329	Continued From page 13	F 329		

No additional information was provided as to why the facility staff failed to monitor Resident #9 for psychotropic and antidepressant drug use.

4. For Resident #11 he facility staff failed to monitor for antidepressant, Cymbalta and Trazodone, drug use to include specific behaviors, interventions, side effects and effectiveness.

Resident #11 was a 69 year old female who was admitted on 8/5/16. Admitting diagnoses included, but were not limited to: diabetes mellitus, asthma, osteoarthritis, depression, anxiety, cerebrovascular accident, congestive heart failure and chronic kidney disease.

The most current Minimum Data Set (MDS) assessments located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 1/30/17. The facility staff coded that Resident #11 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #11 required extensive assistance (3/2) with Activities of Daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #11 received 7 days of an antidepressant.

On February 15, 2017 at 10:55 a.m. the surveyor reviewed Resident #11's clinical record. Review of the clinical record produced signed physician orders dated 12/8/16. Signed orders included, but were not limited to: "Cymbalta Capsule Delayed Release Particles 60 MG (DULoxetine HCl) Give 1 capsule by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (33.9). TraZODone HCL Tablet 100 MG Give 1 tablet by

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F 329	Continued From page 14 mouth at bedtime related to INSOMNIA, UNSPECIFIED (G47.00)." (sic) Continued review of the clinical record produced the January and February 2017 Medication Administration Records (MAR's). Review of the January and February 2017 MAR's documented that the facility staff were administering the Cymbalta and Trazodone as ordered by the physician. Further review of the January and February 2017 MAR's documented the following: "ANTIDEPRESSANT/MEDICATION-MONITOR FOR SEDATION/DROWSINESS, MUSCLE TREMORS, FAST/SLOW/IRREGULAR HEARTBEAT, AGITATION, HEADACHE, EXCESSIVE WEIGHT GAIN, ABNORMAL B/P (blood pressure), HALLUCINATIONS, SEVERE WEAKNESS, CONSTIPATION, DIFFICULT URINATION, BLURRED VISION, CONFUSION/DELIRIUM, SKIN RASH/PHOTOSENSITIVITY, SLURRED SPEECH, NERVOUSNESS/RESTLESSNESS. Document: "Y" if monitored and none if the above observed. "N" if monitored and any of the above was observed, select chart code "Other/See Nurses Notes" and progress note findings as needed. PRN (as needed). "BEHAVIORS-MONITOR FOR THE FOLLOWING: ITCHING, PICKING AT SKIN, RESTLESSNESS (AGITATION), HITTING, INCREASE IN COMPLAINTS, BITING, KICKING, SPITTING, CUSSING, RACIAL SLURS, ELOPEMENT, STEALING, DELUSIONS, HALLUCINATIONS, PSYCHOSIS, AGRESSION, REFUSING CARE. Document: "Y" if monitored and none if the above observed. "N" if monitored and any of the above was observed, select chart code "Other/See Nurses Notes" and progress note findings as needed. PRN (as needed)." (sic)	F 329		

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The surveyor noted that there was no documentation on the January and February 2017 MAR's of the specific behaviors, interventions, side effects and effectiveness related to the antidepressant drug use, Cymbalta and Trazodone for Resident #11.

Further review of the clinical record produced the nursing "Progress Notes." Review of the nursing progress notes did not reveal any monitoring of the antidepressant drug use, Cymbalta and Trazodone, to include specific behaviors, interventions, side effects and effectiveness for Resident #11.

Continued review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP identified the following "Focus, Goals and Interventions." "Focus Mood and Behaviors to monitor: resistive to care, refusing to go to MD appts (appointments), refuses to put items away in room (hoarding), refuses medications, restlessness, at times r/t (related to) adjustment to environment. Goal The resident will cooperate with care through next review. Focus Mood and behaviors requiring psychoactive drug use as evidence by increased complaints, crying, hoarding, depression, refusing to go to appointments (cardiology and neurology) and refusing care. Behavior monitoring PRN (as needed). Goals The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Interventions Monitor for behaviors and document interventions: Crying, increase in complaints, restlessness. Monitor for side effects:

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F 329	Continued From page 16 SEDATION/DROWSINESS, MUSCLE TREMORS, FAST/SLOW/IRREGULAR HEARTBEAT, AGITATION, HEADACHE, EXCESSIVE WEIGHT GAIN, ABNORMAL B/P (blood pressure), HALLUCINATIONS, SEVERE WEAKNESS, CONSTIPATION, DIFFICULT URINATION, BLURRED VISION, CONFUSION/DELIRIUM, SKIN RASH/PHOTOSENSITIVITY, SLURRED SPEECH, NERVOUSNESS/RESTLESSNESS." (sic) On February 15, 2017 at 11:30 a.m. the surveyor notified the Director of Nursing (DON) that Resident #11 was receiving antidepressants, Cymbalta and Trazodone, and that specific behaviors, interventions, side effects or effectiveness for the use of the psychotropic and antidepressant could not be located in the clinical record. The DON stated that the facility staff were monitoring Resident #11 and only charted if Resident #11 had behaviors.. The surveyor notified the DON that monitoring should have been done to include specific behaviors, interventions, side effects and effectiveness. The DON stated that Resident #11 did not have any behaviors documented on the MAR's. The surveyor notified the DON that if no documentation was available then the facility could not validate that the monitoring was done. The surveyor informed the DON that if it's not documented it wasn't done. The DON did not respond to the surveyor statement. On February 15, 2017 at 2:30 p.m. the survey team met with the Administrator (Adm), DON, MDS Nurse and the Staff Development Coordinator. The surveyor notified the Administrative Team (AT) that Resident #11 was	F 329		

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receiving two antidepressants, Cymbalta and Trazodone. The surveyor notified the AT that review of the clinical record failed to produce documentation for monitoring for specific behaviors, interventions, side effects and effectiveness for the psychotropic and antidepressant drug use.

No additional information was provided as to why the facility staff failed to monitor Resident #11 for antidepressant drug use.

5. For Resident #1, facility staff failed to ensure adequate monitoring of administration of antipsychotic medications Saphris and Depakote.

Resident #1 was admitted to the facility on 8/12/09 with diagnoses including diabetes mellitus, hypertension, schizophrenia, major depression, hemiplegia, and morbid obesity. On the annual minimum data set assessment with assessment reference date 12/9/2016, the resident scored 14/15 on the brief interview for mental status and was assessed to be without symptoms of delirium, psychosis, or behaviors affecting others.

During clinical record review, the surveyor noted physician orders for antipsychotic medications Saphris Tablet Sublingual 10 mg give 1 tablet sublingually two times a day related to schizophrenia dated 10/26/2015 and Depakote tablet delayed release 250 mg give 1 tablet by mouth two times a day related to schizophrenia dated 10/30/2015. The medication administration record indicated the medications were administered as ordered December 2016 through the time of the survey on 2/14/17. Medication monitoring for antipsychotic medication side effects and for 'behaviors-monitor for the

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following: restlessness (agitation), hitting, increase in complaints, cursing, delusions, hallucinations, psychosis, aggression, refusing care, sexual ideation" dated 9/14/2016 and discontinued 1/18/17. No side effects or behaviors were documented from December 1 through 2/14/2017. New orders with the same wording, but with frequency PRN (as needed) instead of every shift were entered with start date 1/18/2017. No behaviors or side effects were documented on the MAR after 1/18/2017.

Nurse's notes December 1 through February 14 do not document incidences of the resident exhibiting behaviors listed on the behavior monitoring list. There is a note dated 1/9/17 at 21:33 "30 Day Review: Resident alert, disoriented, to time and place, hollering at times for no reason. Fed meals, eats 100% most of the time. Inc. of bowel and bladder. Lungs clear. No medications change, no hospital visit." The surveyor was unable to locate documentation of hollering incidents or of interventions used to address them. The resident's comprehensive plan of care documents interventions to be used to address behaviors, including documenting those behaviors, and the interventions used, on the behavior sheets.

The psychiatric progress note dated 1/25/2017 documented that nurses notes and staff reports indicated the resident continues to have psychosis without increased psychotic agitations or acting on delusions. The symptoms reported to the physician by staff were not documented in the nurse's notes or behavior notes on the MAR,

The surveyors interviewed the director of nursing(DON) about behavior monitoring and

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symptom monitoring on 2/14/2017. The DON stated that the facility had changed documentation of behaviors to PRN in January for residents who were stable long-term on their psychotropic medications. She stated that all blanks under behavior monitoring indicated there had been continuous monitoring and that there would be a mark in the day's space on the MAR and an associated nurse's note. The surveyor observed that the 1/9/17 nursing 30 day summary and the 1/25/17 psychiatric physician progress notes both indicated that nurse's reported observed resident behaviors which were not documented on the MAR or nurse's notes.

The concerns were discussed with the administrator and director of nursing on 2/16/17 during the summary meeting.

6. For Resident #4, facility staff failed to ensure adequate monitoring of administration of antipsychotic medication Olanzipine.

Resident #4 was admitted to the facility on 6/19/2009 with diagnoses including bipolar dosorder, delusional depression, hypertension.On the quarterly minimum data set assessment (MDS) dated 12/30/2016, the resident scored 8/15 on the brief interview fro mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others.

During clinical record review the clinical record on 2/15/2017 and noted a physician order dated 12/26/2016 for Olanzipine 2.5 mg give 1 tablet by mouth one time a day related to bipolar disorder. Medication monitoring for antipsychotic medication side effects and for 'behaviors-monitor for the following: refuses

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F 329	Continued From page 20 showers at times, also heard things in room, has multiple cups, candles, sexual ideations, sexually inappropriate behavior, racial slurs, insomnia, anxiety, false complaints about other residents" dated 9/14/2016 and discontinued 1/18/17. No side effects or behaviors were documented from December 1 through 2/14/2017. New orders with the same wording, but with frequency PRN (as needed) instead of every shift were entered with start date 1/18/2017. No behaviors or side effects were documented on the MAR after 1/18/2017. The surveyors interviewed the director of nursing(DON) about behavior monitoring and symptom monitoring on 2/14/2017. The DON stated that the facility had changed documentation of behaviors to PRN in January for residents who were stable long-term on their psychotropic medications. She stated that all blanks under behavior monitoring indicated there had been continuous monitoring and that there would be a mark in the day's space on the MAR and an associated nurse's note. The concerns were discussed with the administrator and director of nursing on 2/16/17 during the summary meeting.	F 329		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 514		2/28/17

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F 514	Continued From page 21 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to maintain a complete and accurate clinical record for 1 of 12 residents in the survey sample (Resident #1). Resident #1 was admitted to the facility on 8/12/09 with diagnoses including diabetes mellitus, hypertension, schizophrenia, major depression, hemiplegia, and morbid obesity. On the annual minimum data set assessment with	F 514	For resident #1, 30 day review has been corrected to state resident has a history of yelling out but remains stable and has not had behaviors on current medication regime. All Residents on psychoactive medications were reviewed. 30 day nurse reviews on the same Residents were reviewed as well as corresponding behavior documentation to ensure accuracy.	

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F 514	Continued From page 22 assessment reference date 12/9/2016, the resident scored 14/15 on the brief interview for mental status and was assessed to be without symptoms of delirium, psychosis, or behaviors affecting others. During clinical record review, the surveyor noted physician orders for antipsychotic medications Saphris Tablet Sublingual 10 mg give 1 tablet sublingually two times a day related to schizophrenia dated 10/26/2015 and Depakote tablet delayed release 250 mg give 1 tablet by mouth two times a day related to schizophrenia dated 10/30/2015. The medication administration record indicated the medications were administered as ordered December 2016 through the time of the survey on 2/14/17. Medication monitoring for antipsychotic medication side effects and for 'behaviors-monitor for the following: restlessness (agitation), hitting, increase in complaints, cursing, delusions, hallucinations, psychosis, aggression, refusing care, sexual ideation" dated 9/14/2016 and discontinued 1/18/17. No side effects or behaviors were documented from December 1 through 2/14/2017. New orders with the same wording, but with frequency PRN (as needed) instead of every shift were entered with start date 1/18/2017. No behaviors or side effects were documented on the MAR after 1/18/2017. Nurse's notes December 1 through February 14 do not document incidences of the resident exhibiting behaviors listed on the behavior monitoring list. There is a note dated 1/9/17 at 21:33 "30 Day Review: Resident alert, disoriented, to time and place, hollering at times for no reason. Fed meals, eats 100% most of the time. Inc. of bowel and bladder. Lungs clear. No	F 514	2. All residents on psychoactive medications are at risk. 3. SDC or designee will provide education to nursing staff on the importance of documentation that reflects current behaviors and on management of residents on psychoactive medications. 4. UM or designee will audit 5 residents weekly x 4 weeks then monthly x 3 months to ensure correct documentation of behaviors. 5. Date of compliance 2/28/17	

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medications change, no hospital visit." The surveyor was unable to locate documentation of hollering incidents or of interventions used to address them. The resident's comprehensive plan of care documents interventions to be used to address behaviors, including documenting those behaviors, and the interventions used, on the behavior sheets.

The psychiatric progress note dated 1/25/2017 documented that nurses notes and staff reports indicated the resident continues to have psychosis without increased psychotic agitations or acting on delusions. The symptoms reported to the physician by staff were not documented in the nurse's notes or behavior notes on the MAR,

The surveyors interviewed the director of nursing(DON) about behavior monitoring and symptom monitoring on 2/14/2017. The DON stated that the facility had changed documentation of behaviors to PRN in January for residents who were stable long-term on their psychotropic medications. She stated that all blanks under behavior monitoring indicated there had been continuous monitoring and that there would be a mark in the day's space on the MAR and an associated nurse's note. The surveyor observed that the 1/9/17 nursing 30 day summary and the 1/25/17 psychiatric physician progress notes both indicated that nurse's reported observed resident behaviors which were not documented on the MAR or nurse's notes.

The concerns were discussed with the administrator and director of nursing on 2/16/17 during the summary meeting.