STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E075	A. BUILDING _____ B. WING _____	C 09/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE TERRACE CONV HOME	PO BOX 558 WOODSTOCK, VA 22664

(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	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 9/6/17 through 9/7/17. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 70 certified bed facility was 68 at the time of the survey. The survey sample consisted of 13 current resident reviews (Residents 1 through 13) and two closed record reviews (Residents 14 through 15).

F 157 SS=D 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

F 157

1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?

The MD and RP for resident #1 was notified that the resident's blood pressure medication was held on 07/16/17 and 07/17/17.

09/15/17

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SEP 21 2017
VDH/OLC

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

Rebecca Kline, AIT / Deanne L. Craft, Administrator | 9/18/17

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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(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician and RP (responsible party) of a need to alter treatment for one of 15 residents in the survey sample, Resident #1.

The facility staff failed to notify Resident #1's physician and RP when the resident's blood pressure medication was held on 7/16/17 and 7/17/17.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?

DON or designee will audit the medical records of residents on blood pressure medications for the last 7 days to ensure that the MD and RP were notified if there was a need to hold blood pressure medications. 10/10/17

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?

DON or designee educated facility staff on notifying the MD and RP of any needs to hold a resident's blood pressure medication. 10/10/17

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F 157	Continued From page 2 The findings include: Resident #1 was admitted to the facility on 9/20/16. Resident #1's diagnoses included but were not limited to: Alzheimer's disease (1) and hypertension (high blood pressure). Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/19/17, coded the resident's cognitive skills for daily decision making as severely impaired. Review of Resident #1's clinical record revealed a physician's order dated 6/27/17 for metoprolol succinate (2) 100 milligrams- one tablet by mouth at bedtime. A nurse's note dated 7/16/17 documented metoprolol succinate was not given to Resident #1 due to a low blood pressure of 92/42. A nurse's note dated 7/17/17 documented metoprolol succinate was not given to Resident #1 due to a low blood pressure of 92/56. Further review of Resident #1's clinical record (including the above nurses' notes) failed to reveal Resident #1's physician and RP was made aware the medication was held. Resident #1's comprehensive care plan initiated on 9/20/16 documented, "(Name of Resident #1) has hypertension (HTN) AND IS TAKING HTN MEDICATIONS...Monitor/record use/side effects of medication. Report to MD (medical doctor) as necessary..." The nurse who documented the above notes was unavailable for interview. On 9/7/17 at 3:44 p.m. an interview was	F 157	**4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** DON or designee will audit the medical record of 5 residents 3x/week for 2 weeks to ensure that the MD and RP were notified of any needs to hold a resident's blood pressure medication. DON will report results to the QA committee. Findings and results will be reflected in the QA minutes	10/10/17 10/10/17

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conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what should be done if a resident's blood pressure is low and a blood pressure medication is due for administration to that resident. LPN #1 stated the medication should be held and the physician should be called. LPN #1 stated she also notifies the physician via fax and calls the resident's family. LPN #1 was asked if this information should be documented. LPN #1 stated she documents the medication was held, why the medication was held and physician/family notification in the nursing progress notes in the computer system.

On 9/7/17 at 4:45 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Physician and Responsible Party Notification" documented, "Purpose: To ensure changes in resident condition and medication changes are reported to the family and physician...Facility staff will notify physician of changes in condition or medication changes, administration or medication changes...Documentation shall be complete, legible and entered into the medical record in a timely manner..."

No further information was presented prior to exit.

(1) "Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=

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F 157	Continued From page 4 medlineplus-bundle&query=alzheimers+disease&_ga=2.139266234.802717078.1504827321-1391 20270.1477942321 (2) Metoprolol succinate is used to treat high blood pressure. This information was obtained from the website: http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/PreventionTreatmentofHighBloodPressure/Types-of-Blood-Pressure-Medications_UCM_303247_Article.jsp#.WbHYnNKotKY	F 157		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (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	F 279	**1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** The comprehensive care plan for resident #8 reflects the resident's need for hydration/fluid maintenance. The comprehensive care plan for resident # 13 reflects the resident's psychosocial wellbeing and mood. The comprehensive care plan for resident #5 includes falls.	09/11/17 09/11/17 09/08/17

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physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan for three of 15 residents in the survey

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?

DON or designee will audit resident's medical records to ensure the comprehensive care plans reflect resident's dehydration/fluid maintenance, psychosocial wellbeing, mood and fall needs. — 10/10/17

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?

DON or designee educated MDS Coordinator, ADON and Unit Manager that the comprehensive care plans must reflect dehydration/fluid maintenance, psychosocial wellbeing, mood and fall needs for residents. — 10/10/17

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sample, Residents #8, #13 and #5.

1. The facility staff failed to develop a comprehensive care plan for the triggered care area of dehydration/fluid maintenance in section V CAA (care area assessment) of Resident #8's annual assessment with an ARD (assessment reference date) of 11/20/16.

2. The facility staff failed to develop a comprehensive care plan for the triggered care areas of psychosocial wellbeing and mood on Resident #13's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/23/17.

3. The facility staff failed to develop a comprehensive care plan for the triggered care area of falls on Resident #5's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/9/17.

The findings include:

1. The facility staff failed to develop a comprehensive care plan for the triggered care area of dehydration/fluid maintenance in section V CAA (care area assessment) of Resident #8's annual assessment with an ARD (assessment reference date) of 11/20/16.

Resident #8 was admitted to the facility on 8/14/03. Resident #8's diagnoses included but were not limited to: seizures and urinary tract infection. Resident #8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/24/17, coded the resident's cognition as moderately impaired.

4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?

DON or designee will audit the comprehensive care plan of 5 residents 3x/week for 2 weeks to ensure that the reflect dehydration/fluid maintenance, psychosocial wellbeing, mood and fall needs for residents are on the care plan. — 10/10/17

DON will report results to the QA committee. Findings and results will be reflected in the QA minutes. — 10/10/17

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Resident #8's most recent comprehensive MDS was an annual assessment with an ARD of 11/20/16. Section V CAA (care area assessment) documented an "X" beside the care area of dehydration/fluid maintenance and documented the area would be care planned.

Resident #8's comprehensive care plan revised on 8/3/17 failed to document information regarding dehydration/fluid maintenance.

On 9/7/17 at 1:44 p.m. an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated CAAs are developed on admission, significant change and annual MDS assessments. RN #1 stated the computer system generates the care areas that trigger on the CAAs and then she makes sure the areas are documented on the care plan. RN #1 was asked to identify the dehydration/fluid maintenance area on Resident #8's care plan. On 9/7/17 at 2:27 p.m. RN #1 confirmed the care area of dehydration/fluid maintenance was not documented on Resident #8's care plan. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (resident assessment instrument) manual when developing care plans based on the CAAs on the MDS assessments.

On 9/7/17 at 4:45 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Care Plan Policy" documented, "Procedure: Care plans will be initiated at the time of admission. Care plans will

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reflect areas identified on the CAA..."

The CMS RAI manual documented the following: "Coding Instructions for V0200A, CAAs
·Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.
·For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed."

No further information was presented prior to exit.

2. The facility staff failed to develop a comprehensive care plan for the triggered care areas of psychosocial well-being and mood on Resident #13's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/23/17.

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Resident #13 was admitted to the facility on 3/1/16 with diagnoses that included, but were not limited to; anxiety, urinary tract infection, high levels of lipids in the blood stream, dementia and psychotic disorder.

Resident #13's most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 4/23/17 revealed, in part, that Resident #13 scored an eight out of a possible 15 on her BIMS (brief interview of mental status), indicating that Resident #13 is cognitively moderately impaired to make daily decisions.

Further review of Resident #13's annual MDS assessment with an ARD of 4/23/17, revealed in Section V - Care Area Assessment (CAA) that "07. Mood State and 08. Psychosocial Well-Being" were checked as triggered care areas under column "A" and also checked under column "B. Care Planning Decision." The instruction provided in Section V states, "2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. Check column B if the triggered care area is addressed in the care plan."

A review of Resident #13's comprehensive care plan, dated 7/29/13, did not reveal any documentation regarding mood or psychosocial well-being.

On 9/6/17 at 1:45 p.m. an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 was asked to describe her process for developing a care plan from the

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CAAs. RN #1 stated, "I do an assessment (of the resident). The CAAs are developed with admission assessments, significant change assessments and annual assessments. The computer generates the triggered areas and I care plan whatever is triggered plus more."

On 9/7/17 at 2:27 p.m. RN #1 was asked to provide evidence that a care plan was developed in the areas of psychosocial well-being and mood for Resident #13.

On 9/7/17 at 4:45 p.m. a meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concern at this time. A copy of the policy regarding care plan development was requested at this time.

On 9/7/17 at 4:08 p.m. RN #1 stated that she was unable to locate any evidence that psychosocial well-being and mood were care planned for Resident #1.

No further information was provided prior to the end of the survey process.

3. The facility staff failed to develop a comprehensive care plan for the triggered care area of falls on Resident #5's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/9/17.

Resident #5 was admitted to the facility on 1/30/17 with diagnoses that included, but were not limited to; dementia, high blood pressure, anxiety, cancer, depression and Parkinson's

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disease, a movement disorder.

Resident #5's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/9/17 revealed, in part, that Resident #5 scored a 15 out of a possible 15 on her BIMS (brief interview of mental status), indicating that Resident #5 is cognitively moderately impaired to make daily decisions.

Further review of Resident #5's admission MDS assessment with an ARD of 2/9/17 revealed in Section V - Care Area Assessment (CAA) that "11. Falls" was checked as a triggered care area under column "A" and also checked under column "B. Care Planning Decision." The instruction provided in Section V states, "2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. Check column B if the triggered care area is addressed in the care plan."

A review of Resident #5's comprehensive care plan, dated 1/30/17, did not reveal any documentation regarding falls.

On 9/6/17 at 1:45 p.m. an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 was asked to describe her process for developing a care plan from the CAAs. RN #1 stated, "I do an assessment (of the resident). The CAAs are developed with admission assessments, significant change assessments and annual assessments. The computer generates the triggered areas and I care plan whatever is triggered plus more." RN

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F 279	Continued From page 12 #1 was asked at this time to provide evidence that a care plan was developed in the area of falls for Resident #5. On 9/7/17 at 2:27 p.m. RN #1 stated that she had not completed a falls care plan for Resident #5. When asked what she used as a reference when completing care plans, RN #1 stated that she used the RAI (resident assessment instrument) manual. On 9/7/17 at 4:45 p.m. a meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concern at this time. A copy of the policy regarding care plan development was requested at this time. No further information was provided prior to the end of the survey process.	F 279		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 514	**1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** The non-pharmacological interventions that were attempted prior to administering anxiety medication to resident #7 was documented.	10/10/17

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F 514	Continued From page 13 (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, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of 15 residents in the survey sample, Residents #7 and #5. 1. The facility staff failed to document non-pharmacological interventions that were attempted with Resident #7 prior to the administration of as needed anxiety medication multiple times in August 2017 and September 2017. 2. The facility staff failed to document non-pharmacological interventions prior to administering an anxiolytic (anti-anxiety) medication, Xanax [1], to Resident #5.	F 514	The non-pharmacological interventions that were attempted prior to administering anxiety medication to resident #5 was documented. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON or designee will audit the medical record of residents receiving PRN antianxiety medications for the last 7 days to ensure that non-pharmacological interventions were attempted prior to administering antianxiety medications.	10/10/17 10/10/17

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The findings include:

1. The facility staff failed to document non-pharmacological interventions that were attempted with Resident #7 prior to the administration of as needed anxiety medication multiple times in August 2017 and September 2017.

Resident #7 was admitted to the facility on 6/14/17. Resident #7's diagnoses included but were not limited to: urinary retention, high blood pressure and osteoporosis. Resident #7's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/21/17, coded the resident's cognitive skills for daily decision making as severely impaired. Section N documented Resident #7 received anxiety medication two out of seven days during the look back period.

Review of Resident #7's clinical record revealed a physician's order dated 6/26/17 for Ativan (1) 0.5 milligrams- one tablet by mouth every 12 hours as needed for anxiety. Review of Resident #7's August 2017 and September 2017 MARs (medication administration records) revealed the resident was administered as needed Ativan seven times in August 2017 and twice in September 2017. Further review of Resident #7's clinical record (including the MARs and nurses' notes) failed to reveal documentation that staff attempted non-pharmacological interventions prior to administering as needed Ativan to Resident #7 all seven times in August 2017 and both times in September 2017.

Resident #7's comprehensive care plan initiated on 6/14/17 failed to document information

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?

DON or designee educated facility staff on documenting non-pharmacological interventions prior to the administration of PRN antianxiety medications. — 10/10/17

4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?

DON or designee will audit the medical record of 5 residents with orders for PRN antianxiety medications 3x/week for 2 weeks to ensure non-pharmacological interventions were attempted and documented prior to the administration of PRN antianxiety medications. — 10/10/17

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regarding non-pharmacological interventions prior to the administration of as needed Ativan.

On 9/7/17 at 3:39 p.m. an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated she tries different interventions (such as changing the environment, food or offering a warm blanket) to lower residents' anxiety prior to administering as needed anxiety medication. When asked if she documents the non-pharmacological interventions that she attempts, LPN #3 stated, "I try to. I'm not saying 100 percent but I do try." LPN #3 was made aware that according to Resident #7's MAR, she (LPN #3) administered as needed Ativan to the resident on some days in August 2017 but there was no documentation of any non-pharmacological interventions that were attempted. LPN #3 stated she attempted non-pharmacological interventions but must not have documented them. LPN #3 stated the facility was utilizing a new computer system and she was trying to get used to the system.

On 9/7/17 at 4:45 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Psychoactive Medication Policy" documented, "Procedure: Residents will receive psychoactive medications, as ordered, when necessary to treat conditions or diagnosis...Non-pharmacological interventions will be offered and documented as indicated..."

No further information was presented prior to exit.

(1) Ativan is used to treat anxiety. This

DON will report results to the QA committee. Findings and results will be reflected in the QA minutes. 10/10/17

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information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html

2. The facility staff failed to document non-pharmacological interventions prior to administering an anxiolytic (anti-anxiety) medication, Xanax [1], to Resident #5.

Resident #5 was admitted to the facility on 1/30/17 with diagnoses that included, but were not limited to; dementia, high blood pressure, anxiety, cancer, depression and Parkinson's disease, a movement disorder.

Resident #5's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/9/17 revealed, Resident #5 scored a 15 out of a possible 15 on her BIMS (brief interview of mental status), indicating that Resident #5 is cognitively moderately impaired to make daily decisions.

A review of Resident #5's physician orders dated August 1, 2017 revealed, in part, the following order; "Xanax Tablet 0.25 MG (milligrams). Give 1 tablet by mouth every 12 hours as needed for anxiety. Start Date 6/1/17."

A review of Resident #5's MAR (medication administration record) dated 8/1/17 - 8/31/17 revealed that on the following dates she was administered Xanax and there was no documentation of any non-pharmacological interventions prior to administration; 8/8/17, 8/9/17, 8/19/17, 8/21/17 and 8/23/17.

A review of Resident #5's nursing progress notes did not reveal any documentation of

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non-pharmacological interventions attempted prior to administration of Xanax to Resident #5.

A review of Resident #5's comprehensive care plan dated 1/30/2017 revealed, in part, the following documentation; "(Name of Resident #5) uses anti-anxiety medications r/t (related to) Anxiety disorder. Date Initiated: 1/30/2017. Interventions: Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q (every) -SHIFT. Date Initiated: 1/30/2017."

On 9/7/17 at 9:27 a.m. an interview was conducted with LPN (licensed practical nurse) #4, a floor nurse. LPN #4 was asked to describe her process prior to administering an anxiolytic medication to a resident. LPN #4 stated, "I try to calm them down, if they are in a crowded area I remove them to a quiet area. I give them a warm blanket, if nothing works (helps reduce anxiety) I then administer the medication." When asked where the interventions attempted would be documented, LPN #4 stated, "There is a section in the computer for non-pharmacological interventions, we chart prior to the administration and then go back after about an hour to document the effectiveness (of the medication)." At this time LPN #4 reviewed the entries for 8/8/17, 8/9/17, 8/19/17, 8/21/17 and 8/23/17. LPN #4 confirmed that non-pharmacological medications were not documented. LPN #4 further stated, "A lot of times she (Resident #5) is on her way out with family/friend and she comes up to the desk and asks for her anti-anxiety medication." LPN #4 was asked whether or not the nurse should document the situation. LPN #4 stated, "Yes."

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On 9/7/17 at 9:55 a.m. an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to describe her process prior to administering an anxiolytic to a resident. RN #2 stated, "I check the behaviors, potential for side effects, and help the resident with non-pharmacological interventions." When asked where the non-pharmacological interventions would be documented, RN #2 stated, "In the progress notes." RN #2 was asked to review her documentation completed on 8/21/17 and 8/23/16 for administration of Xanax to Resident #5. RN #2 was asked if she conducted non-pharmacological interventions on those two dates. RN #2 stated that she did. When asked what interventions she had attempted, RN #2 stated, I tried distraction. RN #2 further stated, "I should have documented what I had done, but I didn't."

On 9/7/17 at 11:04 a.m. an interview was conducted with LPN #5, a floor nurse. LPN #5 was asked to describe her process prior to administering an anxiolytic to a resident. LPN #5 stated, "I try non-pharmacological interventions. It really depends what the medication is used for. I offer something to make the resident more comfortable, find out the cause of their anxiety and try to take their mind off of the issue with an activity, some exercise or to visit other residents." When asked where she would document the non-pharmacological interventions, LPN #5 stated, "In the progress notes, I document the type of things offered prior to administering the medication. If they don't want to do anything and just want the medication I do try to document it, though it (documentation) doesn't always happen." LPN #5 was asked to review her documentation completed on 8/9/17. LPN #5

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stated, "It does not appear that I tried non-pharmacological interventions (per the documentation) but I did offer interventions. I think I was trying to indicate that when I wrote, "Hasn't been able to stop feeling anxious." I did not provide the information though as to what I actually did."

A meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, on 9/7/17 at 4:45 p.m.. ASM #1 and ASM #2 were made aware of the above concern and a policy regarding the administration of an anxiolytic and non-pharmacological interventions and maintaining a complete and accurate record was requested at this time.

A policy was not provided specific to the documentation of non-pharmacological interventions. The facility policy titled "Documentation" revealed, in part, the following documentation; "Purpose: To ensure the facility's resident's medical record reflects documentation of pertinent facts, findings and observations about residents. Procedure: Documentation will include, but is not limited to active and relevant resident information, assessments, flowsheets, notes, diagnostic results, plans of care...."

[1] This information was obtained from the following website;
http://www.rxlist.com/xanax-drug.htm

No further information was provided prior to the end of the survey process.