

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151 | (X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 08/14/2012 |
| NAME OF PROVIDER OR SUPPLIER CASHMERE CONVALESCENT CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 817 PIONEER AVENUE CASHMERE, WA 98815 | |
| (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 | <p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Cashmere Convalescent on 8/14/12. A sample of 4 residents was selected from a census of 68. The sample included 4 current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#12-08-23782</p> <p>The survey was conducted by:</p> <p>Priscilla Becker, R.N.</p> <p>The survey team was from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>Received Yakima RCS SEP 6 2012</i></p> <p><i>Robert Gutierrez 8/27/12</i></p> <p>Residential Care Services Date 483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS</p> <p>The resident has the right to be free from any chemical restraints imposed for purposes of</p> | F 000 | <p>PLAN OF CORRECTION FOR SURVEY ENDING 8/14/12 (REC'D 8/31/12) THE FOLLOWING DEFICIENCIES IN:</p> <p><u>F-222 RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS-SS-G</u></p> <p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT;</p> <p>The facility protocol for aggressive/assaultive behaviors has been amended to remove the ability for LN's to administer any type of medication.</p> <p>Resident #1 was admitted to the nursing home on [redacted] 12 with a diagnosis of dementia without behavioral disturbance (ICD9 294.20). An additional diagnosis of dementia with [redacted] was given by the physician after [redacted] causing the behavioral events of 6/17/12 and 7/5/12, but not until 7/10/12.</p> <p>[redacted] 8/1/12 after a third elopement attempt. She was subsequently seen by a mental health practitioner in the community on 8/7/12 and at this time multiple mental health diagnosis were added. She is currently taking routine medication to treatment these. She is</p> |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> | | TITLE <i>[Signature]</i> | (X6) DATE 9-6-12 |

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 222 | <p>Continued From page 1</p> <p>discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 2 sampled residents (#1 & #4) in the sample were free from chemical restraints. For both residents, a facility generated protocol was implemented causing the cognitively impaired residents to experience psychosocial harm as a result of being restrained and given injected medication against their wills and under physical protest. Findings include but were not limited to:</p> <p>Resident #1: Review of the medical record revealed the resident was admitted to the facility on 6/05/12 with multiple mental health diagnoses including [REDACTED] (characterized by an [REDACTED] activity level). Additionally, the resident had a diagnosis of dementia with [REDACTED]</p> <p>According to the resident's plan of care she had communication impairment, walked independently, and demonstrated problematic behaviors such as striking out at others, verbal abuse, elopement, and resistance to care. According to the June 2012 Medication/Treatment Record, a wanderguard was placed on 6/06/12 to alert staff if the resident attempted to exit the building. The admission physician's orders did not include any psychoactive medications to treat her mental</p> | F 222 | <p>and will continue to be monitored for benefits and extrapyramidal symptoms or other side effects of her psychotropic medication. Gradual dose reductions will be attempted per review on a regular basis. She will continue to be seen by a behavioral health specialist as needed.</p> <p>She does not currently have a physician order to give any as needed psychotropic medications.</p> <p>She has not exhibited any signs of distress or fear nor made any comments that would reflect that she has experienced any psychosocial harm as a result of her treatment at the time of either incident or since that time.</p> <p>Changes have been made to her care plan with each [REDACTED] episode after assessment of behaviors and any changes to her medication regime.</p> <p>Residents #2 and #3 were not affected by the deficiency.</p> <p>Resident #4 has a diagnosis of epilepsy which often presents in very different ways. Over time and with continued assessment nursing staff has been able to recognize that one of her "behaviors" is actually a prodromal to seizure activity. She has been and continues to be treated</p> | |

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F 222 Continued From page 2 health conditions.

A 6/17/12 nursing entry, by Staff Member A, documented that at 2:40 a.m. the Licensed Nurse (LN) was summoned by the Nursing Assistants because the resident was attempting to exit the facility doorway. The resident stated 'God told me to leave now.' The resident then began to wander throughout the facility, in and out of other residents' rooms, looking for an open window. The LN contacted the resident's family member and allowed him to talk with her but she only repeated to him that 'God said it was time to leave this place.' Thereafter, the LN talked with the family member and discussed possible options to handle her behavior including giving IM (an injection into the muscle) of [REDACTED] (an anti-psychotic medication) per their Aggressive Behavior Protocol to "help calm resident." It was documented that the family member was in agreement to use [REDACTED] if necessary. The resident continued to wander in and out of others' rooms shouting, 'You're wrong. Someone higher told me to leave.' The resident attempted to strike out at staff members if they attempted to get close to her. At 3:00 a.m. on 6/17/12 (20 minutes after the LN responded to the resident's elopement attempt) [REDACTED] 1 milligram (mg) was injected into the resident's right buttock per the the "facility Aggressive/Assaultive Behaviors Emergency Protocol" as 3 NAs attempted to hold her. "She was swinging and hitting all staff members." The LN notified the family member at 3:20 a.m.

A follow-up nursing entry on 6/17/12 5:49 a.m. documented the resident continued to state that staff were wrong and that a higher power was

F 222 with a routine anticonvulsant medication. Her blood level remains in the low therapeutic range and her physician does not wish to make changes at this time. She currently has a physician order for an as needed medication for treatment of acute seizure activity. Staff will continue to monitor for prodromal or actual seizure activity and notify the physician as needed.

She does not currently have a physician order for any as needed psychotropic medications.

She has not exhibited any signs of distress or fear nor made any comments that would reflect that she has experienced any psychosocial harm as a result of her treatment at the time of either incident or since that time.

The following intervention was added to her care plan; if I am flailing my arms, grabbing at the air or people with a wild scared look I may be getting ready to have a seizure. Take me to a dark quiet area, notify the licensed nurse and follow seizure precautions.

HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS;

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| F 222 | <p>Continued From page 3</p> <p>telling her to leave. The resident was sitting on the floor next to the door. [REDACTED] effective to some extent." The nursing entry also documented that a fax was sent to the physician about the use of the emergency protocol (rather than notifying the physician about the resident's escalated behaviors to seek a resident specific physician directive.</p> <p>Review of the facility's "Aggressive/Assaultive Behaviors Emergency Protocol For All Physicians" revealed that it was the policy of the facility to provide an environment where "the residents are free from abuse." The procedure outlined steps to be taken when the resident became physically aggressive and/or threatening, "our primary concern must be the safety of other residents and staff. If the behaviors and/or threats were determined to actually jeopardize the safety of others (residents or staff)," the protocol would be implemented. Staff were to remove the aggressor or remove other residents in the area. Additional staff were to be called as needed. There was a directive to physically restrain the aggressor only if necessary. If further intervention was needed "to control behavior. [REDACTED] 0.5 mg to 1 mg IM" could be given one time. No oral route was available in the protocol. "The resident will be observed and monitored for possible side effects and for response to the effectiveness of this chemical restraint." Interventions such as calling: the Physician, Mental Health Crisis Line, or the Police, the on-call Administrative LN, and/or the Social Service Director were listed after the directive to give the [REDACTED] IM (with a dose range requiring discretion by the LN).</p> | F 222 | <p>The facility protocol for aggressive/assaultive behaviors has been amended to remove the ability for the LN's to administer any type of medication. All incidents involving aggressive/assaultive residents will be managed on an individual basis and licensed staff will seek appropriate interventions from physicians as needed as each event unfolds. A nursing department meeting is scheduled for 9/06/12 to inform all nursing staff of changes to the protocol. A letter will be sent to all physicians who provide care for our residents to inform them that we will no longer be able to administer medications in an emergency situation without calling them or the on-call physician first because of the changes made in the protocol.</p> <p>MEASURES THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR;</p> <p>The facility protocol for aggressive/assaultive behaviors has been amended to remove the ability for LN's to administer any type of medication. The nursing home will provide on-going in-services to educate staff on appropriate use of psychotropic medications, non-</p> | |

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| F 222 | <p>Continued From page 4</p> <p>Review of [REDACTED] side effects, outlined on the internet medication reference site rxlist.com, noted serious potential side effects including but not limited to: restless muscle movements, tremors, seizures, and stiffness. Additionally, elderly patients with dementia-related psychosis treated with anti-psychotic drugs are at an increased risk of death.</p> <p>According to Resident #1's 7/05/12 nursing entry, by Staff Member B, at approximately 3:30 a.m. the resident was rattling an exit door and then going door to door. When staff attempted to approach her she swung her purse at them. The resident then attempted to exit through an open window but two staff members assisted her. The resident chanted that God had told her to leave. The resident was very angry and was physically assaultive toward staff. While staff restrained the resident, she was given [REDACTED] mg IM. "She was even more angry at this point." The resident's family member was called and he "gave permission to do whatever it took to help her through this." A Physician was called and there was an order for an extra [REDACTED] mg IM dose. "We were just unable to safely restrain her to safely to administer 2nd [REDACTED] dose. 911 called for additional "manpower". The Police Officer arrived and with the help of staff, "the officer was able to restrain her and lower her safely on her stomach onto the mattress" placed next to her wheelchair. The additional [REDACTED] mg IM was then administered. "Assaultive behavior event diffused safely using the Aggressive/Assaultive Emergency Protocol. Plan: Keep safe during effects of [REDACTED]"</p> <p>Staff Member B was interviewed on 8/15/12 at</p> | F 222 | <p>pharmaceutical interventions for aggressive, difficult and or dangerous behaviors and gentle care techniques to avoid catastrophic reactions by residents with dementia and/or psychosis diagnosis.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED;</p> <p>The facility continues to work toward a psychotropic free environment using gradual dose reductions per recommended physician guidelines. Psychotropic drug reviews are & will continue to be done quarterly and as needed. This process reviews all routine and as needed use of psychotropic medications, medical diagnosis, targeted behavioral symptoms and care plan interventions.</p> <p>DATE WHEN CORRECTIVE ACTIONS WILL BE COMPOLETE;</p> <p>9/07/12</p> <p>TITLE OF THE PERSON RESPONSIBLE TO ENUSRE CORRECTION</p> <p>Director of Nursing Services</p> | |

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| F 222 | <p>Continued From page 5</p> <p>approximately 1:21 p.m. and reviewed the details of the 7/05/12 occurrence with Resident #1 as outlined above. Staff Member B recalled the [REDACTED] injection was administered in the hallway, "She was scared. We just had to help her." The resident was resisting/fighting the injection. During the second injection, the resident continued to fight the injection but the Officer was able to divert the resident's attention.</p> <p>Resident #4: Review of the medical record revealed the resident had multiple diagnoses including epilepsy, dementia with [REDACTED] anxiety state, and [REDACTED] disorder with [REDACTED] behavior. According to the resident's plan of care, she wandered throughout the facility in her wheelchair and would exit seek. She required staff assistance for safe transfers and ambulation. The resident had difficulty with communication due to her cognitive impairment. The resident's problematic behaviors included combativeness and resistance to care and verbally abusive behaviors.</p> <p>Review of the nursing entries noted the resident received [REDACTED] 1 mg on 6/06/12 after the Nurse Practitioner (ARNP) was contacted and she ordered the use of the protocol related to the resident's aggressive behaviors toward staff. In addition, the ARNP ordered [REDACTED] (an anti-anxiety medications) 0.5 mg orally as needed every 6 hours for anxiety/agitation.</p> <p>A 6/07/12 nursing entry documented the resident had one-on-one supervision between 2:00 p.m. and 5:30 p.m. The resident was repeatedly attempting to walk without assistance. When staff tried to assist her she became aggressive</p> | F 222 | | |
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| F 222 | <p>Continued From page 6</p> <p>toward staff. The resident resisted non-medical interventions. Per directive of the Director of Nursing (DNS) the house protocol was implemented with the administration of [REDACTED] 1 mg IM at 5:30 p.m. The physician and family member were notified after administration. On 8/14/12 at approximately 5:15 p.m., the DNS recalled the resident was physically resisting during the injection by Staff Member C.</p> <p>The 8/10/12 nursing entry by Staff Member C documented the LN was called by the NAs at 6:45 p.m. as the resident was attempting to hit and bite staff as they attempted to assist the resident to ensure her safety. The resident was attempting to exit her wheelchair and her gait was unsteady. She was refusing oral medication. "Per protocol 1 mg of [REDACTED] given at 7:15 p.m. IM. (1/2 hour following the LN contact). Resident will be monitored closely." The entry also recorded the plan to notify the resident's power of attorney following administration. At 7:30 p.m. on 8/10/12 the resident was observed to have what appeared to be "a seizure" lasting 45 seconds.</p> <p>When interviewed on 7/14/12 at approximately 5:30 p.m., Staff Member C stated the cognitively impaired resident was fighting and combative during the injection. The Staff Member notified the physician after administration of the medication. After the injection the resident experienced seizure activity.</p> <p>Further review of the nursing entries between 6/06/12 through 8/10/12 did not evidence any other documented seizure activity.</p> <p>On 8/24/12 at approximately 1:35 p.m. Staff</p> | F 222 | | |
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| F 222 | Continued From page 7 Member D, a LN, stated she recalled Resident #4 had experienced seizure activity 2-3 times since placement (on 4/30/12). | F 222 | <u>F-281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS-SS-E</u> | | |
| F 281 SS=E | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure professional standards were maintained by 4 of 4 sampled Licensed Nurses (Staff Members A, B, C & the Director of Nursing/DNS) related to administration or directing staff administration of anti-psychotic medication contained on a protocol for 2 of 2 sampled residents (#1 & #4). Administering medication from a protocol not signed by the physician placed the residents at potential risk of adverse medication effects. Additionally, the residents were administered the medication despite their physically resistive behaviors, their sign of resisting treatment. Findings include: When interviewed on 8/14/12 at approximately 5:20 p.m., the facility Administrator and Director of Nursing were unable to recall the actual etiology of the Aggressive/Assaultive Behaviors Emergency Protocol. The Administrator questioned whether the previous DNS might have initiated the policy. Additionally, facility staff were unable to locate a copy signed by the Medical Director or the residents' Physician. Review of the facility's "Aggressive/Assaultive | F 281 | HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT; The facility protocol for aggressive/assaultive behavior has been amended to remove the ability for LN's to administer any type of medication. The resistive/combative behaviors exhibited by Resident #1 were assessed as putting her at significant risk for injury d/t her psychotic episode rather than resistance to treatment as she was unaware of and unable to comprehend that nursing staff was attempting to treat her. She resisted all attempts to keep her safe during these episodes & continued to escalate in her combative and unsafe behavior but at no time expressed fear of staff or of treatment being offered. Treatment was administered with full confidence that the physicians agreed with and had signed the protocol despite not being able to locate signed documents while the complaint surveyor was in the building. | | |

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| F 281 | <p>Continued From page 8</p> <p>Behaviors Emergency Protocol For All Physicians," revised on 7/30/12, revealed that it was the policy of the facility to provide an environment where "the residents are free from abuse." The procedure outlined steps to be taken when the resident became physically aggressive and/or threatening, "our primary concern must be the safety of other residents and staff. If the behaviors and/or threats were determined to actually jeopardize the safety of others (residents or staff)," the protocol would be implemented. Staff were to remove the aggressor or remove other residents in the area. Additional staff were to be called as needed. There was a directive to physically restrain the aggressor only if necessary. If further intervention was needed "to control behavior... 0.5 mg to 1 mg IM (injected into the muscle)" could be given one time. "The resident will be observed and monitored for possible side effects and for response to the effectiveness of this chemical restraint." Interventions such as calling: the physician, Mental Health Crisis Line, or the Police, the on-call Administrative LN, and/or the Social Service Director were listed after the directive to give the IM (with a dose range requiring discretion by the LN).</p> <p>Review of side effects documented on the internet medication reference site, rxlist.com, noted serious potential side effects including but not limited to: restless muscle movements, tremors, seizures, and stiffness. Additionally, elderly patients with dementia-related psychosis treated with anti-psychotic drugs were at an increased risk of death. There was a caution in using the medication in the elderly and residents</p> | F 281 | <p>Resident #1 has not exhibited any signs of distress or fear nor made any comments that would reflect that she has experienced any psychosocial harm as a result of her treatment at the time of either incident or since that time.</p> <p>Residents #2 and #3 were not affected by this deficiency.</p> <p>Likewise, the behaviors exhibited by Resident #4 were assessed as putting her at significant risk for injury rather than resistance to treatment as she was completely unaware of and unable to comprehend that nursing staff was attempting to treat her during her episodes. She remained unaware of treatment even as the injections were given because she was so focused on her own combative efforts. Again treatment was provided with full confidence of physician approval as reinforced by the order received on 6/06/12 by the ARNP to "use the protocol" related to the residents aggressive behaviors.</p> <p>Resident #4 has not exhibited any signs of distress or fear nor made any comments that would reflect that she has experienced any psychosocial harm as a result of her treatment at the time of either incident or since that time.</p> | |
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F 281

Continued From page 9 with seizure disorders.

Resident #1: Review of the medical record revealed the resident was admitted to the facility on [REDACTED]/12 with multiple mental health diagnoses including [REDACTED] based), and [REDACTED] characterized by an [REDACTED]. Additionally, the resident had a diagnosis of dementia with [REDACTED].

According to the resident's plan of care she had communication impairment, walked independently, and demonstrated problematic behaviors such as striking out at others, verbal abuse, elopement, and resistance to care. The admission physician's orders did not include any psychoactive medications, including any anti-psychotic medication to treat her mental health conditions.

According to nursing entries on 6/17/12 and on 7/05/12 the resident was administered [REDACTED] injections at night (by Staff Members A & B) when the resident demonstrated elopement attempts based on a belief that God had told her to leave. In response to the challenging behavioral escalations, rather than as a result of comprehensive assessments and a plan to treat the resident's condition, facility staff made a decision to implement a policy without physician direction/review of suitability for the resident. The medication was administered for the desired effect of calming the resident, a side effect rather than a medical treatment such as giving the medication routinely to address psychotic symptoms. See F222 for additional details

F 281

HOW THE NURSING HOME WILL PROTECT RESIDENTS IN SIMILIAR SITUATIONS;

The facility protocol for aggressive/assaultive behavior has been amended to remove the ability for LN's to administer any type of medication. All incidents involving aggressive/assaultive residents will be managed on an individual basis and licensed staff will seek appropriate interventions from physicians as needed as each event unfolds. A nursing department meeting is scheduled for 9/06/12 to inform all nursing staff of changes to the protocol. A letter will be sent to all physicians who provide care for our residents to inform them that we will no longer be able to administer medications in an emergency situation without calling them or the on-call physician first because of the changes made in the protocol.

MEASURES THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR;

The facility protocol for aggressive/assaultive behavior has been amended to remove the ability for LN's to administer any type of medication. The

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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|--------------------|--|---------------|---|----------------------|
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F 281 Continued From page 10 including interview data.

Resident #4: Review of the medical record revealed the resident had multiple diagnoses including epilepsy (a seizure disorder), dementia with [REDACTED] anxiety state, and [REDACTED] with [REDACTED] behavior. According to the resident's plan of care, she wandered throughout the facility in her wheelchair and would exit seek. She required staff assistance for safe transfers and ambulation. The resident had difficulty with communication due to her cognitive impairment. The resident's problematic behaviors included combativeness and resistance to care and verbally abusive behaviors.

Despite the resident's seizure history and the caution for use in such residents, nursing entries on 6/07/12 and on 8/10/12 noted the use of [REDACTED] 1 mg IM administered by Staff Member C under the direction of the DNS on 6/07/12 and later at his own discretion on 8/10/12. The physician and family member were notified after administration. Seizure activity was observed shortly after administration of the [REDACTED] on 8/10/12. See F222 for additional details and interview data.

Instead of contacting the resident's physician or other staff when there was a significant behavioral escalation, to assist in ascertaining possible underlying causes or identifying other potential interventions, staff utilized a protocol whereby they could use the [REDACTED] IM first and then notify the physician and family member later. The protocol allowed for staff discretion to vary the one time [REDACTED] IM dose between 0.5 mg to 1

F 281 nursing home will provide on-going in-services to educate staff on appropriate use of psychotropic medications, non-pharmaceutical interventions for aggressive, difficult and or dangerous behaviors and gentle care techniques to avoid catastrophic reactions by residents with dementia and/or psychosis diagnosis.

HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED;

The facility continues to work toward a psychotropic free environment using gradual dose reductions per recommended physician guidelines. Psychotropic drug reviews are & will continue to be done quarterly and as needed. This process reviews all routine and as needed use of psychotropic medications, medical diagnosis, targeted behavioral symptoms and care plan interventions.

DATE WHEN CORRECTIVE ACTIONS WILL BE COMPLETE;

9/07/12

TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION

Director of Nursing Services

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| F 281 | <p>Continued From page 11</p> <p>mg. The protocol provided by the facility did not contain the signature of the Medical Director or the Physician of Residents #1 and #4. Additionally, the LNs failed to allow the resident to refuse the medication/treatment in accordance with their resident rights. Staff failed to recognize physical resistance to the injection procedure by both residents as their refusal of treatment.</p> <p>When interviewed on 8/14/12 at approximately 5:20 p.m., the facility Administrator and Director of Nursing were unable to recall the etiology of the Aggressive/Assaultive Behaviors Emergency Protocol. Facility Administrative Staff were unable to locate a copy signed by the Medical Director or the residents' Physician.</p> | F 281 | <p><u>F-329- DRUG REGIME IS FREE FROM UNNECESSARY DRUGS-SS-D</u></p> <p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT;</p> <p>The facility protocol for aggressive/assaultive behaviors has been amended to remove the ability for LN's to administer any type of medication.</p> <p>Resident #1 is being seen by a mental health practitioner in the community for her multiple mental health diagnosis. She is currently taking routine medication to treatment these. She is and will continue to be monitored for benefits and extrapyramidal symptoms or other side effects of her psychotropic medication. Gradual dose reductions will be attempted per review on a regular basis. She will continue to be seen by a behavioral health specialist as needed.</p> <p>She does not currently have a physician order to give any as needed psychotropic medications.</p> <p>Residents #2 and #3 were not affected by this deficiency.</p> <p>Resident #4 has a diagnosis of epilepsy which often presents in very different</p> | |
| F 329 SS=D | <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from 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.</p> <p>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</p> | F 329 | | |

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| F 329 | <p>Continued From page 12 contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 2 sampled residents (#1 & #4) who received injectable [REDACTED] an anti-psychotic medication, received the medication with adequate indication for its use per 42 CFR 483.25(l)(1) (iv) and to treat a specific diagnosed condition after a comprehensive assessment of the resident per 42 CFR 483.25(l) (2)(i). Failure to have sufficient indication for use placed the residents at potential risk for medication associated side effects. Findings include:</p> <p>Review of the facility's "Aggressive/Assaultive Behaviors Emergency Protocol For All Physicians," revised on 7/30/12, revealed that it was the policy of the facility to provide an environment where "the residents are free from abuse." The procedure outlined steps to be taken when the resident became physically aggressive and/or threatening, "our primary concern must be the safety of other residents and staff. If the behaviors and/or threats were determined to actually jeopardize the safety of others (residents or staff)," the protocol would be implemented. Staff were to remove the aggressor or remove other residents in the area. Additional staff were to be called as needed. There was a directive to physically restrain the</p> | F 329 | <p>ways. Over time the staff has been able to recognize that one of her "behaviors" is actually a prodromal to seizure activity. She has been and continues to be treated with a routine anticonvulsant medication. Her blood level remains in the low therapeutic range and her physician does not wish to make changes at this time. She currently has a physician order for an as needed medication for treatment of acute seizure activity. Staff will continue to monitor for prodromal or actual seizure activity and notify the physician as needed.</p> <p>She does not currently have a physician order for any as needed psychotropic medications.</p> <p>The following intervention was added to her care plan- If I am flailing my arms, grabbing at the air or people with a wild scared look I may be getting ready to have a seizure. Take me to a dark quiet area, notify the licensed nurse and follow seizure precautions.</p> <p>HOW THE NURSING HOME WILL PROTECT RESIDENTS IN SIMILIAR SITUATIONS;</p> <p>The facility protocol for aggressive/assaultive behavior has been amended to remove the ability for LN's to administer any type of medication. All</p> | |
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| F 329 | <p>Continued From page 13</p> <p>aggressor only if necessary. If further intervention was needed "to control behavior... 0.5 mg to 1 mg IM (injected into the muscle)" could be given one time. "The resident will be observed and monitored for possible side effects and for response to the effectiveness of this chemical restraint." Interventions such as calling: the physician, Mental Health Crisis Line, or the Police, the on-call Administrative LN, and/or the Social Service Director were listed after the directive to give the Haldol IM (with a dose range requiring discretion by the LN).</p> <p>Review of side effects, documented on the internet medication site rxlist.com, noted serious potential side effects including but not limited to: restless muscle movements, tremors, seizures, and stiffness. Additionally, elderly patients with dementia-related psychosis treated with anti-psychotic drugs were at an increased risk of death. There was a caution in using the medication in the elderly and residents with seizure disorders.</p> <p>Resident #1: Review of the medical record revealed the resident was admitted to the facility on 12 with multiple mental health diagnoses including based), and (characterized by an Additionally, the resident had a diagnosis of dementia with</p> <p>According to the resident's plan of care she had communication impairment, walked independently, and demonstrated problematic</p> | F 329 | <p>incidents involving aggressive/assaultive residents will be managed on an individual basis and licensed staff will seek appropriate interventions from physicians as needed as each event unfolds. A nursing department meeting is scheduled for 9/6/12 to inform all nursing staff of changes to the protocol. A letter will be sent to all physicians who provide care for our residents to inform them that we will no longer be able to administer medications in an emergency situation without calling them or the on-call physician first because of the changes made in the protocol.</p> <p>MEASURES THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR;</p> <p>The facility protocol for aggressive/assaultive behavior has been amended to remove the ability for LN's to administer any type of medication. The nursing home will provide on-going in-services to educate staff on appropriate use of psychotropic medications, non-pharmaceutical interventions for aggressive, difficult and or dangerous</p> | |

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| F 329 | <p>Continued From page 14</p> <p>behaviors such as striking out at others, verbal abuse, elopement, and resistance to care. The admission physician's orders did not include any psychoactive medications, including any anti-psychotic medication to treat her mental health conditions.</p> <p>According to nursing entries on 6/17/12 and on 7/05/12 the resident was administered [REDACTED] injections at night when the resident demonstrated elopement attempts based on a belief that God had told her to leave. In response to the challenging behavioral escalations, rather than as a result of comprehensive assessments and a plan to treat the resident's condition, facility staff made a decision to implement a policy without physician direction/review of suitability for the resident. The medication was administered for the desired effect of calming the resident, a side effect rather than a medical treatment such as giving the medication routinely to address psychotic symptoms. See F222 for additional details.</p> <p>Resident #4: Review of the medical record revealed the resident had multiple diagnoses including epilepsy (a seizure disorder), dementia with [REDACTED] anxiety state, and [REDACTED] with [REDACTED] behavior. According to the resident's plan of care, she wandered throughout the facility in her wheelchair and would exit seek. She required staff assistance for safe transfers and ambulation. The resident difficulty with communication due to her cognitive impairment. The resident's problematic behaviors included combativeness and resistance to care and verbally abusive behaviors.</p> | F 329 | <p>behaviors and gentle care techniques to avoid catastrophic reactions by residents with dementia and/or psychosis diagnosis.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED;</p> <p>The facility continues to work toward a psychotropic free environment using gradual dose reductions per recommended physician guidelines. Psychotropic drug reviews are & will continue to be done quarterly and as needed. This process reviews all routine and as needed use of psychotropic medications, medical diagnosis, targeted behavioral symptoms and care plan interventions</p> <p>DATE WHEN CORRECTIVE ACTIONS WILL BE COMPLETE; 9/07/12</p> <p>TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTIONS; DNS</p> | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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| F 329 | <p>Continued From page 15</p> <p>Despite the resident's seizure history and the caution for use in such residents, nursing entries on 8/07/12 and on 8/10/12 noted the use of [REDACTED] 1 mg IM. The physician and family member were notified after administration. Seizure activity was observed shortly after administration of the [REDACTED] on 8/10/12. See F222 for additional details.</p> <p>Further review of the nursing entries between 6/06/12 through 8/10/12 did not evidence any other documented seizure activity.</p> <p>Instead of contacting the resident's physician or other staff when there was a significant behavioral escalation, to assist in ascertaining possible underlying causes or identifying other potential interventions, staff utilized a protocol whereby they could use the [REDACTED] IM first and then notify the physician and family member later. The protocol allowed for staff discretion to vary the one time [REDACTED] M dose. There was no oral route option, only an injectable route. The protocol provided by the facility did not contain the signature of the Medical Director or the Physician of Residents #1 and #4.</p> <p>When interviewed on 8/14/12 at approximately 5:20 p.m., the facility Administrator and Director of Nursing were unable to recall the etiology of the Aggressive/Assaultive Behaviors Emergency Protocol. Facility Administrative Staff were unable to locate a copy signed by the Medical Director or the residents' Physician.</p> | F 329 | | |
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