STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING ______ B. WING ______	C 03/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to develop a care plan to address the use of antipsychotic and antianxiety medications for 1 of 3 sampled residents (Resident #2) whose medications were reviewed. Findings included: Resident #2 was admitted to the facility on 11/06/12. The resident's documented diagnoses included altered mental status/delirium/psychosis, and advancing dementia.	F 279	Highland House Rehabilitation & Healthcare submits this Plan of Correction (PoC) in accordance with the provisions of Health and Safety Code Section 1280 and C.F.R. 405 1907. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. The Provider has not had any remedies imposed against it as a result of the alleged deficiencies. Without such remedies, the Provider will not be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Connor, NHA	Administrator	04/15/13

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 279	Continued From page 1 On 11/06/12 Resident #2 was admitted to the facility from the hospital on Risperdal (antipsychotic) 1 milligram (mg) twice daily (BID), Zyprexa (antipsychotic) 5 mg BID, Zyprexa 10 mg every night, as needed (PRN) Ativan (antianxiety) 0.5 mg three times daily (TID) by mouth, PRN Ativan 0.5 mg intramuscularly (IM) TID, and PRN Zyprexa 5 mg IM TID. The resident's 11/14/12 admission Minimum Data Set (MDS) documented Resident #2 had short and long term memory impairment, was severely impaired in decision making, and received an antipsychotic for 7 days and an antianxiety medication for 4 days during the look-back period. Review of Resident #2's care plan revealed the only problem associated with psychotropic medications, identified on 11/20/12, was for alteration in mood and behavior due to depression. A hospital Discharge Summary documented Resident #2 was hospitalized from 11/20/12 until 12/04/12. He was readmitted to the facility on 12/04/12 receiving Risperdal 2 mg BID, Zyprexa 5 mg BID (6:00 AM and 4:00 PM), Zyprexa 10 mg every night (8:00 PM), and PRN Zyprexa 5 mg IM TID. The resident ' s Ativan was discontinued. was readmitted to the facility on 12/04/12 receiving Risperdal 2 mg BID, Zyprexa 5 mg BID (6:00 AM and 4:00 PM), Zyprexa 10 mg every night (8:00 PM), and PRN Zyprexa 5 mg IM TID. The resident ' s Ativan was discontinued. The resident's Medication Administration Record (MAR) documented on 01/17/13 he was begun	F 279	granted an appeal before the U.S. Department of Health and Human Services Departmental Appeals Board to challenge the alleged deficiency cited in the HCFA-2567. Initially the Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process. F279 483.20(d), 483.20(k)(1) Develop Comprehensive Care Plans It is this facility's philosophy and normal practice to use the results of the assessment to develop, review and revise the resident's comprehensive care plan. The facility has in place developed written policies and procedures. The Interdisciplinary Care Plan Team are trained during their orientation period on the processes for developing a comprehensive plan of care. The Nurse Consultant, and other support advisors provide routine refresher training and in-services. Physician reviews, consultant reviews, quality assurance monitoring and staff training are examples of the various components utilized. Interdisciplinary Care Plans are developed for each resident, and are designed to address potential problems, and offer approaches designed to meet specific goals.	

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F 279	Continued From page 2 on PRN Klonopin 0.5 mg BID for the management of his anxiety/agitation. Resident #2's quarterly 01/29/13 MDS documented he had short and long term memory impairment, was severely impaired in decision making, and received an antipsychotic for 7 days and an antianxiety medication for 3 days during the look-back period. A hospital Discharge Summary documented Resident #2 was hospitalized between 03/15/13 and 03/23/13. He was readmitted to the facility on 03/23/13 receiving Zyprexa 10 mg nightly, PRN Klonopin 0.5 mg BID, PRN Zyprexa 5 mg IM TID, and PRN Zyprexa 10 mg IM nightly. At 11:15 AM on 03/28/13 the Director of Nursing (DON) and Administrator stated they would expect to see addressed in Resident #2's care plan the use of antipsychotic and antianxiety medications used to help control his psychosis and anxiety/agitation/resistance of care. At 11:38 AM on 03/28/13 the MDS Coordinator stated, after reviewing Resident #2's care plan, the use on antipsychotic and antianxiety medications was not addressed.	F 279	I. The psychotropic plan of care developed for Resident #2 was amended to include the omitted diagnosis of psychosis. II. Clinical Case Manager and/or designee have audited the medical records for those residents who receive antipsychotic medications to ensure that medical diagnoses were included on their care plans. III. Historically, the facility Social Worker made rounds with the Psychiatrist, as the Social Worker knows the residents' social and psychological history. After review of how this isolated omission occurred, this practice was changed. A licensed nurse is now designated to make rounds with the Psychiatrist to ensure that care plans address the use of psychotropic medications when medication orders are added or changed. Facility has implemented a more formal clinical review process to be conducted following Psychiatrist/metal health professional visits. Orders and progress notes will be reviewed for documentation follow through and Care Plan updates when appropriate.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility failed to assess 1 of 4 sampled residents (Resident #2), reviewed for well being, who exhibited congestion and a wet cough resulting in the resident being hospitalized for pneumonia. Findings included: Resident #2 was admitted to the facility on 11/06/12. The resident ' s documented diagnoses included chronic lung disease and percutaneous endoscopic gastrostomy (PEG, feeding tube). Review of Resident #2's Medication Administration Records (MARs) revealed on 11/09/12 a " for your information " (FYI) was added for aspiration precautions. A 11/11/12 physician order documented for excessive secretions Resident #2 was to receive oral suctioning, and the physician was to be notified within 24 hours. The order instructed staff to monitor aspiration precautions due to the resident ' s excessive oral secretions. Daily Medicare Notes documented Resident #2 had occasional coughing, slight bilateral congestion, or rales on 14 days between 11/13/12 and 01/31/13. A hospital Discharge Summary documented Resident #2 was admitted to the hospital on 11/20/12, and initially was admitted to the intensive care unit due to intubation, acute renal	F 309	IV. Psychiatric Care Review Team will report findings monthly to the Quality Assurance Committee for 3 months and quarterly for 3 quarters to monitor effectiveness of plan of correction. Completion Date: 4/15/13 F309 483.25Provide Care/Services for Highest Well Being It is this facility's philosophy and normal practice to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the resident's assessment and plan of care. The facility had in place developed written policies and procedures. Nursing personnel are trained during their orientation process regarding observation and assessment of changes in condition and associated charting. The Staff Development Coordinator and clinical supervisors provide routine refresher training and in-services. Physician reviews, consultant reviews, quality assurance monitoring and staff training are examples of the various components utilized. I. Resident #2 was reassessed on 03/23/13 and again on 4/9/13.	

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F 309	Continued From page 4 failure, and coffee-ground emesis. The resident returned to the facility on 12/04/12. Daily Medicare Notes on 02/04/13 and 02/09/13 documented " cough ", on 02/16/13 and 02/17/13 " rales lower lobes ", on 02/18/13 " cough congestion ", on 02/23/13 and 02/24/13 " cough ", on 02/25/13 " moist rales lower lobe ", on 02/26/13 " some rales ", and on 02/27/13 " some rales lower lobes ". Daily Medicare documentation ended on 02/27/13. A 02/16/13 physician order initiated immediate Duoneb (a bronchodilator used for residents with chronic breathing problems) and Duoneb every six hours for the next 24 hours, then as needed (PRN). Resident #2's MAR documented he received PRN Duoneb on 02/16/13 - 02/18/13 and on 02/19/13 and 02/25/13. A 02/19/13 physician's progress note documented, " No SOB (shortness of breath), no wheeze, no cough, no phlegm, no choking spells. " (There were no further physician ' s progress notes until 03/15/13). A 02/28/13 Nurse's Note documented, " ...Respirations even and unlabored. " PRN Duoneb did not appear on Resident #2's March 2013 MAR. A 03/15/13 physician's progress note documented, " Called by the nurse to see patient coughing noticed a few minutes ago. No fever, but SOB. Oxygen saturation 94% on RA (room	F 309	II. Director of Nursing (DON) and clinical team reviewed those residents not sampled and their medical records to determine if those residents were receiving necessary care and services to maintain well- being and ensuring that a full assessment has been completed in the past month. III. Staff Development Coordinator and DON provided the licensed nursing staff refresher training regarding assessments, changes in condition and acute charting on 4/1/13. The 24-hour nursing report is reviewed in morning stand-up meeting for follow up on changes in condition. Weekly nursing summary charting has been implemented for those residents who aren't concurrently on acute or exceptions charting. IV. DON or designee will randomly audit 10 charts per month for three months to ensure changes in condition are being assessed and charted. Results of chart audits will be presented to Quality Assurance Committee. V. 04/15/13	

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F 309	Continued From page 5 air). Currently on breathing treatment via Nebulizer ....Respiratory: (positive for) SOB, no wheeze, (positive for) cough, no phlegm, no choking spells. " There were no further Nurse's Notes until a 03/15/13 10:30 AM note documented, " ___ (name of primary physician) here to make rounds ...stat (at once) CXR (chest x-ray) ...pt (patient) very congested, Duoneb tx (treatment) done & (and) tolerated well, pt suctioned x 1 moderate amount of thick yellow phlegm noted. A 03/15/13 mobile x-ray report documented, " Small area of consolidation consistent with pneumonia in the right base since prior. This needs clinical correlation and near-term radiographic follow-up. " A 03/15/13 physician's order was obtained for antibiotics to treat an upper respiratory infection. A 03/15/13 6:00 PM Nurse's Note documented Resident #2 was being sent to the emergency room. A 03/23/13 hospital Discharge Summary documented, " In the emergency department, the chest x-ray showed bilateral pulmonary opacities (bilateral lobe pneumonia). " The summary also documented the resident had a bacterial infection of the urine and sputum. At 3:00 PM on 03/27/13 Nurse #2, who cared for Resident #2 on second shift, stated frequent suctioning was baseline for the resident because he had a lot of oral secretions. She reported " not over three or four days " before the resident	F 309		

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F 309	Continued From page 6 was sent out to the hospital on 03/15/13 the resident exhibited congestion and a wet cough which was not baseline. According to the nurse, the level of congestion on 03/15/13 was about the same as it was three or four days before. She stated she passed on the presence of the wet cough and congestion to the third shift nurse who she assumed would see that it was communicated to the resident's primary physician. However, she commented she did not report this information to the physician herself. At 3:33 PM on 03/27/12 Nursing Assistant (NA) #2, who cared for Resident #2 on second shift, stated the resident frequently had trouble breathing and had thick mucous in his mouth. She commented PRN breathing treatments helped the resident a lot. However, she reported one to two weeks before the resident was sent out to the hospital on 03/15/13 the resident began coughing, there was a change in his breathing with a kind of gasping sound at times, shortness of breath, and congestion. She stated these symptoms were not usual for the resident. According to NA #2, she told the nurse about the cough, congestion, and change in breathing patterns. At 4:33 PM on 03/27/13, during a telephone conversation, Resident #2's primary physician stated she was not made aware of the resident having a cough or SOB issues in March 2013, as far as she could remember, until she was making rounds on 03/15/13. At 5:42 PM on 03/27/13 Nurse #3, who cared for Resident #2 on third shift, stated during a telephone interview that he noticed and was	F 309		

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

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F 309	Continued From page 7 made aware of congestion and a wet cough " for more than a couple days " before the resident was sent out to the hospital on 03/15/13. He reported this was not typical for the resident, but he did not personally inform the resident ' s physician about the signs and symptoms. At 11:06 AM on 03/28/13 the facility's Clinical Liaison stated the facility called Resident #2's primary physician when they had concerns about the resident ' s condition. She reported the physician created her own list of residents to be seen during facility visits based on the calls she received from staff and those residents who were due mandated assessments and progress notes. At 11:15 AM on 03/28/13 the Director of Nursing (DON) stated for residents at risk for aspiration pneumonia she would expect to see periodic documentation of respiratory assessment including lung sounds and the presence/lack of wheezing, coughing, shortness of breath, and drooling. She reported if wet congestion was observed or heard she would expect the physician to be notified. According to the DON, respiratory assessment should definitely be documented when there was a change of condition, and if there was no improvement in three days, the family/responsible party and physician should be notified. At 11:40 AM on 03/28/13 the Administrator stated Resident #2 came off Medicare skilled services on 02/27/13 so there would not be as many notes. She reported she thought the staff who cared for Resident #2 did not consider the symptoms of cough and congestion to be anything new for the resident. She explained	F 309		

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F 309	Continued From page 8 there was documentation of cough, congestion, and rales in Medicare skilled notes in November 2012, December 2012, and February 2012. Therefore, she commented the staff did not think the resident was experiencing a change of condition.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on physician interview, pharmacist interview, staff interview, and record review the facility failed to analyze and react to the role psychotropic medications played in falls prevention for 1 of 3 sampled residents (Resident #2), who experienced multiple falls, until after that resident had fallen six times. Findings included: Resident #2 was admitted to the facility on 11/06/12. The resident's documented diagnoses included altered mental status/delirium/psychosis, advancing dementia, hypertension, chronic lung disease, and hip replacement. On 11/06/12 Resident #2 was admitted to the facility from the hospital on Risperdal (antipsychotic) 1 milligram (mg) twice daily (BID), Zyprexa (antipsychotic) 5 mg BID, Zyprexa 10 mg	F 323	F323 483.25(h) Free of Accident Hazards/Supervision/Devices It is this facility's intent and normal practice to ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent falls. The facility had in place written policies and procedures. Physician reviews, consultant reviews, quality assurance monitoring and staff training are examples of the various components utilized to maintain compliance. A clinical pharmacy service is utilized to provide the systems and services of licensed pharmacists in reviewing/ advising on the use of psychotropic medications and the risk benefit assessment relating to falls prevention. The facility had a contract with an outside psychiatric provider group. The provider group was unable to provide a psychiatrist during this past period due to the loss of their sole practitioner. The facility worked diligently to secure a contract with an additional psychiatric provider who could provide the services of a psychiatrist to continue with psychiatric care as needed for residents. A new psychiatrist began seeing patients the latter part of December, 2012.	

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F 323	Continued From page 9 every night, as needed (PRN) Ativan (antianxiety) 0.5 mg three times daily (TID) by mouth, PRN Ativan 0.5 mg intramuscularly (IM) TID, and PRN Zyprexa 5 mg IM TID. (The Centers for Medicare/Medicaid Services State Operation Manual documented the maximum daily dose of Zyprexa should not exceed 7.5 mg daily in the geriatric population). A 11/06/12 Physician's Progress Note documented, "...On Zyprexa & (and) Risperdal for behavior issues with dementia. Evaluated by psychiatrist at the hospital. Refer psych ASAP (as soon as possible) for medication management with dementia." An evaluation by a psychiatrist was ordered by Resident #2's primary physician on 11/06/12. (The first time the resident's medication regimen was reviewed by the psychiatrist was on 01/16/13). A 11/07/12 Nurse's Note documented Resident #2 was found on the floor of his room beside his bed on his back. A 11/07/12 Incident/Accident Report documented a mat at bedside, a bed and chair alarm, and a room change (which placed the resident closer to the nursing station) were put in place to prevent future falls. A 11/09/12 Nurse's Note documented Resident #2 fell from his geri-chair, and was sent to the hospital because of complaints of pain in his right hip and leg. X-rays documented the resident did not experience a new fracture. A 11/09/12 Incident/Accident Report documented an alarm in the geri-chair was put in place to prevent future falls.	F 323	I. Facility had a written order for the addition of the Klonopin which resulted in correct implementation. The Risperdal and Zyprexa reduction recommendation was inadvertently missed due to being on the evaluation note only which was contrary to normal procedure. The reduction was implemented and correct orders followed upon the Resident's re-admission to the facility on 3/23/13. Psychiatrist notified of the previous error on 3/28/13. Resident was re-evaluated by psychiatrist on 4/12/2013 for continued follow up. Psychiatrist discontinued the scheduled Klonopin and added Klonopin TID PRN for agitation. Resident #2 hasn't experienced any falls since 01/14/13. II. To ensure there were no other omissions, the Director of Nursing (DON) and clinical team reviewed medical records for those residents seen by the psychiatrist since beginning service in December 2012. One other omission was found, and corrected. III. Historically, the facility Social Worker made rounds with the Psychiatrist, as the Social Worker knows the residents' social and psychological history. After review of how this isolated omission occurred, this practice was changed. A licensed nurse is now designated to make rounds with the Psychiatrist to ensure that new orders and/or order changes are carried out at the time of visit.	

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F 323	Continued From page 10 A 11/09/12 Physician's Progress Note documented, " ...Follow up on psych referral for medication management with dementia. " A 11/12/12 Nurse's Note documented Resident #2 was found on his knees on the floor mat beside his bed. A 11/12/12 Incident/Accident Report documented two floor mats, bed in the lowest position, and the ordering of a scoop mattress were put in place to prevent future falls. A 11/13/12 Physician's Progress Note documented, " ...Follow up on psych referral for medication management with dementia since in the facility for possible discontinuation of Risperdal or Zyprexa. Nurse reports that he is asleep most of the time though usually gets the Ativan in the evenings. " The resident's 11/14/12 admission Minimum Data Set (MDS) documented Resident #2 had short and long term memory impairment, was severely impaired in decision making, was short tempered/easily annoyed, exhibited no psychosis, exhibited physical behavioral symptoms directed toward others, rejected care, and experienced falls with no injury since admission. A 11/16/12 Physician's Progress Note documented, " ...Refer to the psychiatrist for medication management. " A psychiatric evaluation for medication management due to dementia with behavioral issues/agitation was ordered by Resident #2's primary physician on 11/16/12. (The first time the resident ' s medication regimen was reviewed by	F 323	Licensed Pharmacist will continue to audit medical records to ensure compliance with physician orders. Facility has implemented a more formal clinical review process to be conducted following Psychiatrist/metal health professional visits. Orders and progress notes will be reviewed for documentation follow through and Care Plan updates when appropriate. IV. Psychiatric Care Review Team will report findings monthly to the Quality Assurance Committee for 3 months and quarterly for 3 quarters to monitor effectiveness of plan of correction. Completion Date: 4/15/13	

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	345353	A. BUILDING ______ B. WING ______	C 03/28/2013

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F 323	Continued From page 11 the psychiatrist was on 01/16/13). A 11/17/12 Nurse's Note documented Resident #2 was found on the floor mats beside his bed. A 11/17/12 Incident/Accident Report documented floor mats were in place, the bed was in the low position, the alarm was working, and the scoop mattress was in place, and these interventions were to be continued in order to prevent future falls. On 11/20/12 potential for injury due to falls was identified as a problem on Resident #2's care plan. Interventions included medications as ordered. A hospital Discharge Summary documented Resident #2 was hospitalized from 11/20/12 until 12/04/12 with acute respiratory failure and vomiting of coffee-ground material. Resident #2 was readmitted to the facility on 12/04/12 receiving Risperdal 2 mg BID, Zyprexa 5 mg BID (6:00 AM and 4:00 PM), Zyprexa 10 mg every night (8:00 PM), and PRN Zyprexa 5 mg IM TID. The resident ' s Ativan was discontinued. (The Centers for Medicare/Medicaid Services State Operation Manual documented the maximum daily dose of Risperdal should not exceed 2 mg daily in the geriatric population). A 12/07/12 Nurse's Note documented Resident #2 was found sitting on his buttocks on the floor mat between the bed and window. A 12/07/12 Incident/Accident report documented at the time of the fall Resident #2 ' s fall interventions were in place, and pillows were added for repositioning.	F 323		

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F 323	Continued From page 12 In a 12/17/12 Psychology Progress Note a licensed clinical social worker ((LCSW) documented, " While the patient presents with psychosocial symptoms, the patient is not cognitively capable of engaging appropriately with counseling sessions. " Resident #2's medication was not reviewed as part of the screening. A psychiatric evaluation was ordered by Resident #2's primary physician on 01/04/13. (The first time the resident's medication regimen was reviewed by the psychiatrist was on 01/16/13). A 01/14/13 Nurse's Note documented Resident #2 rose from his geri-chair, and fell in the hallway. A 01/14/13 Incident/Accident report documented a psychiatric consult to review Resident #2's medications and a chair alarm were recommended to prevent future falls. Recommendations from a 01/16/13 psychiatric evaluation documented, " The patient (Resident #2) has had increased agitation, and he has also been trying to get out of his bed and falling when he stands. I suspect that it is the high doses of (Zyprexa), which can cause orthostatic hypotension, as well as the Risperdal. Therefore, I will decrease the Risperdal from 2 mg BID to 1 mg BID. I will decrease his Zyprexa to 5 mg (every night), continue the PRN. I will also add Klonopin 0.5 mg BID PRN agitation ....The patient is unable to communicates, so I am unable to procure any more history from him. " Resident #2's quarterly 01/29/13 MDS documented he had short and long term memory impairment, was severely impaired in decision making, experienced trouble falling	F 323		

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F 323	Continued From page 13 asleep/staying asleep or sleeping too much, exhibited no psychosis or behavioral symptoms, rejected care, and experienced falls with no injury since admission. Review of Resident #2's Medication Administration Records MARs) documented until 03/11/13 the resident continued to receive Risperdal 2 mg BID, until 03/16/13 continued to receive Zyprexa 5 mg BID and Zyprexa 10 mg nightly, but on 01/17/13 PRN Klonopin was added to the resident ' s medication regimen. However, review of the medical record revealed Resident #2 did not experience any more falls after 01/14/13. During a phone interview with the facility's Consultant Pharmacist on 03/27/13 at 2:23 PM she stated Zyprexa and Risperdal by themselves could cause over sedation and falls, but the use of duplicate antipsychotics only increased the chance that these medications could lead to balance problems and falls. At 4:08 PM on 03/27/13 the Administrator stated she had problems with the facility's contracted psychiatric services for a period when they were without a psychiatrist. She reported she thought this was the case during November and December 2012 when primary physicians were reluctant to take recommendations from a LCSW. The Administrator commented the contracted services could have also been without a Nurse Practitioner during this time period, but she was not absolutely sure of that. According to the Administrator, the facility obtained the services on a new psychiatrist who visited the facility for the first time on 12/27/12.	F 323		

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F 323	Continued From page 14 At 4:30 PM on 03/27/13, during a telephone interview, Resident #2's Primary Physician stated she had concerns about the resident ' s medication regimen when he was admitted in November 2012 because the resident was on multiple antipsychotic medications, and began to experience falls. She reported in the hospital the resident was very sick, under acute stress, and was agitated and getting up unassisted. She explained the nursing home environment was different for the resident, with his stress and sickness being less acute, so she desired a psychiatric evaluation to make sure the use of two antipsychotics was still appropriate. According to the Primary Physician, she had even more concerns about Resident #2's medication regimen when he returned from the hospital on 12/04/12 receiving double the Risperdal he had been on previously, and the resident continued to fall. Once again, she explained she wanted the resident to have a psychiatric evaluation.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329	F329 483.25(l) Drug Regimen is Free From Unnecessary Drugs It is this facility's intent and normal practice to ensure that the resident's medication regimen is free from unnecessary medications. The facility had in place developed written policies and procedures. Physician reviews, consultant reviews, quality assurance monitoring and staff training are examples of the various components utilized to maintain compliance. The facility provides psychiatric services as needed for residents. A clinical pharmacy service is utilized to provide the systems and services of licensed pharmacists in reviewing/advising on the necessity of medications regarding indications, dosage, duration and adverse consequences.	

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F 329	Continued From page 15 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on physician interview, pharmacy interview, staff interview, and record review the facility failed to follow a psychiatrist's recommendations which resulted in 1 of 3 sampled residents (Resident #2), whose medications were reviewed, receiving unnecessary amounts of antipsychotics. Findings included: Resident #2 was admitted to the facility on 11/06/12. The resident's documented diagnoses included altered mental status/delirium/psychosis, and advancing dementia. On 11/06/12 Resident #2 was admitted to the facility from the hospital on Risperdal (antipsychotic) 1 milligram (mg) twice daily (BID), Zyprexa (antipsychotic) 5 mg BID, Zyprexa 10 mg every night, as needed (PRN) Ativan (antianxiety) 0.5 mg three times daily (TID) by mouth, PRN Ativan 0.5 mg intramuscularly (IM) TID, and PRN Zyprexa 5 mg IM TID. (The Centers for Medicare/Medicaid Services State Operation	F 329	I. The Risperdal and Zyprexa reduction recommendation was inadvertently missed due to being on the evaluation note only which was contrary to normal procedure. The reduction was implemented and correct orders followed upon the Resident's re-admission to the facility on 3/23/13. Psychiatrist notified of the previous error on 3/28/13. Resident was re-evaluated by psychiatrist on 04/12/2013 for continued follow up. Psychiatrist discontinued the scheduled Klonopin and added Klonopin TID PRN for agitation. II. To ensure there were no other omissions, the Director of Nursing (DON) and clinical team reviewed medical records for those residents seen by the psychiatrist since beginning service in December 2012. One other omission was found and corrected. III. Historically, the facility Social Worker made rounds with the Psychiatrist, as the Social Worker knows the residents' social and psychological history. After review of how this isolated omission occurred, this practice was changed. A licensed nurse is now designated to make rounds with the Psychiatrist to ensure that new orders and/or order changes are carried out at the time of visit.	

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F 329	Continued From page 16 Manual documented the maximum daily dose of Zyprexa should not exceed 7.5 mg daily in the geriatric population). A 11/06/12 Physician's Progress Note documented, " ...On Zyprexa & (and) Risperdal for behavior issues with dementia. Evaluated by psychiatrist at the hospital. Refer psych ASAP (as soon as possible) for medication management with dementia. " Resident #2's primary physician ordered a psychiatric evaluation for the resident on 11/06/12. (The first time the resident ' s medication regimen was reviewed by the psychiatrist was on 01/16/13). Review of Nurse's Notes and Incident/Accident Reports revealed Resident #2 fell on 11/07/12, 11/09/12, and 11/12/12. The resident's 11/14/12 admission Minimum Data Set (MDS) documented Resident #2 had short and long term memory impairment, was severely impaired in decision making, was short tempered/easily annoyed, exhibited no psychosis, exhibited physical behavioral symptoms directed toward others, rejected care, and received an antipsychotic for 7 days and an antianxiety medication for 4 days during the look-back period. A psychiatric evaluation for medication management due to dementia with behavioral issues/agitation was ordered by Resident #2's primary physician on 11/16/12. (The first time the resident's medication regimen was reviewed by the psychiatrist was on 01/16/13). A Nurse ' s Note and Incident/Accident Report	F 329	Licensed Pharmacist will continue to audit medical records to ensure compliance with physician orders. Facility has implemented a more formal clinical review process to be conducted following Psychiatrist/metal health professional visits. Orders and progress notes will be reviewed for documentation follow through and Care Plan updates when appropriate. IV. Psychiatric Care Review Team will report findings monthly to the Quality Assurance Committee for 3 months and quarterly for 3 quarters to monitor effectiveness of plan of correction. Completion Date: 4/15/13	

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F 329	Continued From page 17 documented Resident #2 fell on 11/17/12. Review of Resident #2's care plan revealed the only problem associated with psychotropic medications, identified on 11/20/12, was for alteration in mood and behavior due to depression. A hospital Discharge Summary documented Resident #2 was hospitalized from 11/20/12 until 12/04/12 with acute respiratory failure and vomiting of coffee-ground material. Resident #2 was readmitted to the facility on 12/04/12 receiving Risperdal 2 mg BID, Zyprexa 5 mg BID (6:00 AM and 4:00 PM), Zyprexa 10 mg every night (8:00 PM), and PRN Zyprexa 5 mg IM TID. The resident ' s Ativan was discontinued. (The Centers for Medicare/Medicaid Services State Operation Manual documented the maximum daily dose of Risperdal should not exceed 2 mg daily in the geriatric population). A Nurse's Note and Incident/Accident Report documented Resident #2 fell on 12/07/12. A psychiatric evaluation was ordered by Resident #2's primary physician on 01/04/13. (The first time the resident's medication regimen was reviewed by the psychiatrist was on 01/16/13). A Nurse's Note and Incident/Accident Report documented Resident #2 fell on 01/14/13. Recommendations from a 01/16/13 psychiatric evaluation documented, " The patient (Resident #2) has had increased agitation, and he has also	F 329		

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F 329	Continued From page 18	F 329		

been trying to get out of his bed and falling when he stands. I suspect that it is the high doses of (Zyprexa), which can cause orthostatic hypotension, as well as the Risperdal. Therefore, I will decrease the Risperdal from 2 mg BID to 1 mg BID. I will decrease his Zyprexa to 5 mg (every night), continue the PRN. I will also add Klonopin 0.5 mg BID PRN agitation ....The patient is unable to communicates, so I am unable to procure any more history from him. " (However, PRN Klonopin was initiated for Resident #2 on 01/17/13, but the resident continued to receive Risperdal 2 mg BID until 03/11/13 and 20 mg of Zyprexa daily until 03/16/13).

Resident #2's quarterly 01/29/13 MDS documented he had short and long term memory impairment, was severely impaired in decision making, experienced trouble falling asleep/staying asleep or sleeping too much, exhibited no psychosis or behavioral symptoms, rejected care, and received an antipsychotic for 7 days and an antianxiety medication for 3 days during the look-back period.

A 01/30/12 pharmacy recommendation requested review of duplicate antipsychotic therapy by the physician in hopes that one antipsychotic medication might be discontinued. On 02/01/13 the primary physician replied, " Psychiatrist to make the decision please. "

A 02/26/13 pharmacy recommendation requested review of duplicate antipsychotic therapy by the physician in hopes that one antipsychotic medication might be discontinued. On 03/08/13 the facility's new contracted psychiatrist replied, " Discontinue Risperdal 2 mg BID. "

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Review of Resident #2's March 2013 MAR revealed Risperdal 2 mg BID was stopped for the resident on 03/11/13 without gradual dose reduction.

A hospital Discharge Summary documented Resident #2 was hospitalized between 03/15/13 and 03/23/13 for pneumonia.

The resident was readmitted to the facility on 03/23/13 receiving Zyprexa 10 mg nightly and PRN Zyprexa and PRN Klonopin.

During interviews with Nurse #1 (on 03/27/13 at 10:23 AM) and Nursing Assistant (NA) #1 (on 03/27/13 at 10:38 AM), who both cared for Resident #2 on first shift, stated the only behavior the resident exhibited was combativeness/resistance to care when he was touched.

During a phone interview with the facility's Consultant Pharmacist on 03/27/13 at 2:23 PM she stated the use of duplicate antipsychotic therapy was frowned upon because it increased the chance that residents might experience balance problems and falls. She reported antipsychotic medications should be tapered slowly and not be stopped abruptly because the resident could experience " rebound effects. " She commented, for example, if a resident was receiving Risperdal 2 mg BID, an appropriate taper would be Risperdal 1 mg BID for about six months. Then she explained another taper would be begun.

During interviews with Nurse #2 (on 03/27/13 at

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F 329	Continued From page 20 3:00 PM) and NA #2 (on 03/27/13 at 3:33 PM), who both cared for Resident #2 on second shift, stated the only behavior the resident exhibited was combativeness/resistance to care when he was touched. NA #2 reported Resident #2 was much less agitated since returning from the hospital on 03/23/13, and actually allowed her to shave him without resisting care and fighting her. At 4:30 PM on 03/27/13, during a telephone interview, Resident #2's Primary Physician stated she had concerns about the resident ' s medication regimen when he was admitted in November 2012 because the resident was on multiple antipsychotic medications, and began to experience falls. She reported in the hospital the resident was very sick, under acute stress, and was agitated and getting up unassisted. She explained the nursing home environment was different for the resident, with his stress and sickness being less acute, so she desired a psychiatric evaluation to make sure the use of two antipsychotics was still appropriate. According to the Primary Physician, she had even more concerns about Resident #2's medication regimen when he returned from the hospital on 12/04/12 receiving double the Risperdal he had been on previously, and the resident continued to fall. Once again, she explained she wanted the resident to have a psychiatric evaluation. She commented she did not recall the facility reporting to her about the new psychiatrist recommending antipsychotic dose reductions on 01/16/13. The Primary Physician stated antipsychotic medications should not be immediately stopped, but should be gradually reduced. She reported Resident #2 returned from the hospital on 03/23/13 on less psychotropic medications, and	F 329		

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F 329	Continued From page 21 was experiencing less agitation. At 5:12 PM on 03/27/13 the Director of Nursing (DON) stated the medication recommendations for Resident #2, made by the psychiatrist on 01/16/13, should have been transcribed onto an order form, and the primary physician should have been informed of the recommendations. She reported if the primary physician disagreed with the recommendations the disagreement should be documented in Nurse's Notes, the previously written order should be discontinued, and a new order should be written reflecting any interventions desired by the primary physician. At 5:53 PM on 03/27/13 the DON and Administrator stated they had concerns about the psychiatrist's 01/16/13 antipsychotic dose reduction recommendations not being followed since he was one of the facility's experts on psychotropic medications. They stated when the new psychiatrist first began seeing residents in the facility on 12/27/12 they discussed with him the need to write orders for his recommendations and not just write hard scripts. However, according to the DON and Administrator, this psychiatrist wrote a hard script for the PRN Klonopin he recommended for Resident #2 on 01/16/13, but failed to write an order for the antipsychotic dose reductions he recommended at the same time.	F 329		