STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-GOLDEN RULE	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 10, 11, 14, 15, & 16, 2019 Facility number: 000165 Provider number: 155264 AIM number: 100288220 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 7 Medicaid: 54 Other: 15 Total: 76 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 22, 2019	F 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory requirements.	
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility failed to timely resolve concerns voiced by residents at the resident council meetings for 9 of 10 residents that attended the group meeting. (Residents 5, 7, 16, 20, 35, 49, 56, 64, and 68) Findings include: On 1/14/19, at 10:00 a.m., a resident group meeting was held with 10 residents who routinely attend resident council meetings.	F 0565	F 565 Resident/Family Group and Response The corrective actions accomplished for those residents found to have been affected by this alleged deficient practice are as follows: All concerns voiced in resident council in the last 6 months have been reviewed. The facility will offer the resident whose TV is too	02/01/2019

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	Resident 7 indicated sometimes it takes a long time to resolve the grievances and they are not always given a good reason why it takes so long; sometimes it takes months and some problems they can't seem to get worked out. Eight other resident shook their heads yes in agreement. Resident 7 indicated there is a noise problem with a resident turning up his TV and it is too loud, that even with his door shut, you can hear the TV, and sometimes you can't hear your own TV. Nine other residents agreed. Resident 35 indicated there is more than one person who keeps their TV up too loud and staff have offered one of them ear phones and he refused. Residents 49 and 64 indicated sometimes they have to wait a long time for care, because call lights take longer than they should to be answered. They said staff will answer your call light and turn it off, then they do not return for a long time. Resident 7 said they come in, turn your call light off, say they will be back then they don't return, and she has waited 15 minutes to 1 hour for someone to return. Resident 7 said it seems like you repeat yourself every month, in the resident council meetings, and nothing gets done. On 1/14/19 at 11:02 a.m., the resident council minutes were reviewed and indicated: August 9, 2018: New business: 9 out of 10 residents said call lights were on too long, or answered and staff doesn't come back. September 13, 2018: Old business: Call light on too long or answer light and not come back; 4 residents said it was resolved, and 4 residents said it was not resolved. New business: Call light on too long, 3 out of 8 residents said this was still		loud wireless speakers to place at his bedside near the head of his bed. All residents who reside in the facility have the potential to be affected by this alleged deficient practice. The policy and procedure for Resident Council Process has been reviewed and no changes were made. All department heads have been re-educated on the process of how to address and concerns that are voiced by those in resident council. The Department Response Form was also reviewed with no changes made. (See Attachment ----) The Executive Director or her designee will review resident council minutes monthly. The Executive Director or her designee will log all concerns voiced in resident council monthly and will then follow up within 5 business days after the concerns are voiced in resident council to ensure the department responsible is working to ensure a resolution to said concerns has occurred. (See attachment) All audits will be presented to the quality assurance committee for review during their monthly QAPI meeting with further recommendations as warranted until compliance is maintained for 6 consecutive months. **Completion Date: 2/1/19**	

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	a concern. A TV too loud; 4 out of 8 residents had this concern. October 11, 2018: Old business: 7 residents attended and 0 said the wireless head sets for the loud TV's resolved the issue. November 8, 2018: 12 residents attended. Old business; TV's still loud on the Center hall all day and night; residents indicated this was not resolved. December 13, 2018: Old business: Loud TV; 1 out of 4 residents indicated the issue was not resolved. January 10, 2019: Old business: Loud TV; 10 residents said this was not resolved. New business: 5 out of 10 residents wanted earphones for the TV; 7 out of 10 residents said the call lights were on too long or being put on hold repeatedly. During an interview, on 1/16/19 at 4:12 p.m., the Activity Director indicated they are still working on the loud TVs and are going to try giving the residents their own ear phones. They are also going to see if they can get small speaker bars because the sound goes out the back of the TV and the resident can hear it in the next room. For the call lights; she said she gets this concern almost every month, the unit managers address it, the Director of Nurses sees it, and they try to educate everyone on this. She said that her and Social Services follow up on the grievances, they give them to the Administrator who looks at them and places them in the box of who will take care of them. A policy for "Resident Council Process", last			

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	reviewed on 11/23/18, was provided by the Administrator on 1/16/19 at 5:56 p.m. The policy indicated, but was not limited to; "Procedure Statement: The Resident Council is an important part of the QAPI (Quality Assurance and Performance Improvement) process. It gives the residents the opportunity to address concerns, and the Living Center the opportunity to fix these concerns. In order for this system to work, once concerns are identified by the Council, they need to be addressed by the appropriate department and then brought back to the Council for the members to decide if the problem has been resolved...Council Issues: If one resident has an issue, it is an individual grievance. If two or more residents have issues this will be addressed under "New Business" and the Department Response Form (DFR) is to be utilized...At the next Council Meeting the residents will decide whether the issue has been resolved (at least all but one resident agree) in the "Old Business Section" of the minutes, or if it needs to remain ongoing and be re-addressed using the same format...." 3.1-3(l)			
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment			

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	instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.			

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	(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on interview and record review, the facility failed to ensure accuracy of MDS (minimum data set) assessments regarding skin impairment of a resident's pressure ulcer for 1 of 1 residents reviewed for pressure ulcers. (Resident 71) Findings include: The clinical record for Resident 71 was reviewed on 1/14/19 at 2:09 p.m. The diagnoses included, but were not limited to, peripheral vascular disease, diabetes mellitus and acquired absence of right leg above knee. Resident 71 was hospitalized from 12/3/18 thru 12/8/18. On 1/15/19 at 10:30 a.m., hospital records were reviewed for Resident 71's hospitalization from 12/3/18 thru 12/8/18. A picture of Resident 71's left heel was noted with redness that was worsening in the center of his heel but no open areas present. The discharge diagnoses from the hospital included pressure injury of deep tissue of heel. A readmission nursing assessment, dated 12/8/18, indicated the following, "...Left heel...Stage II...2.0 x 2.0 x <0.1 cm...Description: Redish [sic] purple area. Skin intact. Not open. No drainage...." A physician order, dated 12/8/18, noted the following, "...Zinc Oxide Cream 15%...Apply to left	F 0636	F 636 Comprehensive Assessments and Timing The corrective actions accomplished for those residents found to have been affected by this alleged deficient practice are as follows: Resident 71 has had a new MDS completed and submitted with the correct information. Any resident who has a pressure area has the potential to be affected by this alleged deficient practice All residents who have had a pressure area in the last 3 months most current MDS has been reviewed to ensure that the MDS related to skin alterations was coded correctly. (See Attachment ----) The RN assessment coordinator has reviewed the RAI manual in regards to obtaining supporting documentation for an MDS. (See Attachment ----) The MDS coordinator or her designee will print off the MDS submission log on a weekly basis to present to the DNS or her designee. The DNS or her designee will then complete an audit tool verifying the MDS	02/01/2019

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	heel topically every day and evening shift for Res/bruised [sic] area to left heel...." The medication was signed off twice daily from 12/9/18 through 1/12/19. A significant change MDS, dated 12/15/18, noted no pressure ulcers present for Resident 71. An interview conducted with LPN (licensed practical nurse) 5, on 1/15/19 at 9:25 a.m., indicated Resident 71 has had an area to his left heel for a few months. Just within the last month it has become darker and black. LPN 5 commented that was indicative of an unstageable pressure ulcer when asked by writer. A document that was described as "weekly wound rounds" for Resident 71 was provided by UM (unit manager) 6 on 1/15/19 at 4:10 p.m. The document indicated weekly wound rounds were being conducted for Resident 71 from 12/8/18 to current in regards to his left heel. An interview conducted with RNAC (registered nurse assessment coordinator) 2, on 1/15/19 at 4:45 p.m., indicated there was not enough information in the clinical record to say, for certain, that Resident 71 had a pressure ulcer on the significant change MDS assessment, dated 12/15/18. An interview conducted with the DON (director of nursing), on 1/16/19 at 10:43 a.m., indicated the MDS was incorrect and the skin impairment for Resident 71's left heel should have been noted. There is no policy for MDS and the expectation is to follow the RAI (resident assessment instrument) manual. 3.1-31(d)(3)		submission log for any resident who has a pressure area and then review the MDS to ensure coding related to pressure ulcers was correct weekly for 90 days and then at least monthly until compliance is maintained for 6 consecutive months. (See Attachment) All audits will be presented to the quality assurance committee for review during their monthly QAPI meeting with further recommendations as warranted until compliance is maintained for 6 consecutive months. **Completion Date: 2/1/19**	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review the facility failed to timely assess and investigate bruising on a cognitively impaired resident. This affected 1 of 2 residents reviewed for non pressure related skin conditions. (Resident 63) Findings include: Observation on 1/10/19 at 12:29 p.m., of resident 63 sitting in a broda chair in the dining room indicated, a large bruise on posterior right forearm just above his the wrist. On 1/15/19 at 11:26 a.m., review Physician's recapitulation orders dated January 2019, indicated Resident 63's diagnoses included, but were not limited to, dementia in other diseases classified elsewhere with behavioral disturbance, flaccid hemiplegia affecting left nondominant side, basal cell carcinoma of skin of unspecified parts of face. An order dated 11/10/16, indicated weekly skin assessment document in UDA (user defined assessments) The Minimum Data Set (MDS) Assessment, significant change, dated 12/11/18, indicated,	F 0684	F 684 Quality of Care The corrective actions accomplished for those residents found to have been affected by this alleged deficient practice are as follows: A complete skin assessment was completed on Resident 63 and all abnormal skin areas were assessed, investigated and documented in the resident's medical record per the facility policy and procedure. All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Complete body assessments have been completed on all residents and all areas of concern have been investigated and documented per the facility policy and procedure. The guidelines related to Skin Integrity has been reviewed and no changes were made. (See Attachment ----) All licensed nurses have been	02/01/2019

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	resident does not understand and is not understood. Review of the resident's progress notes dated, "12/23/2018 at 8:15 a.m., General Note Note Text: Return call from NP & given res lab results given, new orders noted to start IV (intravenous fluids)...IV with 20 gauge needle placed to top of (R) forearm, immediate flash return, res tolerated well...Will cont to monitor." A Progress note dated "12/23/2018 at 8:36 p.m., General Note Note Text: Resident pulled out his IV in right wrist. IV reinserted to use 24GA 0.75 IN to right forearm Xs(times) 1 stick. IV is patent and flowing well at this time." Review of a Progress note dated "12/26/2018 at 10:58 p.m., General Note Note Text: Resident IV discontinued, IV removed at 3:15 PM by this Nurse...." Review of weekly skin assessments dated 12/28/18, 1/4/19 and 1/11/19 indicated resident's skin was intact. On 1/15/19 at 11:28 a.m., an interview with the RN unit manger indicated, resident received the large bruised area on his right forearm from the IV's he received toward the end of December. Care plan indicated, "Focus: I am at increased risk for skin breakdown and developing pressure ulcers related to I am incontinent of bowel and bladder and require assist for bed mobility, transfers, and toileting needs due to advancing effects of dementia...(date initiated 10/11/2011). Goal: My skin integrity will remain intact through next review period (date initiated 10/11/2011) (revision on 12/24/2018)...Interventions: ... Notify MD of any changes in skin integrity/redness, excessive bruising, ect., noted during care (date initiated 10/11/2011) (revision on 12/10/2018)... weekly skin assessment and Braden Scale completed quarterly with abnormal assessment		re-educated on the facility policy and procedure in regards to Skin Integrity. (See Attachment ----) The DNS or her designee will assess 5 residents to ensure that a weekly skin assessment has been conducted and any skin areas of concern have been assessed, investigated and documented in the resident's medical record weekly on scheduled days of work for 90 days then monthly until compliance is maintained for 6 consecutive months. (See Attachment ----) All audits will be presented to the quality assurance committee for review during their monthly QAPI meeting with further recommendations as warranted until compliance is maintained for 6 consecutive months. **Completion Date: 2/1/19**	

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	findings reported to MD (date initiated 10/11/2011) (revision on 12/10/2018)" The Skin Integrity Guideline provided by the Executive Director on 1/16/19 at 11:30 a.m. indicated "Purpose: To provide a comprehensive approach for monitoring skin conditions...Objectives: ...Provide a guideline for optimal care to promote healing to patients/residents with all identified alterations in skin integrity (i.e. surgical incisions, skin tears, bruising ect.)...Monitoring Compliance: The following elements are in place to demonstrate satisfactory compliance with guideline: Patient/Resident will be evaluated/observed for risk of skin breakdown and existing areas including but not limited to bruising, skin tears, wounds, abrasions, arterial and venous wounds and pressure ulcers within 24 hours of admission, quarterly, and with decline in condition..." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent			

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	new ulcers from developing. Based on observation, interview and record review, the facility failed to have complete and accurate documentation of the status of a deep tissue injury that was later identified as an unstageable pressure ulcer for 1 of 1 residents reviewed for pressure ulcers. (Resident 71) Findings include: The clinical record for Resident 71 was reviewed on 1/14/19 at 2:09 p.m. The diagnoses included, but were not limited to, peripheral vascular disease, diabetes mellitus and acquired absence of right leg above knee. Resident 71 was hospitalized from 12/3/18 thru 12/8/18. On 1/15/19 at 10:30 a.m., hospital records were reviewed for Resident 71's hospitalization from 12/3/18 thru 12/8/18. A picture of Resident 71's left heel was noted with redness that was worsening in the center of his heel but no open areas present. The discharge diagnoses from the hospital included pressure injury of deep tissue of heel. The picture had a measurement device that noted "12/3/18, 2000 (8:00 p.m.), left heel, 3 x 5.5 x 0 cm [centimeters]". A readmission nursing assessment, dated 12/8/18, indicated the following, "...Left heel...Stage II...2.0 x 2.0 x <0.1 cm...Description: Redish [sic] purple area. Skin intact. Not open. No drainage...." A physician order, dated 12/8/18, noted the following, "...Zinc Oxide Cream 15%...Apply to left heel topically every day and evening shift for Res/bruised [sic] area to left heel...." The medication was signed off twice daily from 12/9/18 through 1/12/19.	F 0686	F 686 Treatment/Services to Prevent/heal pressure Ulcer The corrective actions accomplished for those residents found to have been affected by this alleged deficient practice are as follows: A complete skin assessment was completed on Resident 71 and all abnormal skin areas were assessed, investigated and documented in the resident's medical record per the facility policy and procedure. All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Complete body assessments have been completed on all residents and all areas of concern have been investigated and documented per the facility policy and procedure. The guidelines related to Skin Integrity has been reviewed and no changes were made. (See Attachment ----) All licensed nurses have been re-educated on the facility policy and procedure in regards to Skin Integrity. (See Attachment ----) The DNS or her designee will assess 5 residents to ensure that a weekly skin assessment has been conducted and any skin areas of concern have been assessed, investigated and documented in the resident's	02/01/2019

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	155264	A. BUILDING 00 B. WING	01/16/2019

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	A document titled "Weekly Skin Review" noted the following for Resident 71: 12/3/18- nothing noted about left heel, 12/10/18- nothing noted about left heel, 12/17/18- has a brown area on left heel, 12/24/18- no weekly skin assessment noted, 12/31/18- brown area on left heel, 1/7/19- left heel continues to have discoloration present, & 1/14/19- brown area on left heel. A significant change MDS, dated 12/15/18, noted no pressure ulcers present for Resident 71. An interview conducted with LPN (licensed practical nurse) 5, on 1/15/19 at 9:25 a.m., indicated Resident 71 has had an area to his left heel for a few months. Just within the last month it has become darker and black. LPN 5 commented that was indicative of an unstageable pressure ulcer. An observation conducted of Resident 71's left heel, on 1/15/19 at 9:27 a.m., noted a quarter sized black, hardened area to the left heel. A document that was described as "weekly wound rounds" for Resident 71 was provided by UM (unit manager) 6 on 1/15/19 at 4:10 p.m. The document indicated weekly wound rounds were being conducted for Resident 71 from 12/8/18 to current in regards to his left heel. There were measurements documented but no indication of staging identified. The date(s) of 12/20/18 and 12/27/18 were noted without documentation of the appearance of Resident 71's pressure ulcer to the left heel. This would have included the status of the surrounding tissue, drainage, status of the affected tissue, signs of healing, signs of		medical record weekly on scheduled days of work for 90 days then monthly until compliance is maintained for 6 consecutive months. (See Attachment ----) All audits will be presented to the quality assurance committee for review during their monthly QAPI meeting with further recommendations as warranted until compliance is maintained for 6 consecutive months. **Completion Date: 2/1/2019**	

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	infection, and/or pain. An interview conducted with RNAC (registered nurse assessment coordinator) 2, on 1/15/19 at 4:45 p.m., indicated there was not enough information in the clinical record to say, for certain, that Resident 61 had a pressure ulcer on the significant change MDS assessment, dated 12/15/18. An interview conducted with UM 6, on 1/15/19 at 5:05 p.m., indicated a weekly wound assessment should be conducted weekly in the computer based charting. When a pressure ulcer is identified, an initial assessment, is initiated and that would alert us, UM 6 or the DON (director of nursing), to follow-up with the wound and continue with the weekly wound assessments. This was not completed when the pressure ulcer was first identified, on 12/3/18. UM 6 indicated Resident 71's heel had a dark, leathery appearance that was indicative of eschar (dead tissue) about two weeks ago. An interview conducted with the DON, on 1/16/19 at 10:43 a.m., indicated the nurse, who identified the pressure ulcer, should have created an initial ulcer event that would trigger herself and/or UM 6 to follow-up with the wound and perform weekly wound assessments on the computer charting system. A policy titled "Skin Integrity Guideline", review date of 3/1/18, was provided by the Executive Director on 1/16/19 at 11:30 a.m. The policy indicated the following, "...Objectives...Provide a guideline for optimal care to promote healing to patients/residents with all identified alterations in skin integrity...Evaluation/Observation is to be completed within the first twenty-four hours of			

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	admission/quarterly/significant change of condition using the Weekly Skin Review and/or Wound Evaluation Flow Sheet...Licensed nurse to document weekly on identified wounds using the "Wound Evaluation Flow Sheet"...Monitoring Compliance...Wound Evaluation Flow Sheet UDA is accurately and thoroughly completed for wounds. (one per wound)...." 3.1-40(a)(2)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;			

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	§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to have documented behaviors to be indicative for the use of a psychotropic medication and provide documentation for a rationale for why a gradual dose reduction (GDR) is clinically contraindicated for 1 of 5 residents reviewed for unnecessary medications. (Resident 1) Findings include: The clinical record for Resident 1 was reviewed on 1/11/19 at 1:51 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, Alzheimer's disease, unspecified psychosis and anxiety disorder. Resident 1 was admitted to the facility on 9/18/17.	F 0758	F 758 Free from Unnecessary Medications/PRN use The corrective actions accomplished for those residents found to have been affected by this alleged deficient practice are as follows: The medication list for Resident 1 was reviewed and a new order for a decrease in his psychotropic medication was received. Resident 1's behavior monitoring notes were also reviewed. All residents who reside in the facility and have orders for psychotropic medications have been reviewed to ensure adequate documentation related to behaviors, if present, are	02/01/2019

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	A physician order, dated 1/17/18, indicated the following, "...Zyprexa [antipsychotic] tablet 5 mg [milligrams]...Give 1 tablet by mouth at bedtime related to unspecified psychosis [a disconnect from reality that include delusions, hallucinations, talking incoherently, and agitation]...." A physician order, dated 1/17/18, indicated the following, "..."Olanzapine [generic name for Zyprexa] 2.5 mg Give 1 tablet by mouth one time a day related to unspecified psychosis...." An interview conducted with CNA (certified nursing assistant) 3, on 1/15/19 at 3:30 p.m., indicated Resident 1 has been pleasant without any behaviors noted for a while. A document titled "Behavior Detail Report" was reviewed from the last six months with the only behavior listed is wandering. A Quarterly MDS (minimum data set), dated 9/25/18, noted wandering behavior that occurred 1 to 3 days for Resident 1. No other behaviors marked. Another Quarterly MDS, dated 12/20/18, noted no behaviors occurring for Resident 1. Resident 1 is noted with severe cognitive impairment. A pharmacy recommendation, dated 9/11/18, noted the following, "...Zyprexa 2.5 mg qd [daily] and 5.0 mg qhs [at bedtime]...RECOMMENDATION: Federal guidelines require Gradual Dose Reductions for psychoactive medications to determine the lowest effective dose...[X mark] GDR is contraindicated. The risk vs. benefit has been evaluated and the attempt would likely impair the resident's function or exacerbate the underlying psychiatric		documented in the medical record. All residents who reside in the facility and have orders for psychotropic medications have been reviewed to ensure the facility has documented attempts at gradual dose reduction. The policy and procedure for anti-psychotic medications has been reviewed and no changes were made. (See Attachment) All nurses were re-educated on the policy and procedure. (See Attachment) THE DNS or her designee will review the documentation of 2 residents who anti-psychotic medications to ensure that if behavior is present said behaviors are documented in the residents medical record on scheduled days of work daily for 30 days; 2 times a week for 60 days; then weekly for 90 days. (See Attachment) The DNS or her designee will also review all residents monthly who receive psychotropic medications to ensure that a Gradual Dose reduction has been attempted per the facility policy and procedure and if unsuccessful rational for why it was unsuccessful or why it is clinically contraindicated is present in the residents medical record. (See Attachment) All audits will be presented to the quality assurance committee for review during their monthly QAPI meeting with further recommendations as warranted	

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	condition. *add specific information regarding the patient's current behaviors and/or past GDR failure*...." The document was signed by NP (nurse practitioner) 4 on 9/27/18 but no response noted. Another pharmacy recommendation, dated 11/13/18, noted for a GDR request of Resident 1's Zyprexa, again, with "still behavior" and "0 [no] change" noted under the physician response column. There were no specific information regarding Resident 1's current behaviors and/or past GDR failure noted on the document. The progress notes for Resident 1 noted the following behavior charting since June of 2018: 9/1/18 - resident going through stop signs on resident doors two times, 6/20/18 - resident hit staff member in the arm, & 6/11/18- resident found up against closet door. There were no behaviors noted in Resident 1's clinical record that were indicative of psychosis since June of 2018. An interview conducted with NP 4, on 1/16/19 at 10:30 a.m., indicated she has not recalled any recent events and/or behaviors involving Resident 1. He has been stable for quite a while now. She stated she had no problem with attempting a GDR for Resident 1 and see how he does with it. An interview conducted with the DON (director of nursing), on 1/16/19 at 2:15 p.m., indicated Resident 1 is doing very well and it could be related to his medication. All pharmacy recommendations are reviewed and a monthly behavior meeting is conducted to determine medication management.		until compliance is maintained for 6 consecutive months. **Completion Date: 2/1/2019**	

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	A policy titled "Medication Management", dated 06/15, was provided by the Executive Director on 1/16/19 at 11:30 a.m. The policy indicated the following, "...Antipsychotics. If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) within the first year, unless clinically contraindicated...1. A GDR is considered clinically contraindicated if:...a) Target symptoms returned or worsened after the most recent attempt at a GDR and the physician documents the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. -OR-...b) The continued use is in accordance with relevant current standard of practice and the physician documents the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder...." 3.1-48(b)(2)			