STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165169	A. BUILDING _____ B. WING _____	C 10/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DAVENPORT	700 WAVERLY ROAD DAVENPORT, IA 52804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: ~~11/4/21~~ 11/5/21 The following deficiencies relate to the Survey conducted 9/29/21 - 10/19/21 investigating Complaints #97115, #98125, #98315, #99780, #100076, #100113 and #100133. Complaint #100076 substantiated. (See Code of Federal Regulations (42 CFR), Part 483, Subpart B-C).	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Letha Dodge — TITLE: Administrator — (X6) DATE: 11/8/21

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 755	Continued From page 1 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, resident and Pharmacist interviews, the facility failed to maintain Pharmacy procedures and consultation on all aspects of Pharmacy services that would have notified the facility of irregular staff actions related to medication orders for 1 of 9 resident's reviewed (Resident #3), and ensured continuity of medication orders and supply for 1 of 9 resident's reviewed (Resident #6). The facility reported a census of 102 residents. Findings include 1. The 9/7/21 Minimum Data Set (MDS) Assessment Tool revealed Resident #3 with diagnoses that included cerebrovascular accident (a stroke), diabetes, non-traumatic subdural hemorrhage (bleeding on the brain), depression and generalized muscle weakness. The resident required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed or chair, ambulation, dressing, eating, bathing, personal hygiene and toileting, able to make self understood and understood others. 9/1/21 Physician Orders directed the resident's admission to the facility with orders that included: a. Trazodone (an antidepressant medication) 25 milligrams (mg) oral at hour of sleep (HS) as needed (prn). b. Hydroxyzine (an antihistamine that causes	F 755		

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F 755	Continued From page 2 drowsiness) 25 mg by mouth (po) every 4 hours prn. On 9/9/21 the physician discontinued the prn Trazodone order, and directed staff to administer Trazodone 25 mg oral at HS daily. The record revealed Staff S, Registered Nurse (RN), signed off she completed the discontinued prn Trazodone order. On 10/9/21 the physician discontinued the Trazodone order. A facility form utilized to communicate with the Pharmacy via fax (facsimile) revealed: Resident #3's name on the top of the form, without date or signature, and notation: a. Humalog (insulin) R/O (request for new bottle) b. Hydroxyzine 25 mg po (oral) every 4 hours prn. c. Trazodone 50 mg, 1/2 tablet po every HS prn. The next notation on the form was written under a hand-drawn line, dated 9/22/21 and related to a different resident's discharge. Eight hand written entries appeared below that, 3 dated 9/22/21, 1 dated 9/21/21, the others undated, all unsigned, but evident that at least 4 different staff wrote them. The eighth entry requested Mobic (a non-steroidal anti-inflammatory analgesic - NSAID) for a different resident, with notation "fill through 10/23/21, per previous directions on card label". Per interview with the Director of Nursing (DON) 10/14/21 at 10:02 a.m., Staff R, RN, wrote the resident's name on top of the Pharmacy Fax form with the Humalog request, had not numbered it	F 755		

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F 755	Continued From page 3 and didn't write the other 2 medications, Staff H, Licensed Practical Nurse (LPN), wrote the Mobic request on the bottom of the form and suspected Staff H wrote wrote "1" in front of Humalog, followed by the Trazodone and Hydroxyzine requested on top of the form. The DON stated Pharmacy restocks each skilled resident's scheduled medication supply every 14 days. The DON stated when medications discontinued, the nurse removes the medication from the med cart and places the discontinued medication in the Pharmacy Return Box located in the locked medication room, discontinue the order in the computer, write the medication discontinued on the pharmacy fax form, and sign off that the process completed. An unsigned 9/30/21 entry "Trazodone refill" for the resident was written on another Pharmacy Fax form. Pharmacy invoices revealed: a. 1 bottle of Humalog insulin dispensed 9/21/21. b. 15 doses of Hydroxyzine dispensed 9/23/21. c. 14 doses Trazodone 25 mg tablets dispensed 9/1/21. d. 14 doses Trazodone 25 mg tablets dispensed 9/9/21. e. 14 doses Trazodone 25 mg tablets dispensed 9/23/21. f. 7 doses Trazodone 25 mg tablets dispensed 9/30/21. g. 9 doses Trazodone 25 mg tablets dispensed 10/6/21. Total of 58 Trazodone doses dispensed. Staff D, RN, checked off each medications listed on a 9/22/21 Pharmacy Packing Slip (indicated the listed medications received) that included 14	F 755		

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F 755	Continued From page 4 doses of Trazodone for the resident. Staff D signed her name and wrote 9/22/21 as the date on the form. Medication Administration Records (MAR's) revealed prn Trazodone administered to the resident: a. On 9/1/21 at 8:10 p.m. b. On 9/4/21 at 7:28 p.m. c. On 9/5/21 at 8:01 p.m. d. On 9/7/21 at 8:51 p.m. e. On 9/8/2 at 10:38 a.m. The MAR revealed Trazodone administered 34 times between 9/1/21 and 10/8/21. Pharmacy records revealed 7 Trazodone doses returned after discontinuation 10/9/21. A total of 17 Trazodone doses were not documented as administered and unaccounted for as of 10/19/21. Staff interviews revealed: On 10/14/21 at 2:53 p.m., Staff H, LPN, stated on 9/22/21 she worked the night shift with Staff A, LPN, helped her with the bi-weekly med cart exchange. Staff A told her what they had to order from resident prn medication supplies and she wrote what Staff A said on the pharmacy fax form. Staff H acknowledged she wrote the Mobic request, and Trazodone and Hydroxyzine requested on top of the form. At that time Staff H reviewed documents provided by the surveyor that revealed the prn Trazodone order discontinued on 9/9/21, and was asked why she would request prn Trazodone for the resident on 9/22/21. Staff H then stated when she looked in	F 755		

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F 755	Continued From page 5 the medication cart she saw the resident's prn cards for Hydroxyzine and Trazodone, she thought the Trazodone supply was low, and she just wrote the medication order and directions from the sticker affixed to the prn medication supply on the Pharmacy Fax Form, she wasn't sure what day it was and Staff A had not directed her to request those medications. When asked where Resident #3's 17 unaccounted doses of Trazodone could have gone, Staff H stated she didn't know but wouldn't be surprised if staff that couldn't deal with the resident's behaviors administered them to him. On 10/14/21 at 9:18 a.m., Staff A, LPN, stated Staff H helped her with the medication cart exchange on 9/22/21, there was 1 scheduled medication that wasn't in the exchange, and directed Staff H to write that on the Pharmacy Fax Form, but did not direct her to request any prn medications on the form. On 10/19/21 at 10:18 a.m., Staff D, RN, stated she did not know where 17 unaccounted doses of Trazodone could have gone, the Medication Aides could have given it and didn't tell her On 10/13/21 at 9:08 a.m., Staff Q, Registered Pharmacist (RPh) from the facility's Pharmacy stated they received a fax (facsimile) without staff signature on 9/30/21 that requested Trazodone for the Resident #3. At that time, the medication was scheduled, 14 doses were delivered to the facility on 9/23/21, the medication should have been there and the facility should not have required more. The Pharmacy unable to reach the nurse by phone, faxed the facility and explained the medication was scheduled, 14 doses dispensed on 9/23/21 and should have	F 755		

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F 755	Continued From page 6 been there. The Pharmacy received an unsigned fax response "there was a prn medication card for it but no Trazodone." Staff Q stated that did not address the Pharmacy's question as to where the medication was. The Pharmacy dispensed 7 Trazodone doses that day to ensure the resident had the medication, and did not notify anyone else at the facility or the DON that staff requested medication that should have been at the facility on 9/30/21, and had made a previous attempt to obtain an additional Trazodone supply after the prn Trazodone order was discontinued on 9/9/21. On 10/13/21 at 10:18 a.m., the DON stated she would speak to the Pharmacy, as she expected to be notified, or the manager in charge, of any unusual or suspect medication-related activity, the Pharmacy had her cell phone number and email and could contact her at any time. On 10/14/21 at 10:02 a.m., the DON unable to identify what became of 17 missing Trazodone doses, continued to investigate the matter and it would be addressed with staff at the Nurses meeting scheduled the following day. 2. The 9/1/21 Minimum Data Set (MDS) Assessment tool revealed Resident #6 admitted to the facility 12/8/21 with diagnoses that included anxiety, bipolar manic depression and alcohol cirrhosis of the liver, scored 15 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated no cognitive impairment or symptoms of delirium, had 5 mood indicators, and required staff supervision for eating and bathing. Physician orders directed staff to administer	F 755		

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F 755	Continued From page 7 medications that included: a. On 6/29/21 Trazodone (an antidepressant medication that promoted sleep) 50 milligram (mg) 0.5 tablet oral (po) as needed (prn) for insomnia for 3 months. May take 0.5 or 1 tablets at hour of sleep (HS). The order listed a stop date 9/29/21. b. On 10/6/21 Trazodone 50 mg give 0.5 tablet po prn for insomnia at HS. The order discontinued 10/12/21. c. On 10/6/21 Trazodone 50 mg po prn for insomnia at HS. The order discontinued 10/12/21. d. On 10/12/21 Trazodone 50 mg po prn for insomnia at HS. The Resident #6's record revealed Trazodone ordered and administered to the resident since admitted 12/8/20. Review of the September 2021 Medication Administration Record (MAR) revealed the resident received Trazodone 0.5 tablets (25 mg) 4 times, and 50 mg tablets 23 times. The October 2021 MAR when reviewed 10/13/21 revealed the resident received Trazodone 25 mg 1 time, and 50 mg Trazodone 5 times. Pharmacy records revealed Trazodone 50 mg tablets dispensed to the facility: a. On 9/8/21: 15 tablets. b. On 9/21/21: 15 tablets. c. On 10/6/21: 15 tablets. An antidepressant medication use related to depression and sleeplessness problem initiated 12/9/20 on the Nursing Care Plan with a 12/1/21 goal the resident would be free from discomfort or adverse reactions related to antidepressant	F 755		

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F 755	Continued From page 8 therapy, directed staff to monitor resident's condition based on clinical practice guidelines related to Trazodone. During an interview on 10/14/21 at 10:23 a.m., Resident #6 revealed a history of severe anxiety and mental illness for most of his adult life. Resident #6 stated he was treated for his illness for many years by a local provider and had taken Trazodone and other psychotropic medications for several years prescribed by the provider. While at the facility there were times when his medication was not available. Resident #6 reported as recent as 2 weeks earlier, staff told him there was no Physician Order for the Trazodone and had to go without the medication until he saw the provider several days later. Resident #6 explained the lack of routine medications made his anxiety worse. On 10/14/21 at 1:24 p.m., Staff T, RN, stated staff had not notified the Resident #6's doctor that his Trazodone prescription ended 9/29/21 and required renewal. Staff T reported the resident had an appointment with the provider on 10/6/21 and a new Trazodone prescription provided. Staff T could not identify a reason why staff had not notified the physician that a new Trazodone prescription was required prior to 10/6/21.	F 755		
F 758 SS=G	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §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:	F 758		

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F 758	Continued From page 9 (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; §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	F 758		

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F 758	Continued From page 10 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, physician, Pharmacist and family member interviews, the facility failed to provide a medication regimen free from unnecessary psychotropic medications, administered psychotropic medications without assessment and documentation of the need for the medication, which resulted in the resident's confusion, physical decline, repeated falls, and inability to participate in physician ordered skilled Physical and Occupational Therapy services for strengthening and return to independence for 1 of 9 resident records reviewed (Resident #3). The facility reported a census of 102 residents. Findings include: The 9/7/21 Minimum Data Set (MDS) Assessment Tool revealed Resident #3 with diagnoses that included cerebrovascular accident (a stroke), diabetes, non-traumatic subdural hemorrhage (bleeding on the brain), depression and generalized muscle weakness, scored 10 out of 15 possible points on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated moderate cognitive impairment, without symptoms of delirium or any behavioral symptoms. Resident #3 identified received physical therapy treatment 194 minutes, occupational therapy treatment 190 minutes and 80 minutes of co-therapy treatment by Physical and Occupational Therapists on 4 of 7 days that preceded the assessment. The MDS indicated the resident required extensive assistance of at least 1 staff to reposition in bed, transfer to and	F 758		

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F 758	Continued From page 11	F 758		

from bed or chair, ambulation, dressing, eating, bathing, personal hygiene and toileting. Resident #3 documented able to make self-understood and understood others, had occasional pain rated at 10 on a 0 to 10 pain scale, with 10 rated as the worst pain on the 5 days that preceded the assessment, the pain didn't effect sleep but limited his day-to-day activities. The resident had 2 or more falls without injury since admission to the facility 9/1/21. The assessment revealed both the resident and direct care staff believed the resident was capable of increased independence in at least some activities of daily living (ADL's), an active discharge plan under development, and the resident and family expected discharge to the community at the conclusion of care.

9/1/21 Physician Orders directed the resident's admission to a skilled care facility, to wear a Miami J cervical neck brace collar all times when out of bed, receive Physical and Occupational Therapy services to evaluate and treat the resident, advance activity level as tolerated, follow-up appointment with the physician on 9/27/21 and medication orders that included:
a. Dilaudid 2 milligram (mg) tablet, administer 1 or 2 tablets (2 mg or 4 mg doses) oral (po) every 4 hours as needed (prn) for pain. Dilaudid is a very strong opioid narcotic analgesic.
b. Hydroxyzine hydrochloride 25 mg administered po every 4 hours prn for anxiety. Hydroxyzine is an antihistamine medication that caused drowsiness.
c. Olanzapine 5 mg tablet administered po daily at hour of sleep (HS). Olanzapine is a strong antipsychotic medication, normally prescribed for treatment of Schizophrenia and psychotic disorders.
d. Trazodone 25 mg administered po HS prn to

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GOOD SAMARITAN SOCIETY - DAVENPORT	700 WAVERLY ROAD DAVENPORT, IA 52804

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F 758	Continued From page 12 treat a subdural hemorrhage. Trazodone is an antidepressant with common side effects that included drowsiness and tiredness, per website "https://www.drugs.com/trazodone.html". e. Buproprion 150 mg extended release tablet administered po daily (antidepressant medication). f. Fluoxetine 20 mg administered oral daily. Fluoxetine, trademark name Prozac, is an SSRI antidepressant medication (Selective Serotonin Reuptake Inhibitor). g. Melatonin, a natural human hormone that caused sleep, 5 mg administered po daily at HS. The Dilaudid, Olanzapine, Trazodone, Buproprion and Fluoxetine medication orders were flagged with Black Box warnings in the electronic record; A Black Box warning alerts the provider and staff of potentially serious adverse reactions that could lead to hospitalization and death. A black box warning also explained how reactions could be worse in certain groups of people, such as women who are pregnant or the elderly. The Opioid Black Box warning stated the concurrent use of opioids and benzodiazepines increased the risk of fatal overdose, per website "https://medlineplus.gov/druginfo/meds/a682013.html". The Olanzapine Black Box warning described increased death and heart-related side effects in seniors with dementia-related psychosis, and Olanzapine not approved for treatment of dementia related psychosis, per website "https://pi.lilly.com/us/zyprexa-pi.pdf". The Fluoxetine Black Box warning described increased suicidal thoughts and behaviors in	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165169	A. BUILDING _____ B. WING _____	C 10/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DAVENPORT	700 WAVERLY ROAD DAVENPORT, IA 52804

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F 758	Continued From page 13 children, adolescents and young adults, per website "https://www.drugwatch.com/ssri/prozac/". An automated alert in the resident's electronic record at 5:27 p.m. on 9/1/21 notified the physician of severe drug to drug interactions that included: a. Severe increased risk for Serotonin Syndrome from Fluoxetine and Trazodone administration. b. Moderate risk for Serotonin Syndrome from Dilaudid and Trazodone administration. c. Moderate risk for Neuroleptic Malignant Syndrome from Olanzapine and Trazodone administration. The website "https://www.webmd.com/depression/guide/serotonin-syndrome" described Serotonin Syndrome as too much Serotonin, a chemical in the body, usually because of medication or combinations of medications, often began hours after a new medication that affected Serotonin levels were administered or after current drug dosage increased, and symptoms of Serotonin Syndrome included, but not limited to: a. Confusion. b. Agitation or restlessness. c. Headache. d. Changes in blood pressure and/or temperature. e. Tremor. f. Loss of muscle control or twitching muscles. The website "https://www.webmd.com/schizophrenia/guide/what-is-neuroleptic-malignant-syndrome" described Neuroleptic Malignant Syndrome (NMS) as a rare reaction to antipsychotic drugs that affect the	F 758		

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F 758	Continued From page 14 nervous system and can cause symptoms within 2 weeks after medication initiated, or dosage changed, that include, but not limited to: a. High fever (102 to 104 degrees Fahrenheit). b. Muscle stiffness. c. Profuse sweating. d. Anxiety or other changes in mental state. e. Fast or abnormal heartbeat. NMS can damage muscles and cause very high or low blood pressure, if untreated, more serious conditions could result that required immediate medical treatment and included: a. Kidney failure. b. Heart and lung failure. c. Lack of oxygen in the body. d. Infection in the lungs caused by breathing in fluid (aspiration pneumonia). Other Physician Orders changed the medication regimen as follows: a. On 9/9/21 discontinue prn Trazodone. Start Trazodone 25 mg administered po daily at HS. b. On 9/14/21 Robaxin 1500 mg administered po 3 times daily through 9/30/21, then decreased to 1000 mg administered po 3 times a day from 10/1/21 through 10/21/21. Robaxin is a strong skeletal muscle relaxer with common side effects that included drowsiness, confusion, memory problems, loss of balance or coordination, light-headedness and dizziness, per website "https://www.rxlist.com/robaxin-side-effects-drug-center.htm". c. On 9/19/21 discontinue Olanzapine ordered daily at HS. Start Olanzapine 5 mg po twice daily. d. On 9/27/21 Hydroxyzine discontinued. e. On 9/27/21 Xanax 0.25 mg administered po every 8 hours prn for anxiety. Xanax is a strong Benzodiazepine anti-anxiety medication, a	F 758		

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F 758	Continued From page 15 Schedule IV controlled narcotic with a Black Box warning that stated taking benzodiazepines at the same time as opioids can lead to extreme sedation, slow and ineffective breathing, comas, and even death, per website "https://www.center4research.org/fda-updates-black-box-warning-for-benzodiazepines/". e. On 10/4/21 discontinue Robaxin. f. On 10/6/21 discontinue Dilaudid. g. On 10/9/21 discontinue Xanax, Trazodone and Wellbutrin. h. On 10/9/21 Olanzapine decreased from po twice daily to once daily at HS. Medication Administration Records (MAR's) and narcotic inventory control sheets revealed the following medications administered to the resident: Dilaudid 2 mg Discontinued 10/6/21, stock on hand destroyed: a. On 9/4/21 at 6:10 a.m. by Staff A, Licensed Practical Nurse (LPN). b. On 9/7/21 at 8:45 p.m. by Staff B, Registered Nurse (RN). c. On 9/12/21 at 3:45 p.m. by Staff C, RN. d. On 9/13/21 at 11:55 p.m. by Staff A, LPN. e. On 9/23/21 at 5:45 a.m. by Staff A, LPN. f. On 9/24/21 at 8:10 p.m. by Staff D, RN. g. On 9/29/21 at 8:00 p.m. by Staff E, Certified Medication Aide (CMA), not recorded on MAR. h. On 10/2/21 at 8:48 p.m. by Staff D, RN. Dilaudid 4 mg Discontinued 10/6/21, stock on hand destroyed: a. On 9/1/21 at 9:10 p.m. by Staff D, RN. b. On 9/3/21 at 9:30 a.m. by Staff F, CMA. c. On 9/4/21 at 12:00 p.m. by Staff F, CMA. d. On 9/4/21 at 8:00 p.m. by Staff E, CMA.	F 758		

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	165169	A. BUILDING _____ B. WING _____	C 10/19/2021

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F 758	Continued From page 16 e. On 9/5/21 at 6:21 p.m. by Staff G, LPN. f. On 9/8/21 at 9:30 a.m. by Staff E, CMA. g. On 9/8/21 at 8:00 p.m. by Staff E, CMA. h. On 9/9/21 time and signature not recorded, assigned to Staff A, LPN, not recorded on MAR. i. On 9/9/21 at 9:00 p.m. by Staff F, CMA. j. On 9/12/21 at 8:00 p.m. by Staff H, LPN, not recorded on MAR. k. On 9/14/21 at 8:00 p.m. by Staff H, LPN. l. On 9/15/21 at 8:00 p.m. by Staff G, LPN. m. On 9/16/21 at 8:00 p.m. by Staff H LPN, not recorded on MAR. n. On 9/30/21 at 8:00 p.m. by Staff E, CMA. o. On 10/5/21 at 2:45 p.m. by Staff H, LPN, not recorded on MAR. p. On 10/5/21 at 8:00 p.m. by Staff H, LPN, not recorded on MAR. Hydroxyzine 25 mg every 4 hours as needed (prn) discontinued 9/27/21: a. On 9/1/21 at 7:48 p.m. by Staff I, LPN. b. On 9/8/21 at 10:38 a.m. by Staff E, CMA. c. On 9/12/21 at 3:42 p.m. by Staff C, LPN. d. On 9/25/21 at 5:29 p.m. by Staff C, LPN. Xanax 0.25 mg every 8 hours prn started 9/27/21, discounted 10/9/21, stock on hand destroyed: a. On 9/27/21 at 7:10 p.m. by Staff B, RN. b. On 9/29/21 at 6:00 p.m. by Staff E, CMA. c. On 9/30/21 at 8:00 p.m. by Staff E, CMA. d. On 10/2/21 at 8:48 p.m. by Staff D, RN. e. On 10/4/21 at 8:00 p.m. by Staff J, LPN. f. On 10/5/21 at 8:00 p.m. by Staff H, LPN, not recorded on MAR. Trazodone 25 mg as needed at HS, discontinued 9/9/21, changed to HS daily: a. On 9/1/21 at 8:10 p.m. by Staff D, RN. b. On 9/4/21 at 7:28 p.m. by Staff E, CMA.	F 758		

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F 758	Continued From page 17 c. On 9/5/21 at 8:01 p.m. by Staff G, LPN. d. 9/7/21 at 8:51 p.m. by Staff B, RN. e. On 9/8/21 at 10:38 a.m. by Staff E, CMA (a medication error the facility was not aware of until the investigation). Pharmacy invoices revealed the following account of Trazodone: a. 14 doses Trazodone 25 mg tablets dispensed 9/1/21. b. 14 doses Trazodone 25 mg tablets dispensed 9/9/21. c. 14 doses Trazodone 25 mg tablets dispensed 9/23/21. d. 7 doses Trazodone 25 mg tablets dispensed 9/30/21. e. 9 doses Trazodone 25 mg tablets dispensed 10/6/21. f. A total of 58 doses received. g. A total of 34 documented doses recorded on the MAR. h. A total of 7 doses returned to the pharmacy after 10/9/21 discontinuation order. g. A total of 17 doses were not recorded and unaccounted for as of 10/19/21. Pharmacy invoices revealed the following account of Hydroxyzine: a. 15 Hydroxyzine 25 mg tablets dispensed 9/1/21. b. 15 Hydroxyzine 25 mg tablets dispensed 9/23/21. c. A total of 30 doses received. d. A total of 4 documented doses recorded on the MAR. e. A total of 21 doses returned to the pharmacy after 9/27/21 discontinuation order. 5 Hydroxyzine doses were not recorded and not accounted for as of 10/19/21.	F 758		

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F 758	Continued From page 18 Nursing Progress Notes in the resident's record did not describe behaviors or indications of anxiety at times when Hydroxyzine or Xanax were administered. The computer software used for medication administration documentation placed an automated notation in the Nursing Progress Notes when staff administered a prn medication that stated the order, i.e. "Hydroxyzine 25 mg administered oral every 4 hours as needed for anxiety", appeared in the Progress Note, but without any description of the resident's anxiety or why the resident required the medication. A Hospital ER Progress Note dated 9/28/21 at 8:15 p.m., revealed the resident seen for altered mental status, confusion, falls, worsened mental status and motor function. Upon presentation to the hospital was unable to ambulate, speech mumbled and spoke in broken sentences. A CT (computed tomography) scan of head negative for changes, chest X-ray and lab work negative for findings, diagnosed that symptoms were possibly secondary to polypharmacy from new medications prescribed at facility, and resident discharged to the facility with recommendation for close follow-up with primary care provider. The resident returned to facility 9/29/21 at 1:45 a.m. A Psychotropic Medication Use related to depression and behavioral outburst problem, initiated on the Nursing Care Plan 9/1/21, with an 11/1/21 goal the resident would be free from discomfort or adverse reactions related to antidepressant therapy (implementation date in parenthesis at end of goal), directed staff on the following: a. Educate resident/family about risks, benefits, side effects and toxic symptoms of medication	F 758		

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F 758	Continued From page 19 (9/1/21). b. Report confusion, mood charge, change in normal behavior, hallucinations/delusions, social isolation, suicidal ideation, withdrawal, decline in ability to help with/do activities of daily living (ADL's), cognitive function, shuffled gait, difficulty ambulating, balance problems, falls, fatigue, insomnia, appetite loss, weight loss to the nurse (9/1/21). c. Discuss with health care provider, family ongoing need for use of medication (9/1/21). d. Consult with pharmacy, health care providers to consider dosage reduction when clinically appropriate (9/1/21). A Risk for Fall problem, initiated on the Nursing Care Plan 8/13/21, with an 11/1/21 goal the resident would not sustain serious injury from a fall, directed staff on the following: a. Educate resident/family/staff as to causes of fall (8/13/21). b. Encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility (8/13/21) c. Place fall mat next to bed when in bed. Keep bed in low position. Keep bed remote out of reach of resident due to cognitive deficit impairing safety judgement. Bolsters/Body pillows to edge of bed for boundary identification (9/5/21). d. Review resident's medical record for medications or combinations of medications that could predispose to falls/increase fall risk (10/2/21) e. Check and change resident for incontinence at shift change (9/13/21). f. Contact therapy for consult for strength and mobility (8/13/21).	F 758		

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	165169	A. BUILDING _____ B. WING _____	C 10/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 20 Review of Incident Reports described the following falls: a. On 9/4/21 at 8:25 p.m., bed in lowest position, 2 falls from self-transfers from bed, sustained an abrasion to left knee, resident placed in wheel chair and kept by the nurse. b. On 9/5/21 at 9:45 a.m. found on floor on buttocks, no identified injury, sent to the hospital Emergency Room (ER), computed tomography (CT) scan of head completed without identified injury, returned at 5:37 p.m., 15 minute checks initiated and fall mats placed in room. c. On 9/18/21 at 5:25 a.m. found on fall mat next to bed on stomach, bed in low position, last seen 15 minutes prior, no identified injury, resident stated his bed was uncomfortable. Assisted off floor via mechanical lift and 2 staff, 15 minute checks initiated for 72 hours. d. On 9/21/21 at 5:40 a.m. found face down on fall mat next to bed, bed in low position, last seen 20 minutes prior in bed, awake and alert, call light within reach but not activated. Staff continued 15 minute checks and requested therapy staff to assess if they could provide other interventions to improve resident safety. e. On 10/2/21 at 5:15 a.m. found on floor on stomach, bed in low position, body pillow in place prior to fall, floor mat present, no injury identified, assisted back to bed with mechanical lift and 2 staff. Medication review completed, Robaxin dose recently decreased. f. On 10/4/21 at 10:46 p.m. found on back on floor fall mat, bed in low position, no injury identified. Resident lifted from floor with mechanical lift and 2 staff, placed in wheel chair and brought to the Nurse's Station. Facility made referrals to 2 facilities with behavioral units for resident transfer, awaited screening assessment results.	F 758		

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	165169	A. BUILDING _____ B. WING _____	C 10/19/2021

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GOOD SAMARITAN SOCIETY - DAVENPORT	700 WAVERLY ROAD DAVENPORT, IA 52804

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F 758	Continued From page 21 A Physical Therapist assessment dated 9/2/21 revealed the following on the resident: a. Required substantial/maximal assistance to roll left and right. b. Substantial/maximal assistance required to transition from sitting to lying. c. Substantial/maximal assistance required to transition from lying to sitting. d. Dependent on helper, or 2 or more helpers, for all effort to transition from sit to stand position, resident did not participate in the effort. e. Dependent on helper, or 2 or more helpers, for all effort to transfer from chair to bed or bed to chair, resident did not participate in the effort. f. Ambulation not attempted due to medical condition or safety concerns. A Physical Therapy Plan of Care dated 9/2/21 listed 9/16/21 goals: a. Resident will be able to transfer from bed or chair with front wheeled walker (fww) with moderate assistance of 2 staff, and verbal, tactile and visual instruction cues. b. Resident will ambulate 5 feet on level surfaces with parallel bars with maximum assistance, and verbal instructions/cues to improve posture and sequencing to reduce burden of care. And 9/29/21 goals: a. Resident will ambulate 200 feet on level surfaces with fww and contact guard assist, and verbal instruction/cues to prepare for discharge home. b. Resident will ascend/descend 6 steps/stairs with contact guard assist, 2 hand rails and verbal instruction/cues to prepare for discharge to next site of care. c. Resident will perform sit to stand for transfers	F 758		

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F 758	Continued From page 22 to and from bed or chair with fww with contact guard assist and verbal instructions/cues to prepare for a discharge home. A 9/15/21 Physical Therapist Assessment, completed after 10 therapy sessions detailed progress that included: a. Ambulated length of parallel bars (approximately 12 feet) with moderate assistance for weight shifting, with verbal instructions/cues for sequencing, step length, foot clearance and hand placement. b. Performed supine (laid on back) to and from sitting position with minimal assistance, and visual and verbal instructions/cues. c. Transferred to and from bed and chair with 100 percent assist, and verbal instructions/cues with sit to stand mechanical lift used. Review of Physical Therapist Notes revealed: a. On 9/20/21 ambulated 4 steps twice in parallel bars with maximum assist of 1 and minimum to moderate assist of a second person, demonstrated poor ability to follow cues to correct flexed posture and right lateral lean with maximum assist for weight shifting to offload and allow for advancing lower extremities with swing phase (to move leg forward with ambulation). At times lifted right foot, but did not follow cues to step forward. b. On 9/27/21 co-treat with occupational therapy secondary to need for 2 to 1 assistance required for ambulation in parallel bars, required maximum 2 to 1 assistance with significant posterior lean and no initiation to correct with verbal and tactile cues as well as visual demonstration. Completed 5 steps and 3 steps with verbal and tactile cues for advancing each lower extremity, maximum 2 to 1 assistance for weight shifting secondary to	F 758		

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F 758	Continued From page 23 poor understanding of task. c. On 9/30/21 co-treat with occupational therapy secondary to 2 to 1 assist required for transfers. Resident did not lean forward when seated to prepare for sit to stand transfer despite verbal and tactile cues. Attempted ambulation in parallel bars, but resident unable to offload either foot enough to take a step. d. On 10/4/21 attempted to complete seated exercises, resident too lethargic to participate. When resident in bed, attempted active assisted range of motion (AAROM) and active range of motion (AROM) exercises, resident resistive and unable to follow directions. The 10/4/21 Physical Therapy Discharge Summary stated the resident had not made progress in the last several days due to inconsistent alertness levels and fatigue, limited ability to follow commands, and discharged from Part A skilled Medicare services. The resident was to continue therapy under Part B Medicare, not skilled level of care (less aggressive therapy treatment, shortened therapy sessions, provided fewer times per week) to maximize independence and minimize burden of care. Resident observations revealed: a. On 9/30/21 at 7:48 a.m., resident positioned recumbent in recliner chair with foot rest elevated in room, asleep, snored with mouth open, fall mat placed in front of the chair/under the foot rest, room dark, over-bed table positioned next to the chair, call light looped over the top of the table. b. On 9/30/21 at 8:01 a.m., Staff K, LPN, entered the resident's room, came out of the room at 8:02 a.m. with glucometer in hand, stated he was sound asleep and did not wake up when she	F 758		

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F 758	Continued From page 24 lanced his finger for a blood sample. c. On 9/30/21 at 11:20 a.m. in therapy room, 2 therapists held a gait belt applied to the resident's chest area with both hands, held the resident upright between the parallel bars, both stated their maximal effort was required to hold the resident up. The resident's waist was bent slightly, hand were positioned on the rails, his chest/upper torso leaned to the right, near the bar on that side of his body, unable to move his feet or stand in a more erect posture despite multiple cues and physical guides provided by the staff, unable to ambulate and returned to the wheel chair. The resident did not speak or answer the therapist's questions, but pointed at the therapist when she asked him who spilled his soda. d. On 9/30/21 at 8:12 p.m. seated in a wheel chair in the hall, awake and appeared more alert than earlier in the day. Staff L, certified nursing assistant (CNA) and Staff E, CMA, instructed and assisted the resident to hold the handles of the Tolleo mechanical stand lift, applied the required belt, raised the resident to an upright position and transferred him to the bed. Staff E supported the resident's back to maintain a seated position as Staff L removed the belt, moved the lift away and then lifted his legs to the bed as they laid the resident down. The resident could not maintain a seated position without the staff's support. e. On 10/5/21 at 5:54 a.m. seated in wheel chair somewhat reclined in the hall by the nurses station, asleep, with food crumbs on chest area of shirt. At that time, Staff G, LPN, stated he'd fallen earlier in the night and awake for much of the night shift, the resident had fed himself snacks provided that included cookies, pudding and juice, and calmer when in the hall near staff. f. On 10/6/21 at 3:52 p.m. seated in wheel chair in lobby area, held his Miami J collar that he'd	F 758		

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	165169	A. BUILDING _____ B. WING _____	C 10/19/2021

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F 758	Continued From page 25 removed himself, awake and said hi when greeted. g. On 10/7/21 at 4:41 p.m. seated in recliner chair in his room, yelled "hey" as surveyor passed, held the television remote control in right hand, the cover for the battery compartment in his left hand and said "I need a battery for this". Upon inspection 1 of the 2 batteries was in the device, staff found the other battery in the resident's chair. The resident then changed the television channel with the remote held in his left hand. h. On 10/13/21 at 10:20 a.m. stood between parallel bars in the therapy room, 1 staff stood in front of the resident, held the gait belt applied to chest area with light grip, provided verbal cues to move his hands forward on the bars, sometimes let go of the gait belt and physically assisted the resident to move his hand forward on the rails, resident maintained an upright position and ambulated forward several steps as she continued verbal cues. Another therapy staff member followed closely behind the resident with a wheel chair, but did not physically assist or support the resident's ambulation. i. On 10/18/21 at 4:22 p.m. seated in wheel chair in lobby area, asked for help to go to his room, stated his room number and said he had to call his wife. Staff M, CNA, assisted resident to his room. Physician interviews revealed: a. On 10/13/21 at 8:42 a.m., Staff N, Neurosurgeon, stated at the time of 9/1/21 hospital discharge, the resident's prognosis for return to independence was good with continued Physical Therapy services for strengthening. The prescriptions for Olanzapine, Hydroxyzine and Trazodone were implemented by the Hospital Nurse Practitioner (NP) and likely to treat	F 758		

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F 758	Continued From page 26 sleeplessness, restlessness or anxiety during the hospitalization. The Neurosurgeon reported had not been consulted about the medications, did not believe the symptoms were serious or indicative of further treatment required because they would have been consulted and had to have consulted with Psychiatry if so, and not aware of any concern for possible dementia or schizophrenia. The physician stated the resident remained under their care with a scheduled follow-up appointment, and the facility should have consulted with them in reference to his falls, anxiety or behaviors of concern and implementation of additional sedative medication, so they could have assisted or opined to address the issues as they were likely related to the resident's subdural hemorrhage. b. On 10/18/21 at 2:40 p.m., the facility's Medical Director and resident's physician stated she didn't think facility staff had notified her of the 9/28/21 ER findings, the staff probably would have notified the NP, and noted the NP was off duty on 9/29/21 and 9/30/21, so may not have received a notification until 10/4/21 when back on duty. Staff interviews revealed the following: a. On 10/6/21 at 1:11 p.m. Staff E, CMA, stated she was directed by the nurse to administer Dilaudid, Hydroxyzine and Trazodone at the same time to the resident, she didn't make those decisions on her own, Staff D, RN, didn't like the resident's behaviors and directed her "to give him everything he could have, give him a cocktail" (a combination of medications), Staff D had directed her to administer the medications together on several evenings when she worked on that unit, if the nurse directed the Medication Aides to administer prn medications for behaviors or anxiety, the nurse was supposed to document	F 758		

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F 758	Continued From page 27 that, it wasn't the responsibility of the Medication Aide. Staff E heard the resident would try to get up and had fallen, but she had never observed that or any behaviors, the resident was always agreeable with her when she administered his medication. Staff E stated she administered Trazodone on the morning of 9/8/21 because she was directed to by the nurse. On 10/18/21 at 4:12 p.m., when asked about Dilaudid administrations that she recorded on the Narcotic Inventory Control Sheet but not on the MAR, Staff E stated she administered the medication and must not have documented it in the computer, and did not know how there could be 17 doses of Trazodone undocumented or unaccounted for. b. On 10/12/21 at 10:43 a.m. Staff F, CMA, stated she administered as needed medications when directed by the nurse, but nurses were to document why the medication was given, she never administered prn medication unless the nurse instructed her to. When she worked on the resident's unit the nurse often asked if he could have anything yet, related to medication for anxiety or behaviors, and sometimes the resident's family asked if he could have something for pain, he had headaches. Staff F stated she heard the resident climbed out of bed and had behaviors, but had not witnessed that herself and the resident cooperative when she administered his medication. c. On 10/6/21 at 3:34 p.m. Staff D, RN, stated the resident had behaviors every day, tried to get up, couldn't say what he wanted or needed, or where he wanted to go as he made the attempts. The resident had medications to treat the behaviors, and Dilaudid for pain, sometimes he said he had pain, other times he didn't or couldn't say. The medication helped for 3 to 4 hours and sometimes the symptoms returned, you couldn't	F 758		

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F 758	Continued From page 28	F 758		

reason with him, he wouldn't leave the cervical collar on and he usually did better if the family was there. On 10/18/21 at 10:18 a.m. Staff D stated she directed the CMA to administer Dilaudid, Hydroxyzine and Trazodone together at the same time 2 or 3 times due to his behaviors that included trying to get up and if he had a hold of anything he threw it. When asked if there were any attempted interventions prior to administration of the prn Hydroxyzine or Xanax, Staff D stated they probably tried 10 things and nothing worked. Staff D stated if CMA's administered his prn Hydroxyzine, Trazodone or Xanax, the CMA's documented the behaviors on the MAR, there wasn't any other place to document that but staff could record the medication was effective on the MAR. When asked where 17 missing Trazodone doses could be, Staff D stated the CMA's could have administered it and not told her.

d. On 10/6/21 at 12:55 p.m. Staff A, LPN, stated she worked the night shift (10 p.m. to 6 a.m.), the resident had good and bad nights, sometimes was restless and tried to get up, he'd fallen a few times. When he was restless or anxious he did better if they got him up and kept him where he could see the staff, which seemed to calm him.

e. On 10/6/21 at 12:26 p.m. Staff P, LPN, stated she had assessed the resident and directed the CMA's to administer anti-anxiety medications and analgesics when needed, and then reassessed the resident for medication effectiveness. Staff P was certain she did not and would not direct a CMA to administer Hydroxyzine, Dilaudid and Trazodone at the same time, and quite certain she didn't instruct the CMA to administer Trazodone to the resident at 10:30 a.m. on 9/8/21.

f. On 10/14/21 at 2:53 p.m. Staff H, LPN, stated

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F 758	Continued From page 29 she had not observed aggressive behaviors from the resident, he would yell out and get your attention, he thought he could walk and would try to get up, required frequent redirection and seemed to do better with 1 to 1 direction by staff when he was like that so she put him with her in the hall when needed. When asked about Dilaudid and Xanax medication administration that she had recorded on inventory control sheets but not on the MAR, Staff H stated she had not recorded the administration in the computer, sometimes due to Internet issues/computer problems but tried to improve on that, and made attempts to make sure the documentation was done before she did anything else. When asked where 17 unaccounted doses of Trazodone could have gone, Staff H stated she didn't know but wouldn't be surprised if staff that couldn't deal with behaviors administered it to Resident #3. Staff H stated when she started at the facility 9/1/21 there was a lot of agency staff there, organization was needed and has since improved. g. On 10/7/21 at 3:19 p.m. Staff O, Occupational Therapist (OT), stated if the resident was awake and not in pain, he did better in therapy, was able to follow cues. His participation in therapy was impeded if he was too tired to follow cues or was in pain. h. On 10/7/21 at 11:09 a.m. the Director of Nursing (DON) stated she expected the nurses to assess resident anxiety, attempt at least 3 interventions such as offer a snack or provide 1 to 1 attention prior to medication administration. The DON stated she expected to find documentation of the resident's anxious behaviors and interventions attempted to reduce anxiety in the resident's record, and in the process of staff education to ensure that nurses	F 758		

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F 758	Continued From page 30 did that. The DON stated she reviewed the resident's record and could not find documentation related to behaviors or anxiety that prompted his prn medication administration by staff, other than what was automated in the computer when staff administered the medication. The DON also reported she could not find documentation of other interventions attempted prior to medication administration. The DON stated she understood the concern over too many psychotropic medications and review of the matter was underway. i. On 10/13/21 at 3:10 p.m. the DON stated there was a Nurses Meeting 10/15/21, CMA's would attend, and prn medication administration by CMA's would be addressed at the meeting. j. On 10/14/21 at 10:02 a.m. the DON was not able to identify what became of 17 missing Trazodone and 5 missing Hydroxyzine doses, continued investigation of the matter would occur and be addressed with Nursing Staff at their meeting the following day. During an interview on 10/13/21 at 9:08 a.m., Staff Q, Registered Pharmacist (RPh) from the facility's Pharmacy stated they received a fax (facsimile) without staff signature on 9/30/21 that requested Trazodone for the resident. At that time, the medication was scheduled, 14 doses were delivered to the facility on 9/23/21 and should not have required more. They were not able to reach the nurse by phone and dispensed 7 Trazodone doses that day to ensure the resident had the medication. During an interview on 10/6/21 at 6:05 p.m., the resident's family member/responsible party (RP) stated the resident was supposed to have Physical Therapy for strengthening so he could	F 758		

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F 758	Continued From page 31 return home, but the facility had him on sedative medications because he had repeated falls. The family member/RP stated the medications started without their knowledge or consent, or the facility would call and say a medication was started and they were not consulted prior to that. The family member/RP reported they told nursing staff multiple times and even told the Social Worker they did not want the resident to receive medications that caused or worsened his confusion and lethargy. The family member/RP stated on the evening of 9/24/21, the resident couldn't hold on to the stand lift machine handles. The resident's body hung from the belt hooked to the lift (from arm-pit area) and he was too tired and confused to assist. The family member/RP reported was concerned for his safety and spoke to the nurse on duty at the time, Staff D, RN, told her of the concerns for resident's safety, lethargy, confusion and they didn't want him to receive medications that sedated him. Staff D stated she had no choice and had to follow Physician Orders. The family member/RP stated the facility said the resident's therapy would stop on 10/4/21 because he didn't participate and he needed to transfer to a facility with a Behavior Unit. The family member/RP said the resident had worked with therapy, had ambulated the length of the parallel bars with therapy and gained strength until around 9/15/21. The resident then became confused and lethargic and had progressively worsened since then and he had more falls. On the evening of 9/28/21 the family member/RP called for an ambulance to take the resident to the ER due to his deterioration and wanted a different doctor to evaluate his conditions. Staff D, RN was on duty at the time and said they couldn't take him out of the facility without a Doctor's Order and wouldn't provide a list of his	F 758		

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F 758	Continued From page 32 medications they had requested multiple times. On 9/28/21 the ER physician told the family member/RP there were no signs of injury or more brain bleeding, couldn't find anything wrong and said his confusion, weakness and lethargy was from all the medications the facility gave him.	F 758		

F000 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual

F755 Pharmacy Services

Resident's 3 and 6 medications orders were reviewed on 11/5/21 by Director of Nursing Services to ensure all medications are in place and are followed as directed.

This has the potential to affect all residents receiving medications from pharmacy.

Education was provided to all nurses and medication assistants on 10/15/21 and 11/5/21 by Director of Nursing Services related to the process for ordering, receiving, storing and returning medications. All medications ordered are in place and are refilled as necessary to maintain following of physician orders.

An audit will be completed by the Director of Nursing Services or delegate weekly x 2 then bi weekly x 2 then monthly x 2 to ensure medications are in place and being filled and refilled as appropriate. Pharmacy consultant recommendations will also be reviewed and completed monthly and as needed by Director of Nursing and/or delegate on a monthly basis. All audits will be reviewed at monthly Quality Assurance Performance Improvement meeting for further recommendations.

Compliance Date: 11/5/21

F758 Free from Unnecessary Psychotropic Medications/PRN Use

Resident #3 medication was reviewed on 10/21/21 by Director of Nursing Services and medical provider. Adjustments to medications had been ongoing for this resident.

This has the potential to affect all residents that might require the use of psychotropic medication.

Education was provided by the Director of Nursing Services on 10/15/21 and again on 11/5/21 regarding the use of the least number of and dosage of any psychotropic medication as necessary to enable the highest level of functioning for all residents. Education was also provided on the 14 day review for any PRN psychotropic medication.

The consultant pharmacist will review all medications monthly and recommendations will be followed up on by the Director of Nursing or delegate. An audit will be completed weekly x 2, then bi weekly x 2 then monthly x 2 on the use of psychotropic medication including gradual dose reductions and 14 day review of prn meds. Changes in psychotropic medications will be reviewed at the weekly interdisciplinary team meeting. All reviews and audits will be reviewed at the monthly Quality Assurance Performance Improvement meeting for any further recommendations.

Compliance Date: 11/4/21