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F 000	INITIAL COMMENTS Surveyor: 16893 The following reflects the findings of the California Department of Health Services during an ABBREVIATED Complaint survey. Complaint No: CA00102451, CA00103130, CA00103628 Representing the Department of Health Services: Samuel Obair II, Pharmaceutical Consultant Ruth Hoover, HFEN Linda Goldsmith, HFEN The facility census was 73 patients. IJ (Immediate Jeopardy) was identified on January 11, 2007 at 11:05 AM for the skilled nursing facility's issues at F329, giving psychiatric medications without a psychiatric evaluation; IDT (Interdisciplinary Team) recommendations for psychiatric medication; pharmacist writing prescriptions and staff direction by DON (Director of Nursing) toward the use of psychiatric medications. IJ was lifted on January 19. 2007 at 1 PM.	F 000		
F 222 SS=H	483.13(a) CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 13095	F 222		5/17/07

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

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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Based on observation, interview, record review, review of facility documents and manufacturer's drug literature the facility failed to ensure 16 of 29 sampled residents were free of chemical restraints. (1, 2, 5,6,7,9, 10, 11,12, 14, 18, 19, 21, 24, 27 and 28)

Findings:

Interview with the facility's Director of Pharmacy and nursing staff between January 12, 2007 to January 19, 2007, revealed that the facility's previous Director of Nurses (DON) had instructed facility staff to use Depakote on the residents because this medication did not require informed consent from the residents or their families prior to administration. During an interview with the Director of Pharmacy on January 12, 2007 at 4:40 p.m., the Director of Pharmacy indicated: "(the previous DON) requested me to write orders for these medications." The Director of Pharmacy went on to say that she felt that the previous DON had come to the facility with a wealth of knowledge and "I trusted her (the previous DON)."

Review of a note dated December 25, 2006 in the facility's communication log stated: "Note from (previous DON) > No consent needed for Depakote at all- it is a seizure drug- It is family's responsibility to call DON or MSW (Master of Social Work) for report on IDT decisions. Blaming staff or MD (Medical Doctor) is a guilt reaction- please do not feel responsible as staff, Ok? (signature of previous DON)."

Interview conducted on January 18, 2007 at 11:45 a.m., the MSW stated: "Depakote was off the radar and did not need a consent. If the resident

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did not want to go to the dinning room then an antipsychotic drug would be started. If the residents yelled out the medication would be started. None of the resident's family members were notified about starting Depakote on any of the residents."

Numerous residents were started on Depakote without displaying or having any documented psychotic type behaviors. Depakote is often classified as a "Mood Stabilizing drug", but this drug is similar to other psychiatric drugs, which are currently being used.

Review of the American Society of Health-System Pharmacists (AHFS) text, and the manufacturer's package insert information for Depakote (Valproic acid) in individuals less than 65 years of age, states that: "Valproic acid has been used as monotherapy or as part of combination therapy (e.g. with lithium, antipsychotic agents [i.e. olanzapine], antidepressants, carbamazapine) in the treatment of acute manic episodes. The American Psychiatric Association currently recommends combined therapy with Valproic acid plus an antipsychotic agent or with lithium plus an antipsychotic agent as first-line drug therapy for the acute treatment of more severe manic or mixed episodes, and monotherapy with one of these drugs for less severe episodes... A manic episode is a distinct period of abnormally and persistently elevated, expansive, or irritable mood. Typical symptoms include pressure of speech, motor hyperactivity, reduced need for sleep, flight of ideas, grandiosity, poor judgment, aggressiveness, and possible hostility.... Valproic acid therapy appears to be about as effective as lithium for the treatment of manic episodes."

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The manufacturer also states: "further study is required to establish the efficacy of Valproic acid as maintenance therapy of manic episodes ...the safety and efficacy of long-term (i.e., longer than 3 weeks) Valproic acid therapy have not been established in the treatment of manic episodes. Antimanic response to Valproic acid typically occurs within 1-2 weeks of initiating therapy." The manufacturer further states the following as Geriatric Precautions: "The safety and efficacy of Valproic acid in geriatric patients (older than 65 years of age) for the treatment of manic episodes associated with bipolar disorder or prevention of migraine headaches have not been established.

In a case review of almost 600 patients treated with Valproic acid for manic episodes, approximately 12 percent of patients were older than 65 years of age. A higher percentage of these patients reported accidental injury, infection, pain, somnolence, or tremor during Valproic acid therapy compared with younger patients ...it is recommended that initial dosage of Valproic acid be reduced and subsequent dosages be increased more slowly in geriatric patients. In addition, the manufacturer recommends regular monitoring of fluid and nutritional intake, dehydration, somnolence and other adverse effects in these individuals ...Drug clearance may be decreased in special patient populations (e.g. patients with renal failure, geriatric patients)."

1) Review of the clinical record for Resident 18, a 95 year old with no diagnosis of Psychiatric Behavior on January 20, 2007, revealed there was an order for Depakote 125 mg by mouth twice daily written by the Director of Pharmacy, which was started on November 28, 2006, for one

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week. The order also indicated that after one week, the dose of 125 mg Depakote should be increased to 250 mg by mouth three times daily (contrary to the drug manufacturer's statement that it takes 1-2 weeks before an anti-manic effect can be seen after initiation of this medication). The Depakote was started on November 28, 2006 as evidenced on the facility's Director of Pharmacy and Interdisciplinary Team (IDT) notes from the same date.

The IDT note reads: "Ran into two residents in the morning in wheelchair that afternoon ran into resident's family. Reported deliberate actions and belligerent. Pharmacy and IDT feel that Depakote 125 mg twice daily for one week then 250 mg three times daily. Documented alert charting for 72 hours, mood stabilizer for aggressive behavior. Resident has been alienating herself socially, refuses activities ...".

A review of the nurses and physician's progress notes dated November 28, 2006 was conducted on January 20, 2007 for Resident 18, and no documentation could be found in the clinical record indicating that any of the wheelchair accidents, had been written in the IDT minutes.

Interviews with facility's Director of Pharmacy and licensed nursing staff between January 12, 2007 to January 19, 2007, revealed that the facility's previous Director of Nurses had taken over the IDT committee, and was making unilateral decisions about the resident's care. Facility staff indicated that when they would go back to resident's clinical records to try and find issues which had been reported to the IDT committee, the information had not been documented in the resident's record. Facility staff also indicated

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during these interviews that the facility's previous Director of Nurses had indicated to them that: "the IDT team supersedes anyone else's ability to make any type of clinical decision for the residents. This included: "the resident, the resident's family, the physician and the Medical Director", indicating that no one could changed a decision which had been made for a resident's drug therapy.

Resident 18 was also started on Zyprexa 5 mg intramuscularly every eight hours as needed on December 14, 2006 at 3:20 p.m. by the Director of Pharmacy for allegedly having acute agitation, refusal of care, throwing objects, and striking out. The resident's electric wheelchair had been taken away from the resident on December 14, 2006, earlier in that day, and the removal of the resident's wheelchair had caused the resident's and the husband's agitation, (who is also a resident at the facility, and also received an injection of Zyprexa on December 14, 2006).

On December 14, 2006 at 5 p.m. Resident 18 was given the Zyprexa 5 mg injection as documented in the clinical record, "for agitation, electric chair taken away for one month, and refusing to take meals in the dining room."

Licensed nursing staff, during interview on January 17, 2007 at 9:50 a.m., indicated that this resident was previously receiving Ativan I.M., and the resident thought that this injection was her Ativan.

Review of the Nurses notes dated December 14, 2006 at 11 p.m., for Resident 18, stated the following: "Reported from a.m. LVN (Licensed Vocational Nurse) that resident had received I.M.

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injection of Zyprexa 5 mg. As she has never had this medication previous to this, I went to check on her condition. Resident slow to respond, drooling, hard to awaken, then extremely confused, tremors, complaining of leg pains and had to go to restroom. It took three people to assist her to even stand up, legs shaky and weak. Resident extremely confused and not at all her normal self."

On December 19, 2006 another IDT meeting was held with the following notes, "IDT for behavior: December 14, 2006 power scooter removed related to 3 citations and SNF policy. (The facility's policy per the administrator is, if a resident gets 3 citations for "wreckless" use of their wheelchair, the wheelchair will be taken away from the resident). The Director of Pharmacy ordered Risperdal 1 mg by mouth daily [in addition to all the other drugs for behaviors]. There was no other documentation that could be found in the clinical record as to the reason why this medication had been ordered for this resident.

Interview with Resident 18 on January 18,2007 at 4 p.m., revealed that, "one of the girls [CNAs (Certified Nursing Assistant)] had pushed me down to the cafeteria 4-5 times against my will."

Further review of the clinical record revealed the next nurses notes found were dated December 22, 2006 (8 days later):

a) At 2:30 p.m. on December 22, 2006, the nurses progress note stated: "up in Geri chair for meals (resident previously on electric wheelchair), hands very shaky ...assisted with taking medications, 2 pills at a time. Assisted with

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ADL's and transfers."
b) On December 22, 2006 at 4:30 p.m. the nurse documents: "The resident was not able to feed herself at dinner hands very shaky requires help with eating, refusing to get out of bed. Was combative while pants being put on. Resident was up for breakfast and lunch eating in day room with assist."
c) At midnight on December 22, 2006 the nurse documents: "Resident without change in level of consciousness. Speech slurred and hard to understand, hands trembling... Resident unable to take her bedtime medications. Speech slurred. Resident's body and limbs were trembling with glazed eyes. Continues to show no improvement of mental status. Very lethargic."
d) Review of the Nursing notes on December 30, 2006 at 5:45 p.m. stated: "the resident's physician called and discussed recent weight loss. He discontinued Risperdal. "At 10 p.m. a second nurse documented: "on alert charting for discontinuation of Risperdal-which consent was not signed. No aggressive behaviors seen this evening, in bed watching T.V."
e) On January 11, 2007, nurse's progress notes indicate that "resident is becoming more responsive but continues to be unable to do her normal functions. Unable to dress self and unable to transfer or bare weight."
f) On January 12, 2007 (almost 30 days later) the nurses report "no change in condition."
g) On January 14, 2007 the resident stated for the first time since the medications were administered: "I feel better."

During an interview with one medication nurse on January 17, 2007 at 11:10 a.m., the medication nurse stated, "[Resident 18] had her electric wheelchair taken and she had refused to get up

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for meals. The patient was angry about the wheelchair being taken away and so was the patient's husband (who is also a facility resident). The nurse further stated that she was not aware of any previous history of behaviors with this resident. After the injection, the patient was out of it for 24 to 36 hours. Unable to get up and out of bed now, unable to take evening medications even when roused. During the first 36 hours, her arms and hands were shaking out of control. She was heavily sedated with slurred speech which was unusual. The patient was unable to eat at this time. Both residents thought that this medication was like Ativan and being given to calm their nerves."

During interview with the resident on January 18, 2007 at 4 p.m., the resident revealed that on December 21, 2006, she had a fall (two days after receiving the first injection of Risperdal), while in the bathroom, and she injured her left arm (a flap of skin had lifted) requiring her to be treated at the Acute portion of the hospital. Review of the facility's communication log book entry dated December 21, 2006 read, "(Resident's name) fall today bad skin tear to lower left arm. Did QR (Quality Report) for fall (sent to ER) but not specific to skin tear."

Review of the facility's communication log book entry dated December 15, 2006 which was written by the facility's previous DON read, "(Resident 18) is NOT to have ANY meals served in her room. Her power w/c (wheelchair) is now in storage due to assaultive type behaviors."

Review of the progress note written by the facility social worker on December 27, 2006 at 11:40 a.m., stated, "....during our discussion, I noticed

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patient was having what appears to be EPS in the form of Parkinson Tremors. Social worker will bring this to the attention of Pharmacist, Doctor and Director of Nurses at today's IDT meeting."

The Depakote, Risperdal, and Zyprexa were never care planned despite the facility's policy and procedure entitled: "Care Planning-Permanent", states: "The planning for care, treatment and services will include the following: "Determining how the planned care, treatment and services will be provided, documenting the plan for care, treatment and services, monitoring the effectiveness of care planning and the provision of care, treatment, and services."

Further review of the clinical record showed that an informed consent was never signed by the resident for the Risperdal, which had been administered to the resident. Review of the facility's communication log book entry dated December 22, 2006 read, "Pulled (Resident's name) Risperdal - don't see a consent for it?? Don't know why head injury report filled out ---she only had injury to L (left) arm???".

The medications above were used as chemical restraints when the resident's electric wheelchair had been taken away and when this resident was refusing to have her meals in the dayroom and had requested to enjoy her meals in the comfort of her own room.

After a review of the facility's quarterly (MDS) Minimum Data Set assessments between September 21, 2006 and December 19, 2006 revealed the following areas of decline:

a) Resident 18's bed mobility (how the resident

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moves to and from lying position, turns side to side, and positions body while in bed) on September 21, 2006 was reported by the facility as: "Supervision, (oversight, encouragement or cueing provided 3 or more times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days." Review of the resident's bed mobility on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Extensive Assistance-while resident performed part of activity, over the last 7-day period, help of following types provided 3 or more times: -weight-bearing support; -Full staff performance during part (but not all) of last 7 days."

b) Resident 18's ability to transfer (how the resident moves between surfaces-to/from: bed, chair, wheelchair, standing position (excluding to/from bath and toilet) on September 21, 2006 was reported by the facility as: "Supervision, (oversight, encouragement or cueing provided 3 or more times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days." Review of the resident's ability to transfer on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Extensive Assistance-while resident performed part of activity, over the last 7-day period, help of following types provided 3 or more times: -weight-bearing support; -Full staff performance during part (but not all) of last 7 days."

c) Resident 18's ability to walk in room (how the resident moves between locations in his/her room) on September 21, 2006 was reported by the facility as: "Supervision, (oversight, encouragement or cueing provided 3 or more

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times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days." Review of the resident's ability walk in room on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Activity did not occur during entire 7 days."
d) Resident 18's ability to walk in corridor (how the resident walks in the corridor on the unit) on September 21, 2006 was reported by the facility as: "Supervision, (oversight, encouragement or cueing provided 3 or more times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days." Review of the resident's ability to walk in corridor on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Activity did not occur during entire 7 days."
e) Resident 18's ability to dress (how the resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis) on September 21, 2006 was reported by the facility as: "Supervision, (oversight, encouragement or cueing provided 3 or more times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days." Review of the resident's ability to dress on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Extensive Assistance- while resident performed part of activity, over the last 7-day period, help of following types provided 3 or more times: -weight-bearing support; -Full staff performance during part (but not all) of last 7 days."
f) Resident 18's ability to use the toilet (how the resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses,

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changes pad, manages ostomy or catheter, adjusts clothes) on September 21, 2006 was reported by the facility as: "Supervision, (oversight, encouragement or cueing provided 3 or more times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days." Review of the resident's ability to use the toilet on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Total Dependence- Full staff performance of activity during the entire 7 days."

g) Resident 18's bowel continence (control of bowel movement, with appliance or bowel continence programs, if employed) on September 21, 2006 was reported by the facility as: "Continent- complete control. Review of the resident's bowel continence on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Frequently incontinent- Bladder (tends to be incontinent daily, but some control present."

h) Resident 18's bladder continence (control of urinary bladder function) on September 21, 2006 was reported by the facility as: "Usually Continent- Bladder, incontinent episodes once a week or less." Review of the resident's bladder continence on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Incontinent- Bladder (tends to be incontinent daily)."

i) Resident 18's overall changes in care needs, the resident's overall level of self-sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) on September 21, 2006 was reported by the facility as: "No change." Review of the resident's overall change in care needs on

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December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Deteriorated-receives more support."
j) Resident 18's short term memory (the resident's seems/appears to recall after 5 minutes on September 21, 2006) was reported by the facility as: "Memory Ok." Review of the resident's overall change in care needs on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Memory Problem."

The resident had no history of psychotic behaviors, diagnosis of psychosis, or a psychiatric evaluation documented in the clinical record, which could be provided by the facility's IDT to support the resident's need for this medication.

2. Review of the clinical record for Resident 19 (an 89 year old, with no diagnosis of psychiatric behavior) on January 20, 2007, revealed an order for Risperdal Consta 25 mg intramuscularly every two weeks written by the Director of Pharmacy, which was to be started on November 26, 2006 at 2:30 p.m., for allegedly agitation and psychotic behaviors" (i.e. hitting, throwing food/ trays at staff and refusal of medications and care).

Review of the Nurses notes dated November 20, 2006 at 6:30 p.m., stated, "CNA notified LVN that resident was verbally abusive towards staff secondary to not wanting to eat breakfast before 10:30 a.m. Resident angry as to what was served for breakfast when offered an alternative, resident refused alternatives. Late in the day when CNA took lunch tray resident was verbally abusive stating she did not want her lunch and

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threw her bagel at CNA and stated that she was going to call the ombudsman and report the CNA."

Review of the IDT notes dated November 22, 2006 stated, "IDT is in agreement to request 2 MD approval for consent for antipsychotic injections. This will over ride her refusal ..."

Review of the facility's communication log book dated November 26, 2006 for Resident 19, stated, "(Resident's name) -has order for injectable antipsychotic q (every) 2 wks (weeks). She won't agree but 2 M.D.'s have signed consent. It's probably going to take you and a small army to hold her still. She'll probably call DHS & Ombudsman on us."

During an interview with the Director of Pharmacy on January 12, 2007 at 4:40 p.m. the Director of Pharmacy stated, I thought that if a resident does not have a responsible party, if two physicians would sign the medication order, this made it "ok" for the resident to receive any psychotropic drug.

The Risperdal Consta (which is a long acting drug) was not administered until November 29, 2006 at 9 a.m. because the drug was not available and had to be ordered by Pharmacy. When the medication was received by the facility on November 29, 2006 the medication was administered to the resident. Review of the facility's communication log dated November 29, 2006 stated: "(Room # and Resident 19) - Gave her im (intramuscularly) Risperdal with her yelling and resisting."

Interview with nursing staff between January 16, 2007 and January 19, 2007, revealed that when

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the first injection of Risperdal was given to Resident 19 on November 29, 2006 at 9 a.m., four to five nursing staff were present in the room "holding the resident down" while administering the injection. This resident had never received Risperdal prior to this administration of the drug.

Review of the manufacturer's package insert for this medication states: "For patients who have never taken oral Risperdal, it is recommended to establish tolerability with oral Risperdal prior to initiating treatment with Risperdal Consta." Risperdal Consta can last for at least two weeks, as a result, the resident could be put at risk for long lasting side effects or reactions if prior treatment with a shorter acting form of Risperdal has not been tried first.

Interview with the Director of Pharmacy on January 12, 2007 at 4:30 p.m., revealed that she had heard that the nurses had a "difficult time" giving this resident her intramuscular injection of Risperdal and that it required 4-5 staff to hold the resident down to give the first injection.

A second injection of the Risperdal was given to this resident on December 11, 2006 and interview with the facility nursing staff revealed that there were three nursing staff in the room "holding the resident down" for the administration of the medication.

Interview with the medication nurse on January 19, 2007 at 9:30 a.m., who administered the Risperdal on December 11, 2006, revealed that the resident was not told by any of the staff that they were going to give the injection. Two CNA's were asked to go into the resident's room to change the resident's brief and while the resident

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was rolled on her side by the two CNA's, the medication nurse snuck into the resident's room and gave the injection, while the resident's back was to the medication nurse.

On December 25, 2006 a new order for Risperdal Consta 37.5 mg I.M. every two weeks was written for this resident. The resident received the first dose of the 37.5 mg dose of Risperdal at 9 a.m. on December 25, 2006.

On January 2, 2007 the resident was put on Risperdal 0.5 mg by mouth twice daily along with the injectable form of Risperdal. The Risperdal had never been care planned despite the facility's policy and procedure entitled: "Care Planning-Permanent," states: "The planning for care, treatment and services will include the following: Determining how the planned care, treatment and services will be provided, documenting the plan for care, treatment and services, monitoring the effectiveness of care planning and the provision of care, treatment, and services."

Review of the Nurses progress notes for Resident 19 after the multiple injections of Risperdal read:
a) January 6, 2007 at 3 p.m. state: "resident refused her meds (medications) from night nurse stating she was afraid they would slip her something so she wouldn't be able to stop them from giving her a shot. I talked to her and told her they weren't going to do that and she agreed to take her morning pills ... ."
b) On January 6, 2007 at 10 p.m. notes state: "...Talk to resident this evening because she was still afraid they were going to put something in her medications ...will continue to monitor. Has trouble swallowing .... ."
c) On January 7, 2007 at 10 p.m. notes state:

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"On alert charting for Risperdal and dementia. Has trouble swallowing so all medications were crushed and put into pudding. You have to tell her what she is getting as she is still afraid we are going to put something in her medications."
d) On January 8, 2007 at 6 p.m. notes state: "...Resident is still fearful about taking medications but she is taking them ... ."

Interview with facility Director of Pharmacy on January 16, 2007 at 3:20 p.m. stated: "there was no documentation of behaviors in [Resident 19's] chart during the time that she was on this medication, which was why this medication was ultimately stopped. "The Director of Pharmacy also stated during the interview, "I asked the previous Director of Nurses whether the behaviors of the residents should be documented in the record but the previous Director of Nurses indicated that it was enough for the Pharmacist to document the behaviors in the order and not necessarily in any other part of the clinical record." The Pharmacist further indicated that, "the IDT notes in the chart may not always be complete."

Interview with one of the facility's medication nurse's on January 17, 2007 at 9:50 a.m., the nurse stated, "[Resident 19] was observed having visual disturbances, sluggish speech, and slurred words after the she was given the Risperdal injection."

Resident 19 was interviewed on January 18, 2007 at 4:20 p.m. about the shots of Risperdal that she received. The resident was asked, "how did the shots make you feel?", the resident replied: "they scared me to death and I just felt terrible." The resident stated that she had "one bad dream"

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right after the first shot. The resident also stated in the interview: "I could not sleep a natural sleep, I did not know what was going to happen to me." The resident further stated that one of the facility staff members found her in her room after the second shot completely "nude." The resident also stated during the interview that she was swinging and kicking at the staff trying to hit anyone who she could while nursing staff were trying to give her the injection of Risperdal.

Interview with the medication nurse on January 19, 2007, who had given the second injection of Risperdal to the resident stated, "I did not feel comfortable giving the medication but the other medication nurse who was going to give the injection was crying, so I said I would give the injection."

The resident's Zyprexa, and Seroquel had never been care planned despite the facility's policy and procedure entitled: "Care Planning- Permanent", states: "The planning for care, treatment and services will include the following: "Determining how the planned care, treatment and services will be provided, documenting the plan for care, treatment and services, monitoring the effectiveness of care planning and the provision of care, treatment, and services."

After a review of the facility's quarterly (MDS) Minimum Data Set assessments between September 20, 2006 and December 15, 2006 revealed the following areas of decline:

a) Resident 19's overall changes in care needs, the resident's overall level of self-sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90

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days) on September 20, 2006 was reported by the facility as:
"No change." Review of the resident's overall change in care needs on December 15, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Deteriorated-receives more support."
b) Resident 19's cognitive skills for decision making on September 20, 2006 was reported by the facility as: "independent-decisions consistent/reasonable." Review of the resident's cognitive skills for decision making on December 15, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Severely impaired- never/rarely made decisions."

The resident had no history of psychotic behaviors, diagnosis of psychosis, or a psychiatric evaluation documented which could be provided by the facility 's IDT to support the resident's need for this medication.

3. Review of the clinical record for Resident 5 (an 85 year old resident, with a diagnosis of Alzheimer's, but no psychiatric behavior or diagnosis) on January 20, 2007, revealed that there was an order for Seroquel (a psychotropic drug) 25 mg by mouth every morning written by the Director of Pharmacy, which was started for this resident on September 29, 2006.

Review of the progress notes by both nursing and medical staff indicated that this medication was started to prevent elopement attempts from the facility. Facility staff were monitoring the number of elopements to determine whether this medication was effective for this resident.

Review of the Physician's Order Sheets revealed

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F 222	Continued From page 20 the following: a) On October 3, 2006, the resident's Seroquel was discontinued. b) On October 5, 2006 at 1:20 p.m., an order was written by the facility's Director of Pharmacy: "Add Seroquel to allergy list-extreme lethargy ... ." c) On October 18, 2006, Zyprexa 2.5 mg by mouth every day was ordered. d) On October 26, 2006, the Zyprexa was increased to 5 mg by mouth every evening. e) On November 9, 2006 at 1:50 p.m., the dose of Zyprexa was increased to 10 mg every evening. f) On November 22, 2006 at 10:45 a.m. the order read, "For order made November 22, 2006 and not shown on this chart. November 18, 2006 discontinue Zyprexa probable EPS side effects. Add Zyprexa to allergy list." The resident's Zyprexa was never stopped as the following order was written on November 22, 2006 at 2:10 p.m., by the Director of Pharmacy, "Zyprexa 2.5 mg by mouth daily for 1 week, then 5 mg daily for 1 week, then 10 mg by mouth daily ... ." No allergy to Zyprexa was ever documented in the clinical record for drug allergies. Review of the facility's communication log book shows just how confused facility staff were about this resident's medication orders. The communication log books entry dated November 22, 2006 for this resident stated, "The last 2 alert chartings say Zyprexa was D/C'd (discontinued). The MAR has Zyprexa DC'd on 11-18, BUT I cannot find any order to D/C Zyprexa the alert list doesn't have it DC'd. If it was D/C'd on 11-18 we need the order! (nurse's signature)." g) On January 2, 2007 at 1:20 p.m. an order was written by the Director of Pharmacy: "Add Zyprexa 5 mg by mouth every 5 p.m. (continue 10 mg in morning)."	F 222		

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F 222	Continued From page 21 Review of the IDT notes dated November 22, 2006 read, "...Order written November 18, 2006, discontinue Zyprexa due to Extra Pyramidal Symptoms (EPS) effects, perceived EPS. Hallucinations and trembling were due to a psychotic episode, as a result we advice that Zyprexa will be restarted!" Yet no psychiatric behaviors are described in any of the IDT notes during this period, October 5, 2006 to January 17, 2007. Review of the nurse's progress notes showed the following documentations: a) On October 1, 2006 at 6:40 p.m., stated, "...Some lethargy noted this shift." Nurses notes dated October 2, 2006 at 6:15 p.m. stated, "...Res. (Resident) lethargic this shift ... ." b) On October 3, 2006 at 7 p.m. stated, "...appears to be lethargic this a.m." c) On October 10, 2006 at 7:15 p.m. stated, "...Also noted to sleep in w/c (wheel chair) during day." d) On October 12, 2006 at 2 p.m. stated: "Patient has been very sleepy today." e) On November 10, 2006 at 11:30 p.m. stated: "Res (resident) lethargic when NOCS (night shift) began." f) On November 14, 2006 at 11:30 p.m. stated, "Res (resident) very quiet, almost lethargic, but responsive." g) On November 18, 2006 at 6 a.m. stated, "...Res (resident's) eyes look glazed over, res restless and dull looking. She is not her normal perky, "raring to go self." h) On November 18, 2006 at 2:12 p.m. stated, "Noted today res exhibiting hallucinations of apparent bugs she was trying to remove from body. Also, she had nervous movements all	F 222		

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appearing to be EPS (Extra Pyramidal Symptoms) that may be R/T (related to) Zyprexa side effects. Noted Zyprexa increased November 19, 2006 .... ."
i) On November 22, 2006 at 11:30 p.m. stated: "Res continues to be lethargic. Zyprexa re-started tonight."
j) On November 23, 2006 at 11:30 p.m. stated, "Res (resident) lethargic, hard to awaken to take meds (medications) at HS (bed time)."
k) On November 28, 2006 at 6:30 p.m. stated, "...res (resident) continues to have episodes of lethargy and later in same day becomes agitated. Appetite is very poor." Nurse's note dated December 1, 2006 stated: "Slight lethargy today ... ."
l) On December 6, 2006 at 11:30 p.m. stated: "Res confused and disoriented @ (at) HS (bedtime) ... ."

During an interview with one of the medication nurses on January 17, 2007 at 11:10 a.m., the nurse stated, "This resident who would try to elope, but she did not do this after the medications were started and she became very sedated."

During interview with one of the CNA's on January 17, 2007 at 6:45 p.m., he stated, "During the last few weeks, she has been like a zombie and sits with head down. Very lethargic, follows CNA around usually but not in the last two weeks."

During an interview with the second CNA on January 17, 2007 at 8:20 p.m., he stated, "Resident has not been herself anymore. Sleeps a lot. Use to elope but she does not anymore."

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The resident's Zyprexa, and Seroquel had never been care planned despite the facility's policy and procedure entitled: "Care Planning- Permanent", states: "The planning for care, treatment and services will include the following: "Determining how the planned care, treatment and services will be provided, documenting the plan for care, treatment and services, monitoring the effectiveness of care planning and the provision of care, treatment, and services."

The resident had no history of psychotic behaviors, diagnosis of psychosis, or a psychiatric evaluation documented which could be provided by the facility's IDT to support the resident's need for this medication which was used as a chemical restraint for elopement.

4. Review of the clinical record for Resident 28 (a 83 year old, with no diagnosis of psychiatric behavior) on January 20, 2007 revealed that there was an order for Depakote 125 mg by mouth twice daily written by the Director of Pharmacy, which was started on December 20, 2006, for one week then increase to 250 mg by mouth two times daily (contrary to the drug manufacturer's statement that it takes 1-2 weeks before an anti manic effect can be seen after initiation of this medication). The physician's order read as follows for the reason for starting this medication, "...for refusal of care, refusing to get out of bed for meals."

The Depakote was started on December 20, 2006 based on the facility's Pharmacist and Interdisciplinary Team (IDT) notes from the same date. The IDT note dated December 20, 2006 reads, "...Resident showing beginning behavior problems R/T (related to) dementia. Start

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Depakote 125 mg twice daily for one week, then 250 mg twice daily .... ." No specific behaviors were ever described by the IDT or the Director of Pharmacy as reasons for starting this medication.

During an interview with the medication nurse on January 17, 2007 at 7:30 p.m., the nurse stated, "Resident 18 and Resident 28 were given psychiatric meds (medications) because they did not want to go to the dinning room."

Surveyor: 16893
Resident 6 was an 88 year-old with no psychiatric diagnoses.

During an observation of Resident 6 on January 23, 2007 at 9:55 AM she was sitting in a wheelchair outside her room. She would not talk to surveyor or make eye contact. She had what appeared to be Cream of Wheat coming out of her mouth onto her bottom lip. Observation of Resident 6 at 11 AM found her sitting in her wheelchair outside her room sleeping.

During a review of Resident 6's medical record on January 19, 2007 at 11 AM, IDT notes were read. On July 12, 2006 "Seroquel 25 mg twice a day started on 6-23-06 for hitting, kicking staff, agitation. Pt (Patient) has not started meds yet. Attempting to obtain consent." On August 10, 2006 "Refuses many meds, some will take 2 X a week. Resident has some lethargy - just started Seroquel - started 7/7 - takes one month." On October 10, 2006 "Recommend increase Seroquel to 75 mg at hs (hour of sleep) only, keep 50 mg in AM." On November 22, 2006 "DC (discontinue) bed belt, use geri chair for trunk support when needed."

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Seroquel was ordered for Resident 6 due to hitting, kicking staff and agitation. On July 7, 2006 Resident 6 was started on 25 mg of Seroquel twice a day. On October 10, 2006 it was recommended by IDT to increase the evening dose to 75 mg and to keep the morning dose at 50 mg. Review of the Psychoactive Drug Flow Sheets show Resident 6 was being monitored for Combative Behavior; Agitation; Spitting; Scratching/pinching; Refusing Medication and talking all night. There is no indication in the record where a medical or psychosocial reason for these behaviors was considered and ruled out before beginning the antipsychotic. A nurses note dated October 26, 2006 at 9 AM states "Indicates pain - yelling out and scratching. Vicodin given and resident quiet and calm with decreased agitation.

Resident 7 was an 80 year-old with no psychiatric diagnoses.

During an observation of Resident 7 on January 23, 2007 at 11:22 AM she was in her bed sleeping.

During record review on January 19, 2007 at 1:15 PM it was noted Resident 7 was on Trazodone for combativeness and resistance to care. The IDT decided on October 12, 2006 these behaviors were no longer a problem and recommended to discontinue the medication. On November 14, 2006 the IDT documented "Need to evaluate resident for an antipsychotic med in place of antidepressant, referral to pharmacist or MD, related to behaviors." On December 6, 2006 the Consultant Pharmacist's Recommendation to the Inter-Disciplinary Team for the month of November said "Gradual dose reduction required

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by OBRA regulations. Need order for reduction or documentation that a reduction would be harmful to self or others." The IDT responded "Delay dose reduction until closer to 6 month time period on Seroquel." On December 29, 2006 the IDT reviewed the December 13, 2006 increase in Seroquel from 25 mg twice a day to 50 mg twice a day. They documented "Appears to be controlled with increased dosage." The Seroquel had been ordered for agitation, combativeness and negative behavior.

Nursing notes dated November 20, 2006 "On alert charting for starting new drug Seroquel. Resident has change, she is more agitated and aggressive when you talk to her. When given a pain pill she settles down and lower the head of the bed and she is flat she will go to sleep." November 22, 2006 the first dose of Seroquel was given. November 25, 2006 "Refused 1700 meds, said they were sticking in her." No behavior problems were noted until December 19, 2006 entry "No episodes of biting or screaming today, very pleasant." The Seroquel was increased from 25 mg to 50 mg twice a day on December 13, 2006 but no documentation in the nursing notes existed concerning biting or screaming. Notes are found for urinary tract infection and pain but no behaviors. On January 12, 2007 Resident 7 was not responding to verbal stimuli and on January 13, 2006 it was noted by nursing Resident 7 had not had a bowel movement for six days. An x-ray was ordered and was positive for a large amount of bowel. Resident 7 complained of pain, pointing to her abdomen on January 14, 2006, the physician ordered digital removal of feces to be done on night shift. On January 15, 2006 Resident 7 stated she felt better and was in no pain.

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The Psychoactive Drug Flow Sheets show Resident 7 was being monitored for hallucinations and paranoia. No documentation was found concerning these in the nursing notes to show what Resident 7 was doing during these hallucinations or paranoia so these behaviors could be evaluated by the physician or the ID team. Agitation, hitting, slapping, screaming loud and biting were added in following months but as with the hallucinations and paranoia these added behaviors were not documented in the nursing notes for evaluation. Documentation does show Resident 7 was in pain on numerous occasions.

Resident 10 was a 93 year-old with no psychiatric diagnoses.

During a review of Resident 10's medical record on January 19, 2007 at 2:45 PM documentation showed he was put on Seroquel (antipsychotic) for sexual groping towards staff, wandering, agitation, paranoia and delusions. According to the Federal Regulations an antipsychotic medication should be used only for conditions/diagnoses as documented in the record and as meets the definition in the Diagnostic and Statistical Manual of Mental Disorders. Resident 10 had no psychiatric diagnoses.

During an interview with Staff U on January 17, 2007 at 4:30 PM Staff U stated "She was alert and quick to respond, needed a little basic help, wanted breakfast and personal hygiene a certain way. She propelled on her own in her wheelchair. Now her personality is completely changed, she doesn't care when she gets up, needs more assistance, when asked if she wants socks on

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she doesn't know how to respond. She doesn't tell me how to put her make-up on, isn't particular like she used to be. She offers people money, seems lonely, happy when I am around like she wants company. She fell today, went outside looking for someone and fell down some steps. Trying to escape, looking for people, she's known in the past. Out of it, not herself."

During an interview with Staff D on January 17, 2007 at 9:50 AM Staff D said "She (Resident 21) was sobbing, she was in her wheelchair, came out of her room. She wasn't coming to the medication cart, not going out smoking. She would say 'I just want die, I feel alone.' We would go in and sit with her. She started getting mean, I charted it. Came back one week later, they had discontinued some of her medications, never came back as the (Resident 21) I knew. Depakote I remember because we never gave that before. She had appetite loss, she used to feed herself but started going to the day room so she could be fed."

During an interview with Staff K on January 17, 2007 at 3:44 PM Staff K said "She wasn't completely independent but was one person assist, didn't yell out like she does now, she has gotten meaner also. She can propel somewhat but now not nearly as much, had to go to day room to be fed, she was lethargic quite a few months ago. She had her routine down and wanted it to be just so, then didn't know what she wanted, not her normal self."

During a review of Resident 21's medical record on January 18, 2007 at 10:30 AM it was discovered Resident 21 had no psychiatric diagnoses. An IDT meeting was held on October

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11, 2006. The IDT recommended Depakote due to Resident 21 being "demanding at the time she needs medications and care." The IDT note stated "since resident sensitive to other psychotropics." "Review pain, weight, behaviors over three weeks then review." The IDT notes for November 2, 2006 state "Norco will be increased to four times a day from three times a day due to allergy of multiple narcotics (6-12-18-22) so resident is allowed sleep." The IDT meeting for November 14, 2006 shows "Caught self on fire smoking. Will order lab - resident's behaviors may be changing." The IDT notes from November 21, 2006 "Pharmacy states Lexapro increase to 20 mg every day for depression and anxiety." IDT notes dated November 28, 2006 "Pharmacist and IDT believe Depakote 250 mg twice a day for mood stabilizing." IDT notes for December 6, 2006 "12/4/06 Depakote increased to 250 mg every eight hours, Lexapro is up to 40 mg every day, resident with sad, tearful, inappropriate behaviors." IDT for December 20, 2006 "Effexor XR 37.5 mg the increase to 75 mg and decrease Lexapro to 20 mg for one week then discontinue. Resident noted depressed, tearful. Start Risperdal 0.5 mg twice a day for one week, then 1.0 mg twice a day for agitation, verbal abuse, refusal of care and food and fluids, periods of constant yelling." IDT January 3, 2006 "Discontinue Risperdal, resident refused."

The Depakote was initiated for Resident 21 being demanding for medications and care. She was started on Depakote October 11, 2006 and her pain medication was increased on November 2, 2006. She had no behavior change until she caught herself on fire November 14, 2006 and IDT documented "Caught self on fire, resident's behaviors may be changing." Resident 21

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continued demanding and yelling out plus crying inconsolably, stating she didn't want to live there anymore. The nurses notes documented no change in Resident 21's behaviors through November 27, 2006. On November 28, 2006 the IDT increased Resident 21's Depakote to 250 mg twice a day for mood stabilizing. Resident 21 was noted to continue her demanding and yelling plus she became verbally abusive saying things like "F--- You" and "I don't give a damn." The IDT again increased Resident 21's Depakote on December 4, 2006 to 250 mg every eight hours.

Nurses notes dated December 7, 2006 show "Resident crying inconsolably, very weak, appears frail and fragile." On December 8, 2006 "Resident is unable to feed self - too weak, calls aide repeatedly but forgets what she wants, very fragile." "Resident has increased difficult time feeding herself, needs assistance." Resident 21's behaviors continued as before but on December 15, 2006 "Resident lethargic, with swings to demanding and yelling. Resident wanted to stay in bed. Very difficult for resident to let me know what she wants. Resident fragile, totally dependent." On December 19, 2006 "Resident with 11.7 pound weight decrease in a four month period."

Resident 21 was started on an antidepressant in April of 2006. In October of 2006 she was put on Depakote for demanding behavior. The demanding behavior continued and she also developed crying, saying she wanted to die. In November 2006 the Depakote was increased to "stabilize her mood." Resident 21 was still demanding, crying and then became mean and verbally abusive to staff so in December the Depakote was again increased. Resident 21

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became "very weak, frail and fragile, unable to feed herself and repeatedly forgot what she was calling the staff for." Resident 21 lost weight and according to the nurses notes on December 20, 2006 "Major melt down, crying 'I want to die' and refusing shower."

Resident 24 was a 97 year-old with no psychiatric diagnoses.

During an interview with Staff D on January 17, 2007 at 9:50 AM Staff D stated "(Resident 24) would be agitated at times, then days went by when she wouldn't be agitated. After the Zyprexa started she became more disoriented, got very ornery. When I came back after my days off she was already in the emergency room, then she passed away. She had seemed sedated, just different, she propelled herself before the medication started, it seemed like the medication made her hyperactive. She just looked like she hadn't slept, her eyes were red."

During an interview with Staff G on January 17, 2007 at 11:10 AM Staff G stated "(Resident 24) was pretty feisty, periods of insomnia for days then couldn't get her out of bed. After the medication she had a slow decline, like staying in bed a lot more, no appetite, not eating and more difficulty giving medication to her."

During an interview with Staff O on January 17, 2007 at 7:30 PM Staff O stated "(Resident 24) was sleeping more, was sick, she aspirated and an x-ray was taken. The x-ray was negative for aspiration and I told (Staff S) to get her on thickened liquids."

During a review of the Nursing Communication

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Book on January 18, 2007 some entries were documented concerning Resident 24 these entries were as follows: October 10, 2006 "on a roll, she's sleeping in everyone's bed except her own." November 9, 2006 "fell again this AM at 0735. Went to ER (emergency room) with possible head injury, came back 11:45 AM no order changes." December 10, 2006 "Dying? ADR (Adverse Drug Reaction) to first dose of Depakote? No intake for 2 days.....Labs? Depakote level? Comfort measures? IV (intravenous) fluids? She tries to drink but falls asleep before getting the fluid in her mouth. Please follow up ASAP."

IDT meeting review showed Depakote was ordered for "striking staff" on November 28, 2006. Eight days later during an IDT meeting the Depakote dosage was increased, "Resident has same aggressive behavior, refused some medications. Current dose is 125 mg every morning and 125 mg every evening. Will increase every evening dose to 250 mg every day."

The nursing notes after the Depakote was started show no change in Resident 24's aggressive behaviors. The Depakote was increased on December 6, 2006 and after that increase the nursing notes reflect, December 9, 2006 "Assisted back to bed. Did not eat lunch - Noted to be lethargic." December 10, 2006 "Resident more alert today. Verbalizes, but difficult to understand. Sleeping on and off most of morning." "Resident somnolent, but wants to drink. Takes fluids through straw and falls asleep before it gets to mouth. Was able to feed her a cup of jello and approximately 100 cc of ice chips." December 11, 2006 "Bed rest, asleep,

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easily aroused this AM. Head of bed up, spooned small sip of water, mild cough noted. Change to thickened, taking only few sips at a time, somnolent most of this shift." "Resident lethargic and unable to swallow her meds tonight." December 12, 2006 "Somulant this shift, aroused for few minutes for breakfast, falls back to sleep." "Resident lethargic unable to awaken good enough to administer medications." December 13, 2006 "Resident sleeping most of day. Able to awaken without difficulty."

Resident 27 was a 96 year-old with no psychiatric diagnoses.

During an observation of Resident 27 on January 18, 2007 at 2:03 PM she was found lying in her bed sleeping. Observation on January 23, 2007 at 11:38 AM found Resident 27 in the day room sleeping in her geri chair.

During an interview with Staff D on January 17, 2007 at 9:50 AM Staff D said "(Resident 27) was put on Depakote, now she lays in her geri chair and sleeps. Before the Depakote she would talk if you talked to her, now is very quiet."

During an interview with Staff R on January 23, 2007 at 11:38 AM Staff R said "I didn't notice any hallucinations. She would be in a bad mood at times, when she first got up but after her hair was done and her face washed she was fine and thanking me."

During a review of Resident 27's medical record on January 19, 2007 at 9 AM it was noted in the IDT meeting dated November 21, 2006 "Pharmacist- Add Depakote 125 mg twice a day times one week for psychosis getting out of hand,

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after one week will be Depakote 250 mg twice a day." (contrary to the drug manufacturer's statement that it takes 1-2 weeks before an anti-manic effect can be seen after initiation of this medication). In the IDT meeting dated December 14, 2006 "Start behavior monitor for visual hallucinations."

During a review of the nursing notes no visual hallucinations were documented. The Psychoactive Drug Flow Sheet showed no visual hallucinations documented from December 14, 2006 when they were ordered to be documented until the end of December. The only behavior documented was beginning on November 15, 2006 at 4 PM "I noted resident had been anal digging during her nap, CNA's (Certified Nursing Assistant's) cleaned her, resident did not understand what she had done or how feces were all over her and her bed." Resident 27 had other episodes of anal digging on November 17, 2006; November 18, 2006 and November 19, 2006. Depakote was ordered by the IDT on November 21, 2006.

Surveyor: 20337
On January 24, 2007 at 3 P.M. Resident 2 was observed lying in bed on her back with her eyes open. She points and states, "it's, I'm not sure, it's three". She then nods her head and smiles". Further attempts at conversation were unsuccessful.

On January 23, 2007 at 3 P.M. the clinical record was reviewed for Resident 2. She is a 78 year old female with diagnoses of dementia, urinary retention and diabetes, admitted to the facility on December 5, 2006. The initial assessment by licensed Nurse S on December 5, 2006 at 2:20 P.

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M., the day of admission, states, "Resident is alert but severely combative with all care." On December 5, 2006 at 2:40 P.M. a telephone order was obtained by Licensed Nurse S from Resident 2's physician for an injection of Haldol 2 mg TID (3 times daily) as needed for agitation and fighting care. This was 20 minutes after her initial admission assessment.

The medication Haldol, according to the Federal Guidelines, is classified as an anti-psychotic, administered for conditions documented in the residents record meeting definitions listed in the Diagnostic and Statistical Manuel of Mental Disorders. The recommended dose of Haldol is 2 mg daily after indications for use have been established, behaviors have been monitored and other non-pharmalogical measures have been attempted. The Resident 's initial assessment was completed 20 minutes prior to the order being obtained from the physician for an injection of Haldol 2 mg three times daily as needed on the day Resident 2 was admitted to the facility.

On December 7, 2006 at 6:50 P.M. a nursing note written by Licensed Nurse G states, "On alert charting for new admit. Combative with CNA's during care. Went to Day Room this shift for "Pretty Nails". Ate breakfast and dinner in the Day Room. Can be re-directed if you are gentle with her."

On December 7, 2006 an order was written by the Director of Pharmacy for Risperdal 0.25 mg by mouth two times daily for one week then Risperdal 0.5 mg by mouth two times daily for combativeness with care, hitting, verbal threats and lack of cooperation. Evaluate in IDT (Interdisciplinary Team) in two weeks.

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On December 8, 2006, according to IDT notes of December 12, 2006, "Resident 2 fell when she arose from her wheelchair." "She was confused, complained of right knee pain." "Haldol is being used on an as needed basis and monitoring for safety will continue." No documentation was found in the nursing notes regarding the fall on December 8, 2006.

IDT on December 14, 2006 "for admission" states, "DON (Director of Nurses) spoke with residents husband regarding resident's hallucinations and explained Risperdal effects with him. MDS Nurse explained the Risperdal increases it." Mention of hallucinations could not be found anywhere in the record, either documented as having them or monitoring for them.

Risperdal, like Haldol is also classified as an anti-psychotic according to the Federal Guidelines and administered for conditions documented in the residents' record meeting definitions listed in the Diagnostic and Statistical Manuel of Mental Disorders after indications for use have been established, behaviors have been monitored and non-pharmalogical measures have been attempted. For the medication Risperdal, one of the nursing considerations, according to Mosby's 2007 Nursing Drug Reference, is ambulation is to be supervised since fainting is possible, teach rising slowly to prevent orthostatic hypotension, until the resident is stabilized on the medication.

IDT on December 19, 2006 held "for fall x 2 today." "Charge nurse states resident consistently attempting to transfer self." DON

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states, "her needs are: a lap belt." "Start non-self-releasing lap belt."

IDT on December 19, 2006, "DON states dose increase is definite improvement." Restraint use appropriate." "Resident noted to not mind the non-self releasing lap belt."

On January 18, 2007 at 11 AM during interview with the facility social worker he stated, "The former DON appeared to have extensive experience." Her basic approach was medicate for whatever the issue. She wanted to put people on Depakote and anti-psychotics. She said it's the industry standard. After a few months she would slap the table (during the IDT Meetings) and say, "I think this resident needs Depakote and an anti-psychotic." It felt wrong, we were putting people on anti-psychotics for willy-nilly things. Sometimes it would be for only one bad behavior. "She would constantly refer to the residents as demented and psychotic." I would argue with her and say aggressive, combative behavior is not a psychosis. "There isn't a lot of documentation in the record." "Meds would be given, started in IDT, but there would be no documentation."

Haldol and Risperdal were not care planned despite the facility's policy and procedure entitled: "Care Planning-Permanent", states: The planning for care, treatment and services will include the following: "Determining how the planned care, treatment and services will be provided, documenting the plan for care, treatment and services, monitoring the effectiveness of care planning and the provision of care, treatment, and services."

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Review of the clinical record did not reveal monitoring of behaviors for either medication. Adequate indications or an evaluation by a psychiatrist could not be found in the record. There was no documentation the anti-psychotic medications were used to treat the resident's assessed medical condition. The Haldol and Risperdal were used for combativeness with care, hitting, verbal threats and lack of cooperation. The resident's right to be free from chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's assessed medical condition was not ensured.

On January 24, 2007 at 11:40 A.M. Resident 14 was observed sitting in the dining room in a wheelchair with his wife who visits during lunch each day. "He and his wife were conversing; the resident had his head down, not making eye contact with anyone."

Review of the clinical record for Resident 14 on January 23, 2007 at 2 P.M. found him to be an 81 year old male admitted to the facility on July 22, 2005 with a diagnosis of "Chronic Obstructive Pulmonary Disease, hypertension and other persistent mental disorders classified elsewhere." As of October 31, 2006, Resident 14 received Effexor XR 75 mg daily for depression and Ativan 0.5 mg for restlessness, pain or anxiety.

In the IDT Meeting of October 31, 2006 it was decided the pharmacist would review the residents pain medications for pain management. A document entitled The Consultant Pharmacist Recommendation to IDT dated November 31, 2006, states: recommend antipsychotic, ie. Seroquel 25 mg by mouth every day at 2 P.M.

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On December 6, 2006 Seroquel 25 mg by mouth at 2 PM was ordered and resident received the first dose on December 8, 2006. Nursing notes document:

December 9, 2006: Aggressive toward staff.
December 10, 2006: Continues to be aggressive toward staff.
December 12, 2006: Started on new med Seroquel for combative behavior, behavior continues.

IDT Meeting on December 20, 2006 states: "Pharmacy states DC Ativan, only used 5 times in past month. Resident's behavior improving. Discontinue Seroquel, start Risperdal Consta 25 mg IM every 2 weeks. Evaluate in IDT in 2 weeks."

In the record was found a Psycho-active drug monitoring form for Ativan and Effexor for the month of December. Behavior monitoring for Seroquel could not be found in the record.

Review of the manufacturer's package insert for this medication states: "For patients who have never taken oral Risperdal, it is recommended to establish tolerability with oral Risperdal prior to initiating treatment with Risperdal Consta." Risperdal Consta can last for at least two weeks, as a result, the resident could be put at risk for long lasting side effects or reactions if prior treatment with a shorter acting form of Risperdal has not been tried first.
The first dose of Risperdal Consta was given on December 21, 2006. IDT Meeting of January 4, 2007 states: "Continued weight loss expected, related to Dementia. Social Services to talk to family about Hospice."

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During interview with Licensed Nurse E on January 19, 2007 she stated, "I documented adverse drug reactions on Resident 14 but the former DON said that is not true. Resident 14 was belligerent, hitting, kicking, spitting biting after the anti-psychotic medications were started. The medications made him psychotic. Then the former DON started him on an injection of an antipsychotic medication."

Resident 1 was observed on January 24, 2007 at 2:20 P. M. sitting in a wheelchair in the hallway. She smiles and states hello. She points to a scab on her nose and states, "I'm not sure what this is. When I asked her do you have any problems with your hips?, she pats both hips and states, I don't think so."

On January 22, 2007 at 2 P.M. the clinical record was reviewed for Resident 1. She is a 93 year old, admitted to the facility on August 21, 2006 with diagnoses of dementia, Alzheimer's and depressive disorder. Medications include Aricept 5 mg by mouth at bedtime for dementia, Lexapro 10 mg by mouth at bedtime for depression, Seroquel 25 mg by mouth at bedtime for dementia related psychosis. On August 31, 2006 the Pharmacist Drug Regimen Review states, "need indication for Seroquel." A psychiatric evaluation could not be found in the record.

IDT Meeting of September 16, 2006 states: "May explore increase in Seroquel due to non-compliance with directives." On October 26, 2006 is an order written by the pharmacist as a telephone order from the physician states, "indication for Seroquel- dementia related psychosis." On November 2, 2006, the

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F 222	Continued From page 41 Pharmacist Drug Regimen Review states, "IDT consider increase in Seroquel, but no charting to support this." On November 15, 2006 an order was written by the facility pharmacist to"change Seroquel to 25 mg by mouth every A.M. and Seroquel 50 mg every day at 5:00 P.M." On November 28, 2006 IDT held because of fall while transferring from wheelchair on November 15, 2006. On November 15, 2006 Resident 1 went to the emergency room for pain to head and right elbow; x-rays were taken which were negative. On November 24, 2006 a right hip x-ray was taken and Resident 1 was found to have a right hip fractu	F 222		
F 223 SS=J	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Surveyor: 16893 Based on observation, interview and record review, the facility failed to ensure two of 29 sampled residents were free from abuse when they were given anti-psychotic medications against their will. (18 and 19) Findings: Resident 18 was a 95 year-old with no psychiatric diagnoses.	F 223		5/17/07

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F 223	Continued From page 42 On December 14, 2006 at 5 p.m. Resident 18 was given a Zyprexa 5 mg injection as documented in the clinical record, "for agitation, electric chair taken away for one month, and refusing to take meals in the dining room." During an interview on January 17, 2007 at 9:50 a.m. Staff D, indicated this resident was previously receiving Ativan I.M., and the resident thought this injection was her Ativan. Review of the Nurses' notes dated December 14, 2006 at 11 p.m., for Resident 18, stated the following: "Reported from a.m. LVN (Licensed Vocational Nurse) that resident had received I.M. injection of Zyprexa 5 mg. As she has never had this medication previous to this, I went to check on her condition. Resident slow to respond, drooling, hard to awaken, then extremely confused, tremors, complaining of leg pains and had to go to restroom. It took three people to assist her to even stand up, legs shaky and weak. Resident extremely confused and not at all her normal self." Further review of the clinical record revealed the next nurses' notes found were dated December 22, 2006 (eight days later): a) At 2:30 p.m. on December 22, 2006, the nurses progress note stated: "up in Geri chair for meals (resident previously on electric wheelchair), hands very shaky ...assisted with taking medications, 2 pills at a time. Assisted with ADL's and transfers." b) On December 22, 2006 at 4:30 p.m. the nurse documents: "The resident was not able to feed herself at dinner hands very shaky requires help	F 223		

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with eating, refusing to get out of bed. Was combative while pants being put on. Resident was up for breakfast and lunch eating in day room with assist."
c) At midnight on December 22, 2006 the nurse documents: "Resident without change in level of consciousness. Speech slurred and hard to understand, hands trembling ...Resident unable to take her bedtime medications. Speech slurred. Resident's body and limbs were trembling with glazed eyes. Continues to show no improvement of mental status. Very lethargic."
d) Review of the Nursing notes on December 30, 2006 at 5:45 p.m. stated: "the resident's physician called and discussed recent weight loss. He discontinued Risperdal." At 10 PM a second nurse documented: "on alert charting for discontinuation of Risperdal- which consent was not signed. No aggressive behaviors seen this evening, in bed watching T.V."
e) On January 11, 2007, nurse's progress notes indicate that "resident is becoming more responsive but continues to be unable to do her normal functions. Unable to dress self and unable to transfer or bare weight."
f) On January 14, 2007 the resident stated for the first time since the medications were administered: "I feel better."

During interview with the resident on January 18, 2007 at 4 p.m., she said, on December 21, 2006, she had a fall (two days after receiving the first injection of Risperdal), while in the bathroom, and she injured her left arm (a flap of skin had lifted) requiring her to be treated at the acute portion of the hospital. Review of the facility's communication log book entry dated December 23, 2006 read, "(Resident's name) fall today bad skin tear to lower left arm. Did QR (Quality

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Report) for fall (sent to ER) but not specific to skin tear."

Nursing notes dated December 29, 2006 at 7:20 PM and written by Staff G stated "At breakfast resident threw her milk at a CNA and tried to kick her and tried to hit her. I spoke with resident in her room and told her I would have to give her an injection of Zyprexa if her behavior continued. Resident did not have another episode of bad behavior after that."

Resident 19 had no history of psychotic behaviors, diagnosis of psychosis, or a psychiatric evaluation documented in the clinical record, which could be provided by the facility's IDT to support the resident's need for this unnecessary medication which had been given in the presence of adverse consequences.

2. Resident 19 was an 89 year-old with no psychiatric diagnosis.

Review of the clinical record for Resident 19 on January 20, 2007, revealed an order for Risperdal Consta 25 mg intramuscularly every two weeks. This order was written by the Director of Pharmacy and was to be started on November 26, 2006 at 2:30 p.m., for "allegedly agitation and psychotic behaviors" (i.e. hitting, throwing food/ trays at staff and refusal of medications and care).

Review of the Nurses' notes dated November 20, 2006 at 6:30 p.m., stated: "CNA notified LVN that resident was verbally abusive towards staff secondary to not wanting to eat breakfast before 10:30 a.m. Resident angry as to what was served for breakfast when offered an alternative,

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resident refused alternatives. Late in the day when CNA took lunch tray resident was verbally abusive stating she did not want her lunch and threw her bagel at CNA and stated that she was going to call the ombudsman and report the CNA."

Review of the IDT notes dated November 22, 2006, "IDT is in agreement request 2 MD approval for consent for antipsychotic injections. This will over ride her refusal..."
Review of the facility's communication log book dated November 26, 2006 for Resident 19, "(Resident's name) -has order for injectable antipsychotic q (every) 2 wks (weeks). She won't agree but 2 M.D.'s have signed consent. It's probably going to take you and a small army to hold her still. She'll probably call DHS & Ombudsman on us."

Resident 19 was admitted to the facility on March 10, 2005 and had been making decisions concerning her care since that date. The IDT notes indicated "Resident capable of informed consent." On November 27, 2006 Resident 19's son was called and asked to consent to the antipsychotic injections. The consent shows "T.O. (Telephone Order).....(son). Her son was only to be contacted in the event of an emergency and was not the responsible party.

During an interview with the Director of Pharmacy on January 12, 2007 at 4:40 p.m. the Director of Pharmacy stated, I thought that if a resident does not have a responsible party, if two physicians would sign the medication order, this made it "ok" for the resident to receive any psychotropic drug.

The Risperdal Consta (which is a long acting

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drug) was not administered until November 29, 2006 at 9 a.m. because the drug was not available and had to be ordered by Pharmacy. When the medication was received by the facility on November 29, 2006 the medication was administered to the resident. Review of the facility's communication log dated November 29, 2006 "(Room # and Resident 19) - Gave her im (intramuscularly) Risperdal with her yelling and resisting."

Interview with nursing staff between January 16, 2007 and January 19, 2007, revealed that when the first injection of Risperdal was given to Resident 19 on November 29, 2006 at 9 a.m., four to five nursing staff were present in the room "holding the resident down" while administering the injection. This resident had never received Risperdal prior to this administration of the drug.

Interview with the Director of Pharmacy on January 12, 2007 at 4:30 p.m., revealed that she had heard the nurses had a "difficult time" giving this resident her intramuscular injection of Risperdal and that it required four to five staff to hold the resident down to give the first injection.

A second injection of the Risperdal was given to this resident on December 11, 2006 and interview with the facility nursing staff revealed there were three nursing staff in the room "holding the resident down" for the administration of the medication.

Interview with the medication nurse on January 19, 2007 at 9:30 a.m., who administered the Risperdal on December 11, 2006, revealed the resident was not told by any of the staff that they were going to give the injection. Two CNA's were

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asked to go into the resident's room to change the resident's brief and while the resident was rolled on her side by the two CNA's, the medication nurse snuck into the resident's room and gave the injection, while the resident's back was to the medication nurse.

Review of the Nurses progress notes for Resident 19 after the multiple injections of Risperdal read:
a) January 6, 2007 at 3 PM "resident refused her meds (medications) from night nurse stating she was afraid they would slip her something so she wouldn't be able to stop them from giving her a shot."
b) On January 6, 2007 at 10 PM notes state: "...Talk to resident this evening because she was still afraid they were going to put something in her medications ...will continue to monitor. Has trouble swallowing .... ."
c) On January 7, 2007 at 10 PM notes state: "On alert charting for Risperdal and dementia. Has trouble swallowing so all medications were crushed and put into pudding. You have to tell her what she is getting as she is still afraid we are going to put something in her medications."
d) On January 8, 2007 at 6 PM notes state: "...Resident is still fearful about taking medications but she is taking them ... ."

Interview with facility Director of Pharmacy on January 16, 2007 at 3:20 p.m. stated: "there was no documentation of behaviors in [Resident 19's] chart during the time she was on this medication, which was why this medication was ultimately stopped."

Interview with one of the facility's medication nurse's on January 17, 2007 at 9:50 a.m., the nurse stated: "[Resident 19] was observed having

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visual disturbances, sluggish speech, and slurred words after the she was given the Risperdal injection."

Resident 19 was interviewed on January 18, 2007 at 4:20 p.m. about the shots of Risperdal she received. The resident was asked, "how did the shots make you feel?", the resident replied: "they scared me to death and I just felt terrible." The resident stated that she had "one bad dream" right after the first shot. The resident also stated in the interview: "I could not sleep a natural sleep, I did not know what was going to happen to me." The resident further stated one of the facility staff members found her in her room after the second shot completely "nude." The resident stated during the interview that she was swinging and kicking at the staff trying to hit anyone who she could while nursing staff were trying to give her the injection of Risperdal.

Interview with the medication nurse on January 19, 2007, who had given the second injection of Risperdal to Resident 19 stated: "I did not feel comfortable giving the medication but the other medication nurse who was going to give the injection was crying, so I said I would give the injection."

After a review of the facility's quarterly (MDS) Minimum Data Set assessments between September 20, 2006 and December 15, 2006 the following areas of decline were noted:

a) Resident 19's overall changes in care needs, the resident's overall level of self-sufficiency changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) on September 20, 2006 was reported by

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F 223	Continued From page 49 the facility as: "No change." Review of the resident's overall change in care needs on December 15, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Deteriorated-receives more support." b) Resident 19's cognitive skills for decision making on September 20, 2006 was reported by the facility as: "independent-decisions consistent/reasonable." Review of the resident's cognitive skills for decision making on December 15, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Severely impaired- never/rarely made decisions." The resident had no history of psychotic behaviors, diagnosis of psychosis, or a psychiatric evaluation documented which could be provided by the facility's IDT to support the resident's need for this unnecessary medication which had been given in the presence of adverse consequences.	F 223		
F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Surveyor: 13095 Based on review of the facility's policy and procedure, interview with facility staff, and clinical record review, the facility failed to ensure resident transfers were made in accordance with the	F 246		5/17/07

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facility's policy and procedures to accommodate the resident's preferences for one of 29 sampled residents. (19)

Findings:

Review of the facility's policy and procedure entitled: "Resident Transfers within the Skilled Nursing Center", states: "1. The Skilled Nursing Center will reasonably accommodate individual resident's needs and preferences except where health and safety of the individual or other residents would be endangered."

During an interview with one of the facility's License Nurses on January 19, 2007 at 9:30 a.m., the nurse stated, (resident's name) was transferred out of her room on October 19, 2006 at 3 p.m. kicking, swinging and yelling in anger all the way down the hall. Everyone in the area (SNF) could hear what was going on. None of the other staff would move this resident except for the Activity's Director. After Resident 19 had been removed from her old room the old room remained vacant and no specific resident was moved into the room for at least the next few days.

Review of the clinical record on January 19, 2007 at 10 AM revealed that the facility's Mental Social Worker had documented the following for the resident's need to move: "SNF needs room by nurse station for acute pt's (patients). Res (Resident) agrees w (with)/change, and will have same view from new bed."

No other documentation indicating that the resident had agreed to the room transfer could be provided by the facility after reviewing Resident

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F 246	Continued From page 51 19's clinical record except for the following note which was written by the Mental Social Worker on October 23, 2006 (4 days later): "T/C (telephone call) from resident's Pastor -(name of pastor) re: (regarding) room change for Resident. Apparently resident resisted moving on Friday= 10/18 after agreeing to it on 10/18. Spoke c (with) resident about move. She reports that she was unhappy c (with) her new roommate, who was making noise throughout the night. Roommate was moved to new acute observ. (observation) room due to declining condition. Res (resident) reports she is still not happy about the move: is currently denying that she agreed to move. MSW will continue working c (with) res (resident) to accommodate her needs: wishes."	F 246		
F 329 SS=K	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		5/17/07

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This REQUIREMENT is not met as evidenced by:
Surveyor: 13095
Based on observation, interview and record review, the facility failed to ensure 22 out of 29 sampled residents were free of unnecessary drugs in the presence of adverse reactions and without adequate indications for use. (1,2, 4, 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 19, 21, 23, 24, 27 and 28)

Findings:

Interview with the facility's Director of Pharmacy and nursing staff between January 12, 2007 to January 19, 2007, revealed that the facility's previous Director of Nurses (DON) had instructed facility staff to use Depakote on the residents because this medication did not require informed consent from the residents or their families prior to administration. During an interview with the Director of Pharmacy on January 12, 2007 at 4:40 p.m., the Director of Pharmacy indicated: "(the previous DON) requested me to write orders for these medications." The Director of Pharmacy went on to say she felt the previous DON had come to the facility with a wealth of knowledge and "I trusted her (the previous DON)."

Review of a note dated December 25, 2006 in the facility's communication log stated: "Note from (previous DON) > No consent needed for Depakote at all- it is a seizure drug- It is family's responsibility to call DON or MSW (Mental Social

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Worker) for report on IDT decisions. Blaming staff or MD (Medical Doctor) is a guilt reaction- please do not feel responsible as staff, Ok? (signature of previous DON)."

Interview conducted on January 18, 2007 at 11:45 a.m., the MSW stated: "Depakote was off the radar and did not need a consent. If the resident did not want to go to the dinning room then an antipsychotic drug would be started. If the residents yelled out the medication would be started." None of the resident's family members were notified about starting Depakote on any of the residents.

Numerous residents were started on Depakote without displaying or having any documented psychotic type behaviors. Depakote is often classified as a "Mood Stabilizing drug", but this drug is similar to other psychiatric drugs, which are currently being used.

Review of the American Society of Health-System Pharmacists (AHFS) text, and the manufacturer's package insert information for Depakote (Valproic acid) in individuals less than 65 years of age, states that: "Valproic acid has been used as monotherapy or as part of combination therapy (e.g. with lithium, antipsychotic agents [i.e. olanzapine], antidepressants, carbamazapine) in the treatment of acute manic episodes. The American Psychiatric Association currently recommends combined therapy with Valproic acid plus an antipsychotic agent or with lithium plus an antipsychotic agent as first-line drug therapy for the acute treatment of more severe manic or mixed episodes, and monotherapy with one of these drugs for less severe episodes ...A manic episode is a distinct period of abnormally and

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persistently elevated, expansive, or irritable mood. Typical symptoms include pressure of speech, motor hyperactivity, reduced need for sleep, flight of ideas, grandiosity, poor judgment, aggressiveness, and possible hostility ....Valproic acid therapy appears to be about as effective as lithium for the treatment of manic episodes."

The manufacturer also states: "further study is required to establish the efficacy of Valproic acid as maintenance therapy of manic episodes ...the safety and efficacy of long-term (i.e., longer than 3 weeks) Valproic acid therapy have not been established in the treatment of manic episodes. Ant manic response to Valproic acid typically occurs within 1-2 weeks of initiating therapy. "The manufacturer further states the following as Geriatric Precautions: "The safety and efficacy of Valproic acid in geriatric patients (older than 65 years of age) for the treatment of manic episodes associated with bipolar disorder or prevention of migraine headaches have not been established."

In a case review of almost 600 patients treated with Valproic acid for manic episodes, approximately 12 percent of patients were older than 65 years of age. A higher percentage of these patients reported accidental injury, infection, pain, somnolence, or tremor during Valproic acid therapy compared with younger patients ...it is recommended that initial dosage of Valproic acid be reduced and subsequent dosages be increased more slowly in geriatric patients. In addition, the manufacturer recommends regular monitoring of fluid and nutritional intake, dehydration, somnolence and other adverse effects in these individuals ...Drug clearance may be decreased in special patient populations (e.g. patients with renal failure,

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F 329	Continued From page 55 geriatric patients)." 1. Review of the clinical record for Resident 18, a 95 year old with no diagnosis of Psychiatric Behavior on January 20, 2007, revealed that there was an order for Depakote 125 mg by mouth twice daily written by the Director of Pharmacy, which was started on November 28, 2006, for one week. The order also indicated that after one week, the dose of 125 mg Depakote should be increased to 250 mg by mouth three times daily (contrary to the drug manufacturer's statement that it takes 1-2 weeks before an anti-manic effect can be seen after initiation of this medication). The Depakote was started on November 28, 2006 as evidenced on the facility's Director of Pharmacy and Interdisciplinary Team (IDT) notes from the same date. The IDT note reads: "Ran into two residents in the morning in wheelchair that afternoon ran into resident's family. Reported deliberate actions and belligerent. Pharmacy and IDT feel that Depakote 125 mg twice daily for one week then 250 mg three times daily. Documented alert charting for 72 hours, mood stabilizer for aggressive behavior. Resident has been alienating herself socially, refuses activities ..." A review of the nurses and physician's progress notes dated November 28, 2006 was conducted on January 20, 2007 for Resident 18, and no documentation could be found in the clinical record indicating that any of the wheelchair accidents, had been written in the IDT minutes. Interviews with facility's Director of Pharmacy and licensed nursing staff between January 12, 2007 to January 19, 2007, revealed that the facility's	F 329		

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previous Director of Nurses had taken over the IDT committee, and was making unilateral decisions about the resident's care. Facility staff indicated that when they would go back to resident's clinical records to try and find issues which had been reported to the IDT committee, the information had not been documented in the resident's record. Facility staff also indicated during these interviews that the facility's previous Director of Nurses had indicated to them that: "the IDT team supersedes anyone else's ability to make any type of clinical decision for the residents. This included: "the resident, the resident's family, the physician and the Medical Director," indicating that no one could change a decision which had been made for a resident's drug therapy.

This resident was also started on Zyprexa 5 mg intramuscularly every eight hours as needed on December 14, 2006 at 3:20 p.m. for allegedly having acute agitation, refusal of care, throwing objects, and striking out, by the Director of Pharmacy. The resident's electric wheelchair had been taken away from the resident on December 14, 2006, earlier in that day, and the removal of the resident's wheelchair had caused the resident's and the husband's agitation, (who is also a resident at the facility, and also received an injection of Zyprexa on December 14, 2006).

On December 14, 2006 at 5 PM Resident 18 was given the Zyprexa 5 mg injection as documented in the clinical record, "for agitation, electric chair taken away for one month, and refusing to take meals in the dining room."

Licensed nursing staff, during interview on January 17, 2007 at 9:50 a.m., indicated that this

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resident was previously receiving Ativan I.M., and the resident thought that this injection was her Ativan.

Review of the Nurses notes dated December 14, 2006 at 11 PM, for Resident 18, stated the following: "Reported from a.m. LVN (Licensed Vocational Nurse) that resident had received I.M. injection of Zyprexa 5mg. As she has never had this medication previous to this, I went to check on her condition. Resident slow to respond, drooling, hard to awaken, then extremely confused, tremors, complaining of leg pains and had to go to restroom. It took 3 people to assist her to even stand up, legs shaky and weak. Resident extremely confused and not at all her normal self."

On December 19, 2006 another IDT meeting was held with the following notes, "IDT for behavior: December 14, 2006 power scooter removed related to 3 citations and SNF policy. (The facility's policy per the administrator is, if a resident gets 3 citations for "reckless" use of their wheelchair, the wheelchair will be taken away from the resident). The Director of Pharmacy ordered Risperdal 1 mg by mouth daily [in addition to all the other drugs for behaviors]. There was no other documentation that could be found in the clinical record as to the reason why this medication had been ordered for this resident.

Interview with Resident 18 on January 18, 2007 at 4 p.m., revealed that, "one of the girls [CNAs (Certified Nursing Assistant)] had pushed me down to the cafeteria 4-5 times against my will."

Further review of the clinical record revealed the

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F 329	Continued From page 58 next nurses notes found were dated December 22, 2006 (8 days later): a) At 2:30 p.m. on December 22, 2006, the nurses progress note stated: "up in Geri chair for meals (resident previously on electric wheelchair), hands very shaky ...assisted with taking medications, 2 pills at a time. Assisted with ADL's and transfers." b) On December 22, 2006 at 4:30 p.m. the nurse documents: "The resident was not able to feed herself at dinner hands very shaky requires help with eating, refusing to get out of bed. Was combative while pants being put on. Resident was up for breakfast and lunch eating in day room with assist." c) At midnight on December 22, 2006 the nurse documents: "Resident without change in level of consciousness. Speech slurred and hard to understand, hands trembling ...Resident unable to take her bedtime medications. Speech slurred. Resident's body and limbs were trembling with glazed eyes. Continues to show no improvement of mental status. Very lethargic." d) Review of the Nursing notes on December 30, 2006 at 5:45 p.m. stated: "the resident's physician called and discussed recent weight loss. He discontinued Risperdal." At 10 PM a second nurse documented: "on alert charting for discontinuation of Risperdal- which consent was not signed. No aggressive behaviors seen this evening, in bed watching T.V." e) On January 11, 2007, nurse's progress notes indicate that "resident is becoming more responsive but continues to be unable to do her normal functions. Unable to dress self and unable to transfer or bare weight." f) On January 12, 2007 (almost 30 days later) the nurses report "no change in condition."	F 329		

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g) On January 14, 2007 the resident stated for the first time since the medications were administered: "I feel better."

During an interview with one of the medication nurses on January 17, 2007 at 11:10 a.m., the medication nurse stated: "[Resident 18] had her electric wheelchair taken and she had refused to get up for meals. The patient was angry about the wheelchair being taken away and so was the patient's husband (who is also a facility resident). The nurse further stated that she was not aware of any previous history of behaviors with this resident. After the injection, the patient was out of it for 24 to 36 hours. Unable to get up and out of bed now, unable to take evening medications even when roused. During the first 36 hours, her arms and hands were shaking out of control. She was heavily sedated with slurred speech which was unusual. The patient was unable to eat at this time. Both residents thought that this medication was like Ativan and being given to calm their nerves."

During interview with the resident on January 18, 2007 at 4 p.m., the resident revealed that on December 21, 2006, she had a fall (two days after receiving the first injection of Risperdal), while in the bathroom, and she injured her left arm (a flap of skin had lifted) requiring her to be treated at the acute portion of the hospital. Review of the facility's communication log book entry dated December 21, 2006 read, "(Resident's name) fall today bad skin tear to lower left arm. Did QR (Quality Report) for fall (sent to ER) but not specific to skin tear."

Review of the facility's communication log book entry dated December 15, 2006 which were

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written by the facility's previous DON read, "(Resident 18) is NOT to have ANY meals served in her room. Her power w/c (wheelchair) is now in storage due to assaultive type behaviors."

Review of the progress note written by the facility social worker on December 27, 2006 at 11:40 a.m., stated, "....during our discussion, I noticed patient was having what appears to be EPS in the form of Parkinson Tremors. Social worker will bring this to the attention of Pharmacist, Doctor and Director of Nurses at today's IDT meeting."

The Depakote, Risperdal, and Zyprexa were never care planned despite the facility's policy and procedure entitled: "Care Planning-Permanent", states: "The planning for care, treatment and services will include the following: "Determining how the planned care, treatment and services will be provided, documenting the plan for care, treatment and services, monitoring the effectiveness of care planning and the provision of care, treatment, and services."

Further review of the clinical record showed that an informed consent was never signed by the resident for the Risperdal, which had been administered to the resident. Review of the facility's communication log book entry dated December 22, 2006 read, "Pulled (Resident's name) Risperdal - don't see a consent for it?? Don't know why head injury report filled out ---she only had injury to L (left) arm???."

The medications above were used as chemical restraints when the resident's electric wheelchair had been taken away and when this resident was refusing to have her meals in the dayroom and had requested to enjoy her meals in the comfort

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F 329	Continued From page 61 of her own room. After a review of the facility's quarterly (MDS) Minimum Data Set assessments between September 21, 2006 and December 19, 2006 revealed the following areas of decline: a) Resident 18's bed mobility (how the resident moves to and from lying position, turns side to side, and positions body while in bed) on September 21, 2006 was reported by the facility as: "Supervision, (oversight, encouragement or cueing provided 3 or more times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days." Review of the resident's bed mobility on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Extensive Assistance- while resident performed part of activity, over the last 7-day period, help of following types provided 3 or more times: -weight-bearing support; -Full staff performance during part (but not all) of last 7 days." b) Resident 18's ability to transfer (how the resident moves between surfaces-to/from: bed, chair, wheelchair, standing position (excluding to/from bath and toilet) on September 21, 2006 was reported by the facility as: "Supervision, (oversight, encouragement or cueing provided 3 or more times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days." Review of the resident's ability to transfer on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Extensive Assistance- while resident performed part of activity, over the last 7-day period, help of following types provided	F 329		

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F 329	Continued From page 62 3 or more times: -weight-bearing support; -Full staff performance during part (but not all) of last 7 days." c) Resident 18's ability to walk in room (how the resident moves between locations in his/her room) on September 21, 2006 was reported by the facility as: "Supervision, (oversight, encouragement or cueing provided 3 or more times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days." Review of the resident's ability walk in room on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Activity did not occur during entire 7 days." d) Resident 18's ability to walk in corridor (how the resident walks in the corridor on the unit) on September 21, 2006 was reported by the facility as: "Supervision, (oversight, encouragement or cueing provided 3 or more times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days." Review of the resident's ability to walk in corridor on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Activity did not occur during entire 7 days." e) Resident 18's ability to dress (how the resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis) on September 21, 2006 was reported by the facility as: "Supervision, (oversight, encouragement or cueing provided 3 or more times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days." Review of the resident's ability to dress on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as:	F 329		

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"Extensive Assistance- while resident performed part of activity, over the last 7-day period, help of following types provided 3 or more times: -weight-bearing support; -Full staff performance during part (but not all) of last 7 days."

f) Resident 18's ability to use the toilet (how the resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes) on September 21, 2006 was reported by the facility as: "Supervision, (oversight, encouragement or cueing provided 3 or more times during the last 7 days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during the last 7 days." Review of the resident's ability to use the toilet on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Total Dependence- Full staff performance of activity during the entire 7 days."

g) Resident 18's bowel continence (control of bowel movement, with appliance or bowel continence programs, if employed) on September 21, 2006 was reported by the facility as: "Continent- complete control. Review of the resident's bowel continence on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Frequently incontinent- Bladder (tends to be incontinent daily, but some control present."

h) Resident 18's bladder continence (control of urinary bladder function) on September 21, 2006 was reported by the facility as: "Usually Continent- Bladder, incontinent episodes once a week or less." Review of the resident's bladder continence on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Incontinent- Bladder

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F 329	Continued From page 64 (tends to be incontinent daily)." i) Resident 18's overall changes in care needs, the resident's overall level of self-sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) on September 21, 2006 was reported by the facility as: "No change." Review of the resident's overall change in care needs on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Deteriorated-receives more support." j) Resident 18's short term memory (the resident seems/appears to recall after five minutes on September 21, 2006 was reported by the facility as: "Memory Ok." Review of the resident's overall change in care needs on December 19, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Memory Problem." The resident had no history of psychotic behaviors, diagnosis of psychosis, or a psychiatric evaluation documented in the clinical record, which could be provided by the facility's IDT to support the resident's need for this unnecessary medication which had been given in the presence of adverse consequences. 2. Review of the clinical record for Resident 19 (an 89 year old, with no diagnosis of psychiatric behavior) on January 20, 2007, revealed an order for Risperdal Consta 25 mg intramuscularly every two weeks written by the Director of Pharmacy, which was to be started on November 26, 2006 at 2:30 PM, for "allegedly agitation and psychotic behaviors" (i.e. hitting, throwing food/ trays at staff and refusal of meds and care).	F 329		

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Review of the Nurses notes dated November 20, 2006 at 6:30 PM, stated: "CNA notified LVN that resident was verbally abusive towards staff secondary to not wanting to eat breakfast before 10:30 AM. Resident angry as to what was served for breakfast when offered an alternative, resident refused alternatives. Late in the day when CNA took lunch tray resident was verbally abusive stating she did not want her lunch and threw her bagel at CNA and stated that she was going to call the ombudsman and report the CNA."

Review of the IDT notes dated November 22, 2006 stated: "IDT is in agreement to request 2 mg approval for consent for antipsychotic injections. This will over ride her refusal ... ."

Review of the facility's communication log book dated November 26, 2006 for Resident 19, stated: "(Resident's name) -has order for injectable antipsychotic q (every) 2 wks (weeks). She won't agree but 2 M.D.'s have signed consent. It's probably going to take you and a small army to hold her still. She'll probably call DHS & Ombudsman on us."

During an interview with the Director of Pharmacy on January 12, 2007 at 4:40 PM the Director of Pharmacy stated, I thought that if a resident does not have a responsible party, if two physicians would sign the medication order, this made it "ok" for the resident to receive any psychotropic drug.

The Risperdal Consta (which is a long acting drug) was not administered until November 29, 2006 at 9 AM because the drug was not available and had to be ordered by Pharmacy. When the medication was received by the facility on November 29, 2006 the medication was

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administered to the resident. Review of the facility's communication log dated November 29, 2006 stated: "(Room # and Resident 19) - Gave her im (intramuscularly) Risperdal with her yelling and resisting."

Interview with nursing staff between January 16, 2007 and January 19, 2007, revealed that when the first injection of Risperdal was given to Resident 19 on November 29, 2006 at 9 AM, four to five nursing staff were present in the room "holding the resident down" while administering the injection. This resident had never received Risperdal prior to this administration of the drug.

Review of the manufacturer's package insert for this medication states: "For patients who have never taken oral Risperdal, it is recommended to establish tolerability with oral Risperdal prior to initiating treatment with Risperdal Consta." Risperdal Consta can last for at least two weeks, as a result, the resident could be put at risk for long lasting side effects or reactions if prior treatment with a shorter acting form of Risperdal has not been tried first.

Interview with the Director of Pharmacy on Janaury 12, 2007 at 4:30 PM, revealed that she had heard that the nurses had a "difficult time" giving this resident her intramuscular injection of Risperdal and that it required four to five staff to hold the resident down to give the first injection.

A second injection of the Risperdal was given to this resident on December 11, 2006 and interview with the facility nursing staff revealed that there were three nursing staff in the room "holding the resident down" for the administration of the medication.

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F 329	Continued From page 67 Interview with the medication nurse on January 19, 2007 at 9:30 a.m., who administered the Risperdal on December 11, 2006, revealed that the resident was not told by any of the staff that they were going to give the injection. Two CNA's were asked to go into the resident's room to change the resident's brief and while the resident was rolled on her side by the two CNA's, the medication nurse snuck into the resident's room and gave the injection, while the resident's back was to the medication nurse. On December 25, 2006 a new order for Risperdal Consta 37.5 mg I.M. every two weeks was written for this resident. The resident received the first dose of the 37.5 mg dose of Risperdal at 9 a.m. on December 25, 2006. On January 2, 2007 the resident was put on Risperdal 0.5 mg by mouth twice daily along with the injectable form of Risperdal. The Risperdal had never been care planned despite the facility's policy and procedure entitled: "Care Planning-Permanent", states: "The planning for care, treatment and services will include the following: "Determining how the planned care, treatment and services will be provided, documenting the plan for care, treatment and services, monitoring the effectiveness of care planning and the provision of care, treatment, and services." Review of the Nurses progress notes for Resident 19 after the multiple injections of Risperdal read: a) January 6, 2007 at 3 PM state: "resident refused her meds (medications) from night nurse stating she was afraid they would slip her something so she wouldn't be able to stop them from giving her a shot. I talked to her and told her	F 329		

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they weren't going to do that and she agreed to take her morning pills ... ."
b) On January 6, 2007 at 10 PM notes state: "...Talk to resident this evening because she was still afraid they were going to put something in her medications ...will continue to monitor. Has trouble swallowing .... ."
c) On January 7, 2007 at 10 PM notes state: "On alert charting for Risperdal and dementia. Has trouble swallowing so all medications were crushed and put into pudding. You have to tell her what she is getting as she is still afraid we are going to put something in her medications."
d) On January 8, 2007 at 6 PM notes state: "...Resident is still fearful about taking medications but she is taking them ... ."

Interview with facility Director of Pharmacy on January 16, 2007 at 3:20 PM stated: "there was no documentation of behaviors in [Resident 19's] chart during the time that she was on this medication, which was why this medication was ultimately stopped." The Director of Pharmacy also stated during the interview, "I asked the previous Director of Nurses whether the behaviors of the residents should be documented in the record but the previous Director of Nurses indicated that it was enough for the Pharmacist to document the behaviors in the order and not necessarily in any other part of the clinical record." The Pharmacist further indicated that, "the IDT notes in the chart may not always be complete."

Interview with one of the facility's medication nurse's on January 17, 2007 at 9:50 AM, the nurse stated, "[Resident 19] was observed having visual disturbances, sluggish speech, and slurred words after the she was given the Risperdal

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injection."

Resident 19 was interviewed on January 18, 2007 at 4:20 PM about the shots of Risperdal that she received. The resident was asked, "how did the shots make you feel?", the resident replied: "they scared me to death and I just felt terrible." The resident stated that she had "one bad dream" right after the first shot. The resident also stated in the interview: "I could not sleep a natural sleep, I did not know what was going to happen to me." The resident further stated that one of the facility staff members found her in her room after the second shot completely "nude." The resident also stated during the interview that she was swinging and kicking at the staff trying to hit anyone who she could while nursing staff were trying to give her the injection of Risperdal.

Interview with the medication nurse on January 19, 2007, who had given the second injection of Risperdal to the resident stated, "I did not feel comfortable giving the medication but the other medication nurse who was going to give the injection was crying, so I said I would give the injection."

The resident's Zyprexa, and Seroquel had never been care planned despite the facility's policy and procedure entitled: "Care Planning- Permanent", states: The planning for care, treatment and services will include the following: "Determining how the planned care, treatment and services will be provided, documenting the plan for care, treatment and services, monitoring the effectiveness of care planning and the provision of care, treatment, and services."

After a review of the facility's quarterly (MDS)

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F 329	Continued From page 70 Minimum Data Set assessments between September 20, 2006 and December 15, 2006 revealed the following areas of decline: a) Resident 19's overall changes in care needs, the resident's overall level of self-sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) on September 20, 2006 was reported by the facility as: "No change." Review of the resident's overall change in care needs on December 15, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Deteriorated-receives more support." b) Resident 19's cognitive skills for decision making on September 20, 2006 was reported by the facility as: "independent-decisions consistent/reasonable." Review of the resident's cognitive skills for decision making on December 15, 2006 after starting on the medications above, the resident's decline was rated by the facility as: "Severely impaired- never/rarely made decisions." The resident had no history of psychotic behaviors, diagnosis of psychosis, or a psychiatric evaluation documented which could be provided by the facility's IDT to support the resident's need for this unnecessary medication which had been given in the presence of adverse consequences. 3. Review of the clinical record for Resident 25 (an 87 year old, with no diagnosis of psychiatric behavior) on January 20, 2007 revealed that there was an order for Depakote 250 mg by mouth every 12 hours written by the Director of Pharmacy, which was started on September 15, 2006 at 1 PM. The above order was changed to	F 329		

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Depakote sprinkles 250 mg by mouth every 12 hours with pudding or applesauce on September 18, 2006 (three days after). On October 1, 2006, the order for Depakote was changed to 125 mg sprinkles by mouth four times daily then, on October 26, 2006 at 2 PM the order was increased to 250 mg by mouth four times daily, without any explanation for the increase.

This resident was started on Depakote, but had no previous history of behavioral problems documented in the clinical record.

On November 16, 2006, this resident was started on Zyprexa 2.5 mg I.M. every 24 hours.

The nurses progress note revealed the following:
a) On November 16, 2006 at 1:15 p.m., reads, "reported to CNA from LVN that resident had smacked another resident on the hand in hallway, no trauma or pain noted. Resident put to bed."
b) At midnight on November 16, 2006, the nurse documented in the progress notes: "At 5:00 p.m. when passing medication in hall resident was following me from room to room. When I opened narcotic drawer she reached in to grab at the medication cards. I yelled at her to not touch them and to get her hands out of the drawer but never touched her. Resident started yelling that I grabbed her. I told her I did not touch her. Later resident was being combative toward another resident. I asked her CNA to put her into bed now."
c) On November 17, 2006 at 1:30 PM nursing administered the first dose of Zyprexa I.M.
d) On November 20, 2006 Seroquel 25 mg by mouth at 5 PM was ordered and after one week the dose was increased to 25 mg by mouth twice daily. By December 25, 2006, this resident's

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dose of Seroquel had been decreased to Seroquel 25 mg by mouth daily at 2 PM.
e) On November 26, 2006 at 10 PM stated: "...Resident was sleeping for about 2 hours in her wheelchair."
f) On November 28, 2006 at 11:30 p.m. stated: "....Resident lethargic this evening tonight. Very hard to awaken for evening meals." Only two other nurses progress notes in the clinical record until January 1, 2007 at 10 PM state: "...She is now so lethargic that she can't eat dinner. She slept in wheelchair in room and in day room. She is now so lethargic that she doesn't wheel herself up and down hallway."
g) On January 2, 2007 at 1 PM stated: "Up in wheelchair, quiet, eyes closed most of the time. Awakens easily to take medications ... ."
h) A late entry for January 2, 2007 stated: "After lunch resident was sleeping with her mouth open and hand-full of food pocketed in her mouth."
i) On January 4, 2007 at 11:30 PM stated: "Resident somewhat lethargic. Very difficult to awaken for medications ... ."
j) On January 5, 2007 at 2 PM stated.: "notified daughter, name, that we are discontinuing Seroquel secondary to lethargy. Daughter was pleased to know."
k) On January 7, 2007 at 10 PM stated: "...The old (Resident 19) is back up and down hallway. Talking to anyone who will listen ....now that she is not so lethargic she is more awake and alert so that she is able to have evening snack ... ."
l) On January 8, 2007 at 10 PM stated.: "...Lethargic and behavioral episodes ... ."
m) On January 9, 2007 at 11:30 PM stated: "Hooray! Seroquel was discontinued and we have our (Resident 25) back .... ."

On January 5, 2007 at 10:37 AM the facility's

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Director of Pharmacy wrote the following order: "Discontinue Seroquel- (extremely lethargic, falling asleep with food in mouth- choking hazard) ... ."

Review of the facility's IDT notes dated August 17, 2006, prior to any of the above medications being started states: "...Inappropriate behaviors is decreasing due to psychotropics... ." No other documentations were noted as to the specific inappropriate behaviors in the IDT notes for this resident.

Interview with one of the medication nurses on January 17, 2007 at 9:50 AM, the nurse stated: "[Resident 25] stopped roaming around the halls about three weeks ago and had food hanging from her mouth had lost her appetite and was very sedated. The charge nurse went to talk to the Director of Pharmacy about discontinuing the Seroquel. After the Seroquel was discontinued the resident returned to normal within 24 hours."

Interview with a second medication nurse on January 17, 2007 at 11:10 AM, the medication nurse stated: "[Resident 25] is back to her normal self today but this resident would sleep through the day in her wheelchair after receiving Depakote."

During an interview with one of the charge nurses on January 17, 2007 at 12:03 PM, the nurse stated: "[Resident 25] was not getting up which is not the norm (normal) for her. Resident is almost back to normal now."

During an interview with a third medication nurse on January 17, 2007 at 7:30 PM, the nurse stated: "Depakote began to snow the resident and

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she would sleep or stare into space. She was not able to put her arms in her sweater anymore like she could before."

During an interview with the fourth medication nurse on January 19, 2007 at 9:30 AM, the nurse stated: "[Resident 25] could not be feed because she was in a coma state and the nurse asked the Pharmacist to come over to look at the resident and the pharmacist decreased the resident's dose. [Resident 25] was so snowed that she could not take medications."

The resident's Zyprexa, and Seroquel had never been care planned despite the facility's policy and procedure entitled: "Care Planning- Permanent", states: The planning for care, treatment and services will include the following: "Determining how the planned care, treatment and services will be provided, documenting the plan for care, treatment and services, monitoring the effectiveness of care planning and the provision of care, treatment, and services."

The resident had no history of psychotic behaviors, diagnosis of psychosis, or a psychiatric evaluation documented which could be provided by the IDT to support the resident's need for this unnecessary medication which had been given in the presence of adverse consequences.

4. Review of the clinical record for Resident 23 (a 76 year old resident, with no diagnosis of psychiatric behavior) on January 20, 2007 revealed that there was a physician's order for Seroquel (a psychotropic drug) 25 mg by mouth twice daily, which was started for this resident on October 19, 2006. On November 1, 2006 the

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resident's Seroquel was increased to 50 mg by mouth twice daily, with no explanation documented.

On November 15, 2006 (14 days after the Seroquel was increased), the resident was started on Depakote 125 mg by mouth twice daily for one week, and then, it was increased to 250 mg by mouth twice daily. On November 20, 2006 at 9:30 AM, the order was "changed to Depakote 125 mg sprinkles instead of tablets, unable to swallow. 125 mg by mouth twice daily thru November 22, 2006 10:00 p.m. then 2x (two times) 125 mg sprinkles twice daily starting November 23, 2006 at 9:00 a.m."

On December 6, 2006, the Director of Pharmacy wrote an order for Zyprexa 2.5 mg by mouth daily for one week, then 5 mg by mouth daily. This resident was started on Zyprexa, Seroquel and Depakote, even though the resident had no previous history of behavioral problems documented in the clinical record.

Interview with the Director of Pharmacy on January 12, 2007 at 4:40 PM, the Pharmacist stated: "I was unaware that this resident had a responsible party (his son). I was told that this resident had no responsible party, that is why we had two physicians sign any psychiatric drug ordered for this resident, and we thought that this made it ok."

Review of the nurse's progress notes revealed the following:
a) On December 9, 2006 at 2:40 PM which reads, "Resident noted to be lethargic today....." At 10:00 p.m. on December 9, 2006, the nurse documented in the progress notes, "...Started

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F 329	Continued From page 76 Zyprexa for repetitive yelling out. Very lethargic this evening ... ." b) On December 10, 2006 at 10 PM the nurse documented in the nurses notes again: "Started Zyprexa for repeative yelling ... ." c) On December 12, 2006 at 2:52 PM, the nurse documented in the progress notes: "at about 1:50 p.m. noticed excessive somnolence. CNA reported removing pudding from mouth because not swallowing ...sent to Emergency Room for evaluation, called son." d) On December 13, 2006 at 6:15 PM the nurse documented in the progress notes: "Resident sleeping most of day, but able to arouse for medications." e) On December 15, 2006 at 11:30 PM, the nurse documented in the progress notes, "Very unusual and not like himself at all." f) On December 16, 2006 at 10 PM, the nurse documented in the nursing progress notes, "Awake enough to take medication and eat pudding and cookie for evening snack." g) On December 17, 2006 at 1 PM, the nurse documented in the nursing progress notes, "...ate 40% of breakfast and 50% of lunch." Nursing staff documented in the nurses progress note on November 1, 2006 at 11:30 p.m., the following, "...Noticed on October 24, 2006 that resident was pursing lips. Would not open up mouth to take spoon of medications secondary to pursing of lips. Appeared to be involuntary movements. Also have noticed was chewing and chewing ...when I look he has nothing in his mouth. Last note dated October 31, 2006, these two facial movements were even more pronounced. Informed Director of Pharmacy as this is a side effect from Seroquel."	F 329		

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F 329	Continued From page 77 On November 2, 2006 at 9:20 AM the Director of Pharmacy wrote the following order, "Discontinue Seroquel secondary to Adverse Drug Reaction, chewing, smacking lips." Review of the IDT notes for October 19, 2006 read, "Obtain consent/start Seroquel 25 mg every evening for one week then twice daily for behaviors." No specific psychiatric behaviors identified in any other section of the clinical record. Review of the facility's IDT notes for November 1, 2006 read: "...Seroquel increase to 25 mg twice daily. Today Pharmacist states increase Seroquel to 50 mg twice daily. Re-evaluate in IDT in 2 to 3 weeks. Will maintain present restraint reduction to Geri chair until dose adjustment of anti-psychotic is completed." Review of the IDT notes for November 15, 2006, read, "continues to have repetitive remarks ...Recommend Depakote for these behaviors ... ." Yet no psychiatric behaviors are described in any of the IDT notes during this period. The resident's Zyprexa, and Seroquel had never been care planned despite the facility's policy and procedure entitled: "Care Planning- Permanent", states: The planning for care, treatment and services will include the following, "Determining how the planned care, treatment and services will be provided, documenting the plan for care, treatment and services, monitoring the effectiveness of care planning and the provision of care, treatment, and services." The resident had no history of psychotic behaviors, diagnosis of psychosis, or a psychiatric evaluation documented which could be provided by the facility's IDT to support the	F 329		

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resident's need for this unnecessary medication which had been given in the presence of adverse consequences.

5. Review of the clinical record for Resident 5 (an 85 year old resident, with a diagnosis of Alzheimer's, but no psychiatric behavior or diagnosis) on January 20, 2007, revealed that there was an order for Seroquel (a psychotropic drug) 25 mg by mouth every morning written by the Director of Pharmacy, which was started for this resident on September 29, 2006.

Review of the progress notes by both nursing and medical staff indicated that this medication was started to prevent elopement attempts from the facility. Facility staff were monitoring the number of elopements to determine whether this medication was effective for this resident.

Review of the Physician's Order Sheets revealed the following:
a) On October 3, 2006, the resident's Seroquel was discontinued.
b) On October 5, 2006 at 1:20 PM, an order was written by the facility's Director of Pharmacy: "Add Seroquel to allergy list-extreme lethargy ... ."
c) On October 18, 2006, Zyprexa 2.5 mg by mouth every day was ordered.
d) On October 26, 2006, the Zyprexa was increased to 5 mg by mouth every evening.
e) On November 9, 2006 at 1:50 PM, the dose of Zyprexa was increased to 10 mg every evening.
f) On November 22, 2006 at 10:45 AM the order read, "For order made November 22, 2006 and not shown on this chart. November 18, 2006 discontinue Zyprexa probable EPS side effects. Add Zyprexa to allergy list." The resident's Zyprexa was never stopped as the following order

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was written on November 22, 2006 at 2:10 PM, by the Director of Pharmacy, "Zyprexa 2.5 mg by mouth daily for 1 week, then 5 mg daily for 1 week, then 10 mg by mouth daily ... ." No allergy to Zyprexa was ever documented in the clinical record for drug allergies. Review of the facility's communication log book shows just how confused facility staff were about this resident's medication orders. The communication log books entry dated November 22, 2006 for this resident stated: "The last 2 alert chartings says Zyprexa was D/C'd (discontinued). The MAR has Zyprexa DC'd on 11-18, BUT I cannot find any order to D/C Zyprexa the alert list doesn't have it DC'd. If it was D/C'd on 11-18 we need the order! (nurse's signature)."
g) On January 2, 2007 at 1:20 PM an order was written by the Director of Pharmacy: "Add Zyprexa 5 mg by mouth every 5 p.m. (continue 10 mg in morning)."

Review of the IDT notes dated November 22, 2006 read, "...Order written November 18, 2006, discontinue Zyprexa due to Extra Pyramidal Symptoms (EPS) effects, "perceived EPS." Hallucinations and trembling were due to a psychotic episode, as a result we advice that Zyprexa will be restarted!" Yet no psychiatric behaviors are described in any of the IDT notes during this period, October 5, 2006 to January 17, 2007.

Review of the nurse's progress notes showed the following documentations:
a) On October 1, 2006 at 6:40 PM, stated: "...Some lethargy noted this shift." Nurses notes dated October 2, 2006 at 6:15 PM stated: "...Res. (Resident) lethargic this shift ... ."
b) On October 3, 2006 at 7 PM stated:

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F 329	Continued From page 80 "...appears to be lethargic this a.m." c) On October 10, 2006 at 7:15 PM stated: "...Also noted to sleep in w/c (wheelchair) during day." d) On October 12, 2006 at 2 PM stated: "Patient has been very sleepy today." e) On November 10, 2006 at 11:30 PM stated: "Res (resident) lethargic when NOCS (night shift) began." f) On November 14, 2006 at 11:30 PM stated: "Res (resident) very quiet, almost lethargic, but responsive." g) On November 18, 2006 at 6 AM stated: "...Res (resident's) eyes look glazed over, res restless and dull looking. She is not her normal perky, "raring to go self." h) On November 18, 2006 at 2:12 PM stated: "Noted today res exhibiting hallucinations of apparent bugs she was trying to remove from body. Also, she had nervous movements all appearing to be EPS (Extra Pyramidal Symptoms) that may be R/T (related to) Zyprexa side effects. Noted Zyprexa increased 11-19-06 .... ." i) On November 22, 2006 at 11:30 PM stated: "Res continues to be lethargic. Zyprexa re-started tonight." j) On November 23, 2006 at 11:30 PM stated: "Res (resident) lethargic, hard to awaken to take meds (medications) at HS (bed time)." k) On November 28, 2006 at 6:30 PM stated: "...res (resident) continues to have episodes of lethargy and later in same day becomes agitated. Appetite is very poor." Nurse's note dated December 1, 2006 stated: "Slight lethargy today ... ." l) On December 6, 2006 at 11:30 PM stated: "Res confused and disoriented @ (at) HS (bedtime) ... ."	F 329		

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F 329	Continued From page 81 During an interview with one of the medication nurses on January 17, 2007 at 11:10 AM, the nurse stated: "This resident who would try to elope, but she did not do this after the medications were started and she became very sedated." During interview with one of the CNA's on January 17, 2007 at 6:45 PM, he stated: "During the last few weeks, she has been like a zombie and sits with head down. Very lethargic, follows CNA around usually but not in the last two weeks." During an interview with the second CNA on January 17, 2007 at 8:20 PM, she stated, "Resident has not been herself anymore. Sleeps a lot. Use to elope but she does not anymore." The resident's Zyprexa, and Seroquel had never been care planned despite the facility's policy and procedure entitled: "Care Planning- Permanent", states: The planning for care, treatment and services will include the following: "Determining how the planned care, treatment and services will be provided, documenting the plan for care, treatment and services, monitoring the effectiveness of care planning and the provision of care, treatment, and services." The resident had no history of psychotic behaviors, diagnosis of psychosis, or a psychiatric evaluation documented which could be provided by the facility's IDT to support the resident's need for this unnecessary medication which had been given in the presence of adverse consequences and used as a chemical restraint for elopement.	F 329		

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6. Review of the clinical record for Resident 28 (a 83 year old, with no diagnosis of psychiatric behavior) on January 20, 2007 revealed that there was an order for Depakote 125 mg by mouth twice daily written by the Director of Pharmacy, which was started on December 20, 2006, for one week then increase to 250 mg by mouth two times daily (contrary to the drug manufacturer's statement that it takes 1-2 weeks before an anti manic effect can be seen after initiation of this medication). The physician's order read as follows for the reason for starting this medication, "...for refusal of care, refusing to get out of bed for meals."

The Depakote was started on December 20, 2006 based on the facility's Pharmacist and Interdisciplinary Team (IDT) notes from the same date. The IDT note dated December 20, 2006 reads, "...Resident showing beginning behavior problems R/T (related to) dementia. Start Depakote 125 mg twice daily for one week, then 250 mg twice daily .... ." No specific behaviors were ever described by the IDT or the Director of Pharmacy as reasons for starting this medication.

During an interview with the medication nurse on January 17, 2007 at 7:30 PM, the nurse stated: "Resident 18 and Resident 28 were given psychiatric meds (medications) because they did not want to go to the dinning room."

Review of the clinical records for the residents identified above revealed that the Director of Pharmacy had written 95 percent or more of the above orders for Depakote and the Psychotropic drugs (e.g. Seroquel, Risperdal, and Zyprexa) without contacting the resident's physician prior to

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starting these medications. Interview with the facility's Director of Pharmacy on January 12, 2007 at 4:40 PM revealed that the Director of Pharmacy had not contacted the resident's physician prior to writing these drug orders in the resident's clinical records. Interview with both the facility's Director of Pharmacy on January 12, 2007 at 4:40 PM and interview with the facility's Medical Director on January 16, 2007 at 5:10 PM revealed that the ordering of Depakote and Psychotropic medications had been initiated and documented in the resident's clinical record by the Director of Pharmacy. Despite the fact that the orders for these medications were written to look like telephone or verbal orders, the Director of Pharmacy and the Medical Director indicated that they would casually discuss these new orders after the orders had been written. The Pharmacy Director and the Medical Director indicated that they would have these discussions in the hallway as they passed or by cellphone, during the course of the day.

During an interview with the Medical Director on January 16, 2007 at 5:10 PM the Medical Director stated: "I have noticed a slight increase in the last two months in the use of Depakote and Psychotropic medications. The Pharmacist and I have an informal understanding about the Director of Pharmacy writing medication orders." The Medical Director also indicated that: "it was difficult some times to get accurate information about the residents from nursing staff." Interview with the Director of Pharmacy on January 16, 2007 at 3:20 PM revealed that the Director of Pharmacy would write the orders on a triplicate physician's order sheet. The top "white" copy would remain in the clinical record and the "yellow" copy would be put in the resident's

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physician's mailbox for signature on the physician's next visit (which may be the first time that the physician sees the medication order according to an interview with the Director of Pharmacy). The "yellow" copy would then be taped back into the clinical record after the physician has signed the order. Drug labs (blood tests) were also ordered by the Director of Pharmacy for the residents on the Depakote and Psychotropic medications.
The Director of Pharmacy, the Medical Director, and the Chairman of the Pharmacy and Therapeutics Committee (P&T) were all unable to provide any type of protocol or policy which would allow the Director of Pharmacy to order medications for the residents. The Director of Pharmacy, the Medical Director, and the Chairman of the P&T were also unable to provide a protocol or policy which would allow the Director of Pharmacy to order lab. Review of the policy entitled: "Protocol for Lab Orders-Drug Monitoring-Consultant Pharmacist" which was dated September 29, 1998, referred to a pre-printed order sheet and a protocol, but no true "protocol" (other than the pre-printed laboratory order sheet which was entitled: "Physician Orders for Drug Monitoring Lab Tests") as referred to in the facility's policy and procedure could be provided by the facility. The above information demonstrates that the facility's Director of Pharmacy was practicing outside of her scope of practice by writing medication and lab orders without prior notification of each resident s physician.

A copy of a Memorandum which had been written on facility letterhead dated January 4, 2007, addressed to: "Nursing Center Licensed Staff ", from: "Chief Nursing Officer and the Director of

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Pharmacy", with a subject heading of: "Antipsychotic Medications", read: "(Director of Pharmacy) and I want to thank you for all your input and concern about giving antipsychotic medication to our residents. We have discussed this issue with our physician's and the IDT Committee. It has been decided to form a committee to look closely at every resident (13) who are on antipsychotics. Some of you will be asked to participate. May I again say that complete and proper documentation is the only way the IDT team and the doctor know the residents' true behaviors. Please listen to your CNA's. Help them with the correct way to approach residents and to redirect them. As a nurse, I take my license very seriously. I cannot ever 'practice medicine'. Please address your concerns in the proper manner to the IDT team and/or the physician."

Surveyor: 16893
7. Resident 4 was a 91 year-old with diagnoses which included other persistent mental disorders due to conditions classified elsewhere.

During observation of Resident 4 on January 18, 2007 at 2:53 PM he was found sleeping in his bed, mats were noted on the floor beside his bed and he had a vest restraint on.

During an interview with Staff S on January 23, 2007 at 10:15 AM she said "Other than charting 'Hallucinations' or 'Delusions', charting was no more specific than that. Yes, I've heard of some hallucinations but not more specific than that. Noone told me what the hallucinations were for the residents."

During an interview with Staff R on January 23,

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2007 at 11:15 AM she said "The only thing I can remember is he was really mean and moody, but they sent him to x-ray and he had an impaction but was too far up and he would yell out or strike out in pain, pushing us away. I don't remember any hallucinations or anyone talking about him having hallucinations. He was always sweet and he would stand for me without any problems."

During record review on January 18, 2007 at 10 AM Resident 4's diagnoses included "Other persistent mental disorders due to conditions classified elsewhere." According to the record Seroquel was ordered for Resident 4 on admission October 24, 2006, 25 mg (milligrams) every morning and 100 mg every night for Dementia. He was also on Paxil for depression. According to the IDT (Interdisciplinary Team) notes dated November 7, 2006 Resident 4 was on Seroquel for visual hallucinations. The Drug Regimen Review on November 3, 2006 shows Dementia as a reason for the Seroquel. The Psychoactive Drug Flow Sheets for the month of October show monitoring for behaviors including hallucinations/delusions; confusion; sedation. The Flow Sheets for November show monitoring for Depression and Dementia. According to the federal guidelines Dementia and Visual Hallucinations are not indications for the use of Seroquel which is an antipsychotic medication. The symptoms for the use of Seroquel do include Hallucinations if the Hallucinations present a danger to the resident or others or if the resident is experiencing persistent distress such as fear. The target behavior for the antipsychotic must be clearly and specifically identified and monitored objectively and qualitatively in order to ensure the behavioral symptoms are not due to a medical condition, cannot be relieved by

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non-pharmacological interventions and are not due to environmental (i.e.: hunger, thirst, excessive noise) or psychological stressors (loneliness, misunderstanding related to cognitive impairment). Antipsychotics are not indicated for restlessness, uncooperativeness or impaired memory.

Resident 4 was being monitored for confusion and dementia. The Psychoactive Drug Flow Sheet for October showed Resident 4 had two hallucinations between October 24 and October 31, 2006. The two hallucinations/delusions are not documented in the nursing notes or on the flow sheet to describe what the resident was doing at the time of the hallucination/delusion. There is no documentation as to whether these upset the resident or caused him to be a danger to himself or others, or if he could be redirected easily. The Flow Sheet for November 2006 has Depression and Dementia listed to monitor but no criteria as to exactly what the nurse should document for Dementia.

Review of the nurses notes for November 2006 through January 15, 2007 show "No noted change in behavior. Cooperative with care." "Pleasantly confused." "No behavioral problems noted." On December 13, 2006 at 6 PM "Resident has attempted to hit times one last evening and this evening. Resident has been yelling out. Resident has been cooperative and pleasant through most of day. Seems to be a little agitated this evening." On December 16, 2006 documentation regarding a pain medication was noted in the nursing notes. The nurses have continued "Alert Charting" for the use of Ultram for pain through December 22, 2006. "Resident does not seem as agitated since starting Ultram."

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On December 25, 2006 he went for an x-ray as he was "very uncomfortable with abdominal pain" and his abdomen was "slightly distended." He was given Milk of Magnesia, Dulcolax tablets, two fleet enemas, tap water enema and Citrate of Magnesia with "no significant stool being expelled." He was sent to the emergency room where he "had an extra large bowel movement which was loose and liquids." "Resident appears to be without pain at this time."

The care plan for Psychotropic medications dated November 16, 2006 has a goal of "improved mood and behaviors." The approaches included "2. Explore possible reasons for the resident's distress (e.g., environmental/psychosocial stressors, treatable medical conditions, etc.")

Resident 4's medical record did not contain an adequate clinical indication for the Seroquel; establish identified therapeutic goals for the medication or monitor Resident 4 for progress towards the therapeutic goals.

8. Resident 6 was an 88 year-old with diagnoses which included Senile Dementia, uncomplicated.

During an observation of Resident 6 on January 23, 2007 at 9:55 AM she was sitting in a wheelchair outside her room. She would not talk to surveyor or make eye contact. She had what appeared to be Cream of Wheat coming out of her mouth onto her bottom lip. Observation of Resident 6 at 11 AM found her sitting in her wheelchair outside her room sleeping.

During an interview with Staff C on January 11, 2007 at 3:10 PM, Staff C said "(Resident 6) is the most recent one put into a geri chair."

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During an interview with Staff K on January 17, 2007 at 3:44 PM, Staff K said "About two weeks ago (Resident 6's) daughter said 'what is she doing in this chair?' I never noticed anything wrong with her to be put in a geri chair and her daughter had no knowledge of the geri chair, no consent was signed."

During a review of Resident 6's medical record on January 19, 2007 at 11 AM, IDT notes were read. On July 12, 2006 "Seroquel 25 mg twice a day started on 6-23-06 for hitting, kicking staff, aggitation. Pt (Patient) has not started meds yet. Attempting to obtain consent." On August 10, 2006 "Refuses many meds, some will take 2 X a week. Resident has some lethargy - just started Seroquel - started 7/7 - takes one month." On October 10, 2006 "Recommend increase Seroques to 75 mg at hs (hour of sleep) only, keep 50 mg in AM." On November 22, 2006 "DC (discontinue) bed belt, use geri chair for trunk support when needed." On December 28, 2006 "Resident reported fall from wheelchair in day room, appears to have released own self releasing lap belt. Order for geri chair when available related to poor trunk balance." January 9, 2007 "IDT for fall 1/5/07 at 0500 found at side of bed. Out of 6 last falls at SNF, 5 were related to resident releasing her self releasing belt. Specific interventions: Obtain geri chair for resident, will DC self releasing belt, DC pummel seat, DC wheelchair. Will review application of bed belt, and mittens with staff."

Seroquel was ordered for the resident due to hitting, kicking staff and aggitation. On July 7, 2006 Resident 6 was started on 25 mg of Seroquel twice a day. On October 10, 2006 it

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was recommended by IDT to increase the evening dose to 75 mg and to keep the morning dose at 50 mg. Review of the Psychoactive Drug Flow Sheets show Resident 6 was being monitored for Combative Behavior; Agitation; Spitting; Scratching/pinching; Refusing Medication and talking all night. There is no indication in the record where a medical or psychosocial reason for these behaviors was considered and ruled out before begining the antipsychotic. A nurses note dated October 26, 2006 at 9 AM states "Indicates pain - yelling out and scratching. Vicodin given and resident quiet and calm with decreased agitation.

9. Resident 7 was an 80 year-old with diagnoses which included pneumonia, malnutrition and general symptoms, other convulsions.

During an observation of Resident 7 on January 23, 2007 at 11:22 AM she was in her bed sleeping.

During record review on January 19, 2007 at 1:15 PM it was noted Resident 7 was on Trazodone for combativeness and resistance to care. The IDT decided on October 12, 2006 these behaviors were no longer a problem and recommended to discontinue the medication. On November 14, 2006 the IDT documented "Need to evaluate resident for an antipsychotic med in place of antidepresant, referral to pharmacist or MD, related to behaviors." On December 6, 2006 the Consultant Pharmacist's Recommendation to the Inter-Disciplinary Team for the month of November said "Gradual dose reduction required by OBRA regulations. Need order for reduction or documentation that a reduction would be harmful to self or others." The IDT responded

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"Delay dose reduction until closer to 6 month time period on Seroquel." On December 29, 2006 the IDT reviewed the December 13, 2006 increase in Seroquel from 25 mg twice a day to 50 mg twice a day. They documented "Appears to be controlled with increased doseage." The Seroquel had been ordered for aggitation, combativeness and negative behavior.

Nursing notes dated November 20, 2006 "On alert charting for starting new drug Seroquel. Resident has change, she is more aggitated and aggressive when you talk to her. When given a pain pill she settles down and lower the head of the bed and she is flat she will go to sleep." November 22, 2006 the first dose of Seroquel was given. November 25, 2006 "Refused 1700 meds, said they were sticking in her." No behavior problems were noted until December 19, 2006 entry "No episodes of biting or screaming today, very pleasant." The Seroquel was increased from 25 mg to 50 mg twice a day on December 13, 2006 but no documentation in the nursing notes exhisted concerning biting or screaming. Notes are found for urinary tract infection and pain but no behaviors. On January 12, 2007 Resident 7 was not responding to verbal stimuli and on January 13, 2007 it was noted by nursing Resident 7 had not had a bowel movement for six days. An x-ray was ordered and was positive for a large amount of bowel. Resident 7 complained of pain, pointing to her abdomen on January 14, 2007, the physician ordered digital removal of feces to be done on night shift. On January 15, 2007 Resident 7 stated she felt better and was in no pain.

The Psychoactive Drug Flow Sheets show Resident 7 was being monitored for hallucinations

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F 329	Continued From page 92 and paranoia. No documentation was found concerning these in the nursing notes to show what Resident 7 was doing during these hallucinations or paranoia so these behaviors could be evaluated by the physician or the ID tea	F 329		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 13095 Based on review of the clinical record and interview with the unit secretary the facility failed to ensure antibiotics which had been ordered by resident's physicians were administered as ordered for 2 of 29 sampled residents. (12, 29) Findings:	F 425		5/17/07

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F 425	Continued From page 93 1. Review of the clinical record for Resident 12 on January 19, 2007 at 4:30 p.m. revealed that the resident's physician had ordered Amoxicillin 500 mg by mouth three times daily for 10 days for UTI (urinary tract infection), on November 22, 2006 at 8:40 a.m. Further review of the clinical record revealed that the Amoxicillin had not been administered to the resident until December 5, 2006 at 6:00 a.m. (13 days after the physician had ordered this medication). Interview with the unit secretary on January 19, 2007 at 5:00 p.m. revealed that the order had gotten "missed" in the clinical record and it was not until December 5, 2006 at 4:30 a.m. that the order was discovered by her. Interview with charge nurse and facility administrative staff on January 19, 2007 at 5:00 p.m. revealed that the facility's policy for administering antibiotics was to start these medications no longer than 4 hours after being ordered by the physician. 2. Review of the clinical record for Resident 29 on January 19, 2007 at 5:30 p.m. revealed that the resident's physician had ordered Levaquin 500 mg by mouth daily for 10 days for pneumonia, on December 5, 2006 at 10:35 a.m. Further review of the clinical record revealed a physician's order on December 5, 2006 at 3:20 p.m. to Discontinue Levaquin and start Ciprofloxacin 500 mg by mouth twice daily for 10 days. On December 7, 2006 at 6:42 p.m. a physician's order was written for Levaquin 250 mg by mouth every day for 7 days. On December 8, 2006 at 11:15 a.m. an order was written by the Director of Pharmacy to discontinue Levaquin and continue the Ciprofloxacin by mouth twice daily for 6 days.	F 425		

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F 425	Continued From page 94 Between the first order for Levaquin which was written on December 5, 2006 and December 8, 2006, the resident never received a dose of Levaquin as ordered by the resident's physician despite the facility's policy. Interview with charge nurse and facility administrative staff on January 19, 2007 at 5:00 p.m. revealed that the facility's policy for administering antibiotics was to start these medications no longer than 4 hours after being ordered by the physician.	F 425		
F 492 SS=K	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Surveyor: 16893 Based on interview and record review, the facility administration failed to effectively use it's resources to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 29 of 29 sampled residents. (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29) Interview with the facility's Director of Pharmacy and nursing staff between January 12, 2007 to January 19, 2007 revealed that the facility's previous Director of Nurses (DON) had instructed facility staff to use Depakote on the residents because this medication did not require informed	F 492		5/17/07

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consent from the residents or their families prior to administration. During an interview with the Director of Pharmacy on January 12, 2007 at 4:40 PM, the Director of Pharmacy indicated: "(the previous DON) requested me to write orders for these medications." The Director of Pharmacy went on to say she felt the previous DON had come to the facility with a wealth of knowledge and "I trusted her (the previous DON)."

Review of a note dated December 25, 2006 in the facility's communication log stated: "Note from (previous DON) - No consent needed for Depakote at all - it is a seizure drug - It is family's responsibility to call DON or MSW for report on IDT (Interdisciplinary Team) decisions. Blaming staff or MD is a guilt reaction - please do not feel responsible as staff, Ok? (Signature of previous DON)."

Interview conducted on January 18, 2007 at 11:45 AM, the MSW (Master of Social Work) stated: "Depakote was off the radar and did not need a consent. If the resident did not want to go to the dinning room then an antipsychotic drug would be started. If the residents yelled out the medication would be started." None of the resident's family members were notified about starting Depakote on any of the residents.

Numerous residents were started on Depakote without displaying or having any documented psychotic type behaviors. Depakote is often classified as a "Mood Stabilizing drug", but this drug is similar to other psychiatric drugs, which are currently being used.

During a review of the clinical records for residents 5, 18, 19, 23, 25, and 28 it was revealed

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the Director of Pharmacy had written 95% or more of the above orders for Depakote and the Psychotropic drugs (e.g. Seroquel, Risperdal, and Zyprexa). Interview with the facility's Director of Pharmacy on January 12, 2007 at 4:40 PM revealed the Director of Pharmacy had not contacted the resident's Physician prior to writing these drug orders in the resident's clinical records. Interview with both the facility's Director of Pharmacy on January 12, 2007 at 4:40 PM and interview with the facility's Medical Director on January 16, 2007 at 5:10 PM revealed the ordering of Depakote and Psychotropic medications was initiated and documented in the resident's clinical record by the Director of Pharmacy, prior to the Director of Pharmacy making contact with the resident's physician. Both the Director of Pharmacy and the Medical Director indicated the medication orders for Depakote and the Psychotropic drugs were casually discussed for the most part when (the Director of Pharmacy and the resident's physician) passed in the hallway during the course of the day or when the Director of Pharmacy would contact the resident's physician after writing the drug orders, by cell phone.

During an interview with the Medical Director on January 16, 2007 at 5:10 PM the Medical Director stated: "I have noticed a slight increase in the last two months in Depakote and Psychotropic medications. The Pharmacist and I have an informal understanding about the Director of Pharmacy writing medication orders." The Medical Director also indicated that: "it was difficult some times to get accurate information about the residents from nursing staff. "Interview with the Director of Pharmacy on January 16, 2007 at 3:20 PM revealed the Director of

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Pharmacy would write the orders on a triplicate physician's order sheet. The top "white" copy would remain in the clinical record and the "yellow" copy would be put in the resident's physician's mailbox for signature on the physician's next visit (which may be the first time the physician sees the medication order). The "yellow" copy would then be taped back into the clinical record after the physician has signed the order. Drug labs (blood tests) were also ordered by the Director of Pharmacy for the resident on the Depakote and Psychotropic medications. The Director of Pharmacy, the Medical Director and the Chairman of the Pharmacy and Therapeutics Committee (P&T) were all unable to provide any type of protocol or policy which would allow the Director of Pharmacy to order medications for the residents'. The Director of Pharmacy, the Medical Director and the Chairman of the P&T were also unable to provide a protocol or policy which would allow the Director of Pharmacy to order labs. Review of the policy entitled: "Protocol for Lab Orders-Drug Monitoring - Consultant Pharmacist" which was dated September 29, 1998, referred to a pre-printed order sheet and a protocol, but no true "protocol" (other than the pre-printed order sheet which was entitled: "Physician Orders for Drug Monitoring Lab Tests") as referred to in the facility's policy and procedure could be provided by the facility. The above information demonstrates the facility's Director of Pharmacy was practicing outside of her scope of practice by writing medication and lab orders without prior notification of each resident's physician.

A copy of a Memorandum which had been written on facility letterhead dated January 4, 2007, addressed to: "Nursing Center Licensed Staff ",

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from: "Chief Nursing Officer (CNO) and the Director of Pharmacy", with a subject heading of: "Antipsychotic Medications", read: "(Director of Pharmacy) and I want to thank you for all your input and concern about giving antipsychotic medication to our residents. We have discussed this issue with our physician's and the IDT Committee. It has been decided to form a committee to look closely at every resident (13) who are on antipsychotics. Some of you will be asked to participate. May I again say that complete and proper documentation is the only way the IDT team and the doctor know the residents true behaviors. Please listen to your CNA's Help them with the correct way to approach residents and to redirect them. As a nurse, I take my license very seriously. I cannot ever 'practice medicine'. Please address your concerns in the proper manner to the IDT team and/or the physician."

During an interview with the Administrator on January 11, 2007 at 2:20 PM she stated, "The pharmacist used to write orders for psychotropic's because she has a special degree in gerontology. We were shocked about the number of patients on psych meds but I was assured this was the current standard of care by the former DON. We knew we had a problem, psychotropic's came up two weeks ago when the MSW came to me."

During an interview with the Chief Nursing Officer on January 11, 2007 at 2:30 PM she stated, "We got heads up last week after staff came and said concerned about use of psychotropic meds. We knew we had a problem."

During an interview with Staff W on January 9, 2007, Staff W was asked if the facility used the

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services of a psychiatrist or a psychologist. Staff W responded "We have the services of a social worker." When asked if a resident needed a psychological evaluation what would happen, Staff W said "They could be taken to Bakersfield to get one if the facility or a volunteer could provided transportation."

During an interview with the MSW on January 18, 2007 he said, "The former DON appeared to have extensive experience. Her basic approach was medicate for whatever issue. She wanted to put people on Depakote and antipsychotic. She said it's the industry standard. After a few months she would slap the table and say "I think the resident needs Depakote and Antipsychotics'. It felt wrong, we were putting people on antipsychotics for willy nilly things. Sometimes it would happen with only one behavior. She would constantly refer to people as demented and psychotic. I would argue with her, aggressive, combative behavior was not a psychosis; there isn't a lot of documentation in the record. My colleagues would say thanks for arguing with her. I encouraged my colleagues to speak up. She (former DON) took over the IDT process. I went to the administrator and said (former DON) can take those charts into her office and make the decisions. The LVN's (Licensed Vocational Nurses) on the med carts would voice concerns about giving so many antipsychotics. I was told by (former DON) two residents were resisting their injections. She stated 'those residents are psychotic, they must be held down. It would be like them not eating'. One resident was held down against her will, left undressed and given an injection. She called the Ombudsman. She is reliable; she scores high on the MME (mental status exam). (The former DON) didn't have a

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good relationship with the Ombudsman. She said 'don't you tell the Ombudsman anything'. After (Resident 18's) electric wheelchair was taken away (former DON) had (Staff G) give (Resident 18) Zyprexa because she refused to get out of bed. I went to the administrator and the chief nursing officer and said someone just gave Zyprexa to (Resident 18). (Former DON) was so inflexible and rude to the CNA's 'they are a dime a dozen'. A psychiatrist in Bakersfield put (Resident 20) on meds. She used to be up and around, (former DON) put her in a Geri chair. Her (Resident 20) whole life changed, before she was up, smoking. (Former DON) had a thing about Geri chairs. She thought the state would want residents to be in Geri chairs. She had catalogs out asking family to order the Geri chairs. She was asking the controller how many Geri chairs can I order. She said it was for trunk balance. I deferred to her because of all of her years of experience. Meds would be given, started in IDT but there would be no documentation."

During an interview with the Administrator on January 19, 2007 she said "I didn't realize we had so many Geri chairs until Christmas when I went down to the SNF (Skilled Nursing Facility). I saw the Geri chairs all lined up against the walls. I didn't know there were so many because the cost was less than $500.00. Anything less than $500.00 I do not have to approve."

During an interview with Staff V on January 18, 2007 at 9:45 AM Staff V stated, "We interviewed (former DON) the staff chose her. The room was full of staff. She (former DON) came across as being experienced, she took control of the interview. She was asking the questions. I had concerns about her from the beginning. At first

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she made positive changes. She helped with dining issues. Staff came to me crying because (former DON) said residents would not be fed unless they came to dining room. I told them the patients could be fed, just don't do it in front of (former DON). She was firm about not feeding patients if they didn't go to the dining room. (The former DON) is tyrannical in her approach. She will attack. When I was talking to the staff yesterday it was like diarrhea of the mouth. I am so ashamed they did not feel they could come to me. The IDT was more organized initially, then later it was doctorial, she (former DON) wouldn't allow input. In October I told the administrator I cannot work with (former DON) and the administrator took over the responsibility for the SNF. The MSW came to me in November to let me know 'things are impossible with the SNF'. The administrator started talking with (former DON), a disciplinary process. (Former DON) told me she keeps a black book and no one will get rid of her easily. Staff went to the MSW about the issues in the SNF; the activity director went to the administrator. From the beginning I didn't like her (former DON). I told the administrator she is controlling, we will have a problem. I did not see her talk to one resident and I did not observe her talking to any staff. She spent a lot of time in her office with the door closed."

During an interview with Staff E on January 19, 2007, Staff E stated, "I talked to (the MSW), he said people are working on it, but we didn't see evidence of that. I went to (the CNO) and said 'I am worried that some of these people will die'. I also said to (the Director of Pharmacy), you need to look at (Resident 25) she is comatose." "I went to (the CNO) again and said I'm worried that (Resident 23) will die, she said 'oh he had a

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major system event, if you hadn't kept them all snowed with Ativan .... 'I said that was not the case. We were not. I think (the former DON) and (CNO) were friends." "The (former DON) accused us of throwing residents medications away. She even came in on the night shift and checked the garbage cans. She was worried about psych meds. When a patient was comatose we would hold the med and at times they refused. (The former DON) said we cannot refuse to give the patient meds." "I thought I was going to crack. Actually I went to the Administration two weeks ago, actually last Tuesday I talked to the Administrator. She said (former DON) is so brilliant you need to try to work with her. We (the nursing staff) were beat down. The Administrator would tell us (former DON) has to get us through the state. The (CNO) didn't say anything to give us hope. We all feel Administration let us down."

During an interview with Staff D on January 17, 2007 at 9:50 AM Staff D said, "(Former DON) tried to avoid the residents. Some of the residents would talk about her. She didn't have good interaction with her employees. As employees we had no input, it was her way. Staff asked about Ativan for a resident, she (former DON) stated 'No the (resident) will get Zyprexa'." "We were concerned about Depakote. As LVN's we were concerned about getting labs prior to increases. She said 'no we aren't treating seizures it's therapeutic'. When we stated we had a problem giving Zyprexa because we read the insert, (the former DON) said 'call the doctor and tell him you won't give it, then you will loose your license'." "(The former DON) accused us of throwing away psychotropics, one resident in hall

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1 refused Depakote. We went to (the administrator) almost immediately, about two weeks after (the former DON) came and nothing happened."

During an interview with Staff G on January 17, 2007 Staff G stated, "She (former DON) was very controlling, she wanted to change everything. She changed meal situation, everyone had to go to the dining room or they didn't eat. They should have the right to eat in their room. (The administrator) sent a memo saying we could feed people in their rooms. She (former DON) called herself a "wall" in one of our meetings, I was very disappointed, I was looking forward to change. I don't think she cared about the residents. I had a conversation with her about a resident's wound; she said 'maybe the best thing would be if he got septic. Maybe Hospice would be called'. We got another patient in on Hospice, he was dehydrated, we gave him fluids, he got gurgley, she said 'let him drown.' With staff, they didn't like her, when the activities director was gone for a month and returned she (activities director) said 'what is wrong with this place, some one has sucked the life out of it.' She (former DON) wasn't a people person."

During an interview with Staff H on January 17, 2007 Staff H said, "In IDT she (former DON) gave false information, (i.e. one resident 'she steals from people'), when I checked it out she (the resident) didn't steal. She (former DON) accused the CNA's of lying to the nurses. In IDT, the MSW and the activities director viewed concerns. (The former DON) banged on the table and said 'don't listen to other people, listen to me.' The IDT was not a team; it was (the former

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DON's) show."

During an interview with Staff J on January 17, 2007 Staff J stated, "(The former DON) sent out a memo stating the residents can decide if they want to eat or not, I can decide where they eat. (The former DON) took me aside and said under no circumstances are you to give (a resident) a tray. (The former DON) is a dictator." "In the introductory meeting with (the former DON) one of the residents was wanting dollars for sodas, she (former DON) said 'are we going to have to put up a sign that says don't feed the animals?" "I never saw (former DON) interact with the residents."

During an interview with Staff K on January 17, 2007 Staff K said, "(The former DON) was rude, she didn't care about anyone except herself. I felt unworthy around her. We were talking about giving money to residents for sodas; she said we should put a sign up that says 'Don't feed the animals'. I was intimidated by her, she was very angry; she would act intimidating to make herself look better."

During an interview with Staff M on January 17, 2007 Staff M stated, "(The former DON) was not compassionate. During a staff meeting she referred to the patients as animals in a zoo. She seemed cold, the residents made comments about her wheeling herself fast down the hallways and moving them out of the way. She was cold." "She wouldn't speak to the residents when she went down the hall. (Former DON) stated if they don't go to the dining room they don't get a tray. The CNA's would sneak food to them."

During a review of the facility "Summary of

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F 492	Continued From page 105 Internal Review Process Conducted January 17th and 18th 2007 ", on January 23, 2007, it was discovered that "Administration became aware of some issues in November 2006. These issues were surrounding (former DON's) approach to staff." Interview by a facility staff member of a facility Registered Nurse revealed the following, "In the IDT meetings (former DON) would state things like 'Be quiet, I will take care of this'. Other times when input was attempted (former DON) would tell her that she was rude to interrupt or say things like 'Perhaps you would like to take over'. In IDT (former DON) would frequently slap hand on the table and speak very loudly. (Former DON) told staff to hold trays to patients that did not go to the dining room and spoke out loud to staff that the residents were animals. I felt like a few residents were medicated because of inappropriate reasons. (Former DON) would diagnose residents at IDT and then would have the Pharmacist write orders to match her diagnosis. Many times the charts did not substantiate (former DON's) diagnosis. On one resident who bumped into another resident with his electric wheelchair, (former DON) wrote on the MD orders-' Deliberate use of power wheelchair to harm others'. She included on MD order 'sexual harassment of other residents'. Both of these statements written on the chart registered nurse felt were unsubstantiated and unfair to the resident. In addition medications were increased because of this allegation."	F 492		
F 501 SS=K	483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the	F 501		5/17/07

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Depakote and the Psychotropic drugs were casually discussed for the most part when (the Director of Pharmacy and the resident's physician) passed in the hallway during the course of the day or when the Director of Pharmacy would contact the resident's physician after writing the drug orders, by cell phone.

During an interview with the Medical Director on January 16, 2007 at 5:10 PM the Medical Director stated: "I have noticed a slight increase in the last two months in Depakote and Psychotropic medications. The Pharmacist and I have an informal understanding about the Director of Pharmacy writing medication orders." The Medical Director also indicated that: "it was difficult some times to get accurate information about the residents from nursing staff. "Interview with the Director of Pharmacy on January 16, 2007 at 3:20 PM revealed the Director of Pharmacy would write the orders on a triplicate physician's order sheet. The top "white" copy would remain in the clinical record and the "yellow" copy would be put in the resident's physician's mailbox for signature on the physician's next visit (which may be the first time the physician sees the medication order). The "yellow copy would then be taped back into the clinical record after the physician has signed the order. Drug labs (blood tests) were also ordered by the Director of Pharmacy for the resident on the Depakote and Psychotropic medications. The Director of Pharmacy, the Medical Director and the Chairman of the Pharmacy and Therapeutics Committee (P&T) were all unable to provide any type of protocol or policy which would allow the Director of Pharmacy to order medications for the residents'. The Director of Pharmacy, the Medical Director and the Chairman of the P&T

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were also unable to provide a protocol or policy which would allow the Director of Pharmacy to order labs. Review of the policy entitled: "Protocol for Lab Orders-Drug Monitoring - Consultant Pharmacist" which was dated September 29, 1998, referred to a pre-printed order sheet and a protocol, but no true "protocol" (other than the pre-printed order sheet which was entitled: "Physician Orders for Drug Monitoring Lab Tests") as referred to in the facility's policy and procedure could be provided by the facility. The above information demonstrates the facility's Director of Pharmacy was practicing outside of her scope of practice by writing medication and lab orders without prior notification of each resident's physician.

A copy of a Memorandum which had been written on facility letterhead dated January 4, 2007, addressed to: "Nursing Center Licensed Staff ", from: "Chief Nursing Officer (CNO) and the Director of Pharmacy", with a subject heading of: "Antipsychotic Medications", read: "(Director of Pharmacy) and I want to thank you for all your input and concern about giving antipsychotic medication to our residents. We have discussed this issue with our physician's and the IDT Committee. It has been decided to form a committee to look closely at every resident (13) who are on antipsychotics. Some of you will be asked to participate. May I again say that complete and proper documentation is the only way the IDT team and the doctor know the residents true behaviors. Please listen to your CNA's Help them with the correct way to approach residents and to redirect them. As a nurse, I take my license very seriously. I cannot ever 'practice medicine'. Please address your concerns in the proper manner to the IDT team

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and/or the physician."

During an interview with the Administrator on January 11, 2007 at 2:20 PM she stated, "The pharmacist used to write orders for psychotropic's because she has a special degree in gerontology. We were shocked about the number of patients on psych meds but I was assured this was the current standard of care by the former DON. We knew we had a problem, psychotropic's came up two weeks ago when the MSW came to me."

During an interview with the MSW on January 18, 2007 he said, "The former DON appeared to have extensive experience. Her basic approach was medicate for whatever issue. She wanted to put people on Depakote and antipsychotic. She said it's the industry standard. After a few months she would slap the table and say "I think the resident needs Depakote and Antipsychotics'. It felt wrong, we were putting people on antipsychotics for willy nilly things. Sometimes it would happen with only one behavior. She would constantly refer to people as demented and psychotic. I would argue with her, aggressive, combative behavior was not a psychosis; there isn't a lot of documentation in the record. My colleagues would say thanks for arguing with her. I encouraged my colleagues to speak up. She (former DON) took over the IDT process. I went to the administrator and said (former DON) can take those charts into her office and make the decisions. The LVN's (Licensed Vocational Nurses) on the med carts would voice concerns about giving so many antipsychotics. I was told by (former DON) two residents were resisting their injections. She stated 'those residents are psychotic, they must be held down. It would be like them not eating'. One resident was held

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F 501	Continued From page 110 down against her will, left undressed and given an injection. She called the Ombudsman. She is reliable; she scores high on the MME (mental status exam). (The former DON) didn't have a good relationship with the Ombudsman. She said 'don't you tell the Ombudsman anything'. After (Resident 18's) electric wheelchair was taken away (former DON) had (Staff G) give (Resident 18) Zyprexa because she refused to get out of bed. I went to the administrator and the chief nursing officer and said someone just gave Zyprexa to (Resident 18). (Former DON) was so inflexible and rude to the CNA's 'they are a dime a dozen'. A psychiatrist in Bakersfield put (Resident 20) on meds. She used to be up and around, (former DON) put her in a Geri chair. Her (Resident 20) whole life changed, before she was up, smoking. (Former DON) had a thing about Geri chairs. She thought the state would want residents to be in Geri chairs. She had catalogs out asking family to order the Geri chairs. She was asking the controller how many Geri chairs can I order. She said it was for trunk balance. I deferred to her because of all of her years of experience. Meds would be given, started in IDT but there would be no documentation."	F 501		