STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425316	A. BUILDING _____ B. WING _____	03/05/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN AGE - INMAN	82 N MAIN STREET INMAN, SC 29349

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F 0155 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Let the resident refuse treatment or refuse to take part in an experiment and formulate advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, review of the facility policy entitled Advance Directives, and review of the South Carolina Adult Healthcare Consent Act, the facility failed to ensure that 1 of 15 sampled residents reviewed had the opportunity to develop their own advance directive. There was no documentation in the record to indicate Resident #23 desired a Do Not Resuscitate DNR status. An Emergency Medical Services EMS order for DNR was signed by the resident's Responsible Party. Two physicians had not determined that Resident #23 was unable to make his/her own healthcare decisions. The findings included: The facility admitted Resident #23 with [DIAGNOSES REDACTED]. Record review on 3/4/15 at 3:18 PM revealed current Physician's Orders for a DNR code status for Resident #23. Further review revealed a Physician's Telephone Order dated 8/13/13 stating Res(ident) is DNR since 8-8-13. A Progress Note Addressing Decisional Capacity dated 8/15/13 revealed one physician had signed that the resident was not able to make healthcare decisions for him/herself. A Nurse Practitioner's Progress Note dated 7/31/13 documented This patient lacks decision-making capacity. There was no documentation noted that a second physician had certified that the resident lacked decisional capacity. There was nothing noted in the record to indicate that facility staff had spoken with the resident about his/her code status and that a DNR status was what the resident desired. There was nothing noted in the record to indicate the resident was on hospice. During an interview on 3/4/15 at 3:40 PM, the Director of Nursing (DON) reviewed the documentation in the medical record and verified there was no evidence that 2 physicians had determined that Resident #23 was unable to make his/her own healthcare decisions. The DON stated s/he would check the thinned records to see if additional documentation could be found. During an interview on 3/5/15 at 11:27 AM, the Social Services Director (SSD) stated they could find no additional information. The SSD verified that 2 physicians had not determined that Resident #23 was unable to make his/her own healthcare decisions. When asked, the SSD stated s/he could not find documentation that the DNR was the resident's wishes. A review of the policy provided by the facility entitled Advance Directives revealed The resident has a right to .formulate an advance directive in accordance with state and federal law . According to the policy, on admission, .If a resident has not executed an advance directive and the resident has the capacity to make health care decisions, the social services department should contact the resident to determine whether the resident wishes to make an advance directive . Review of the South Carolina Adult Healthcare Consent Act Section 44-66-20 revealed that Unable to consent means unable to appreciate the nature and implications of the patient's condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner . A patient's inability to consent must be certified by two licensed physicians, each of whom has examined the patient. However, in an emergency the patient's inability to consent may be certified by a health care professional responsible for the care of the patient if the health care professional states in writing in the patient's record that the delay occasioned by obtaining certification from two licensed physicians would be detrimental to the patient's health. A certifying physician or other health care professional shall give an opinion regarding the cause and nature of the inability to consent, its extent, and its probable duration
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop a care plan related to the use and monitoring of psychoactive medications for 1 of 5 sampled residents reviewed for unnecessary medications. Resident #24 was receiving multiple psychoactive medications but had no care plan related to their use, monitoring, or managing of risk factors. Also, based on observations, record review, and interviews, the facility failed to develop a behavioral care plan for 1 of 2 sampled residents reviewed for respiratory care. Resident #30 was observed multiple times with no oxygen on or with 2 liters of oxygen infusing when physician's orders [REDACTED]. The Comprehensive Care Plan for Resident #30 did not include behaviors of removing the oxygen and/or changing the oxygen settings. The findings included: Cross Refer to F-329 The facility admitted Resident #24 with [DIAGNOSES REDACTED]. On 3/4/15, review of the physician's orders [REDACTED].#24 was receiving multiple psychoactive medications including [MEDICATION NAME] Oxalate once daily for Depression, [MEDICATION NAME] Sprinkles two times a day for Senile Dementia with Depressive Features, [MEDICATION NAME] three times daily for Anxiety, and [MEDICATION NAME] every 24 hours as needed for Anxiety. A review of the Comprehensive Care Plan on 3/4/15 revealed that it did not include a focus area for psychoactive medications. There were no goals or interventions listed to direct nursing staff as to the care and monitoring required for Resident #24 related to his/her psychoactive medication use. During an interview on 3/4/15 at approximately 4:00 PM, the Director of Nursing verified a care plan had not been developed relative to Resident #24's psychoactive medications. Cross Refer to F-328 The facility admitted Resident #30 with [DIAGNOSES REDACTED]. The resident was admitted to hospice care on 2/9/15 with [DIAGNOSES REDACTED]. Review of the 2-18-15 Readmission Minimum Data Set Assessment revealed that the resident had a Brief Interview for Mental Status Score of 8, indicating moderate cognitive impairment. No rejection of care was documented under the behavior section of the assessment. Record review on 3/5/15 at 10:25 AM revealed 2/9/15 physician's orders [REDACTED]. Observation on 3/3/15 from 10:40 AM to 10:50 AM revealed the resident sitting in his/her wheelchair in the room with Oxygen infusing via nasal cannula at 2 liters per minute by Oxygen concentrator. Observation on 3/4/15 at 8:46 AM revealed the resident sitting at the dining room table feeding her/himself. The resident was on room air. There was no oxygen tank or concentrator present for the 15 minute meal observation. Observation with the Director of Nursing (DON) on 3/5/15 at 10:30 AM revealed Resident #30 sitting in his/her wheelchair in

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the room with oxygen infusing via nasal cannula by concentrator at 2 liters per minute. According to the DON, hospice had ordered the oxygen at 5 liters upon return from the hospital in early February. S/he stated Resident #30 did not like to wear the oxygen at times, and turned the oxygen down or took it off. Review of the Care Plan with the DON revealed the resident had not been care planned for removing or turning down the oxygen. The DON was informed of previous surveyor observations of the resident without oxygen for a breakfast meal and with the oxygen at 2 liters. A review of the care plan revealed the resident was to have oxygen settings per orders via nasal cannula, and that If the resident is allowed to eat, oxygen still must be given to the resident . During an interview on 3/5/15 at 11;58 AM, Licensed Practical Nurse (LPN) #1 stated that s/he had been aware that the resident turned down and/or took off his/her oxygen. According to the nurse, the resident got confused and thought the oxygen was his/her nebulizer treatment and the resident would state s/he was only to get this treatment for 15 minutes. During an interview on 3/5/15 at 11:53 AM, the MDS (Minimum Data Set) Coordinator stated s/he had been aware that the resident took off his/her oxygen at times. When asked, the MDS Coordinator stated the care plan probably should have been updated with this information under behaviors.
F 0282 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement the Care Plan for 1 of 1 sampled resident reviewed for pressure ulcers. Skin care and pressure ulcer treatments were not provided per the Care Plan for Resident #37, resulting in a Stage IV pressure ulcer. The findings included: The facility admitted Resident #37 with [DIAGNOSES REDACTED]. Review of the 2/25/2015 Weekly Pressure Ulcer Record on 3/4/2015 at 12:06 PM revealed that Resident #37 acquired a new pressure ulcer to the sacrum with an onset date of 2/20/2015. The Pressure Ulcer was identified as a Stage IV Pressure Ulcer. Review of the Care Plan on 3/4/2014 at 11:30 AM revealed an intervention for the Pressure Ulcer to: Administer treatments as ordered and observe for effectiveness. Another problem area on the Care Plan was the potential for impaired skin integrity r/t (related to) incontinence episodes, catheter, [MEDICAL CONDITION], and decreased mobility. A listed intervention for this problem was tx (treatment)/care of cyst per physicians orders. Review of the physician's orders [REDACTED]. Pack with normal saline gauze and apply [MEDICATION NAME] adhesive. Change qd (daily) and prn (as needed). Further review of the physician's orders [REDACTED]. Apply dry dressing over area on sacrum everyday and prn soiling one time a day for cyst. This treatment started 11/6/2014. 2. Apply Calazyyme cream to area on buttocks below the coccyx every night shift for irritation (of the skin). This treatment started 9/1/2014. The Calazyme cream treatment was not listed as an intervention on the Care Plan. Review of the Treatment Administration Record (TAR) on 3/4/2015 at 11:05 AM revealed that pressure ulcer treatments (start date 2/20/2015) were not documented as done daily as ordered on February 20, 23, 24, 26, 27, and 28, 2015. The treatment for [REDACTED]. Eighteen of 28 daily treatments for the cyst were not done in February, 2015. Three daily treatments for the cyst to the sacrum were not documented as done in December, 2015. treatment for [REDACTED]. The Calazyme cream to the buttocks was also not documented as done daily as ordered. The documentation noted that the Calazyme cream was applied to the buttocks on only 10 of 28 days in February, 2015. During an interview on 3/4/2015 at 1:41 PM, the Director of Nursing (DON) confirmed that the daily pressure ulcer treatment had not been documented as done daily as ordered and per the Care Plan. S/he confirmed that the treatment for [REDACTED]. The DON verified that the Calazyme cream for skin irritation was not listed on the Care Plan and not documented as done daily as ordered
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that 1 of 1 sampled resident reviewed with a pacemaker received the necessary care and services. Resident #4 had no physician's orders for pacemaker checks and there was no documentation to determine the type of pacemaker the resident had or how often the pacemaker should be checked/monitored. The findings included: The facility admitted Resident #4 with a [DIAGNOSES REDACTED]. Record review on 3/05/15 at approximately 10 AM revealed a radiology report dated 10/25/14 and 12/30/14 that indicated the resident had a pacemaker. There was an Electrocardiogram (EKG) dated 5/29/14 that indicated the physician was notified with no new orders. There was no documentation in the chart to indicate the type of pacemaker the resident had or how often the pacemaker should be checked/monitored. Review of the February, 2015 cumulative physician's orders and treatment sheets and review of the resident's care plan revealed no reference to a pacemaker. During an interview on 3/05/15, the Director of Nursing (DON) confirmed that Resident #4 had a pacemaker and stated the pacemaker checks were to be done yearly. The surveyor requested documentation to confirm the pacemaker should be checked yearly. The DON reviewed the resident's medical record and stated s/he was unable to find the verification in the chart. During an interview on 3/05/15 at approximately 11:31 AM, the Care Plan Coordinator (CPC) stated that residents with pacemakers would be care planned for monitoring/precautions and how often the pacemaker would be checked. The CPC confirmed Resident #4 was not care planned for the pacemaker care and services. During an interview on 3/05/15 at approximately 11:39 AM, the DON stated s/he had spoken with the resident's cardiologist and was informed that the type of pacemaker the resident had required checks every 6 months.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy entitled Skin Management Program, the facility failed to provide treatments and services to prevent development of a Stage IV pressure ulcer for 1 of 1 sampled resident reviewed for pressure ulcers. The facility failed to complete weekly skin audits and provide skin treatments as ordered for Resident #37, resulting in the Stage IV ulcer. The findings included: The facility admitted Resident #37 with [DIAGNOSES REDACTED]. Review of the 2/25/2015 Weekly Pressure Ulcer Record on 3/4/2015 at 12:06 PM revealed that Resident #37 acquired a new pressure ulcer to the sacrum on 2/20/2015. The pressure ulcer was identified as Stage IV. Review of the Physician's Orders on 3/4/2015 at 10:43 AM revealed a 2/20/2015 treatment order to: Clean open areas to buttocks. Pack with normal saline gauze and apply [MEDICATION NAME] adhesive. Change qd (daily) and prn (as needed). Further review of the Physician's Orders revealed the following treatment orders: 1.Apply calazyyme cream (a skin protectant) to area on buttocks below the coccyx (tail bone area) every night shift for irritation (of the skin). This treatment started 9/1/2014. 2. Apply dry dressing over area on sacrum everyday and prn soiling one time a day for cyst. This treatment started 11/6/2014. Review of the Care Plan on 3/4/2014 at 11:30 AM revealed a problem of (Resident #37) has pressure ulcer (to) buttocks or potential for pressure development r/t (related to) Immobility, poor nutrition. Interventions included: 1. Administer

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) treatments as ordered and observe for effectiveness. 2. Complete a full body check weekly and document. Another problem on the Care Plan for this resident was the potential for impaired skin integrity r/t incontinence episodes, catheter, [MEDICAL CONDITION], and decreased mobility. A listed intervention for this problem was for tx (treatment)/care of cyst per physicians orders. Calazyme cream to the buttocks was not listed as an intervention on the Care Plan. Review of the Treatment Administration Record (TAR) on 3/4/2015 at 11:05 AM revealed that pressure ulcer treatments (start date 2/20/2015) were not documented as done daily as ordered on February 20, 23, 24, 26, 27, and 28, 2015. Further review revealed that the Calazyme cream to the buttocks had not been documented as done daily as ordered on 18 out of 28 days in February, 2015. In addition, the treatment for [REDACTED]. 3 daily treatments for the cyst to the sacrum were not documented as done in December, 2015. treatment for [REDACTED]. Review of the weekly Head to Toe Skin Checks on 3/4/2015 at 12:28 PM revealed that the skin audits had not been done weekly. The weekly Head to Toe Skin Check was documented as done 1 time in December (12/6/2014) and 1 time in January (1/14/2015). The weekly skin check was not documented as done in February, 2015 prior to identifying the Stage IV Pressure Ulcer. During an interview on 3/4/2015 at 1:41 PM, the Director of Nursing (DON) confirmed that the weekly Head to Toe Skin Checks should have been done and were not documented as done weekly. S/he confirmed that the daily pressure ulcer treatment had not been documented as done daily as ordered. In addition, the DON confirmed that the treatment for [REDACTED]. Review of the facility policy entitled Skin Management Program on 3/4/2015 at 2:45 PM revealed that newly identified residents with skin breakdown should have weekly skin checks.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure the safety of 1 of 1 sampled resident on aspiration precautions during meal service. Resident #41 was served an incorrect diet during one of one meal observed. Based on observations and interview, the facility failed to ensure there was a safe and systematic method of identifying residents for 4 of 4 residents observed during the medication (med pass). There was no picture or wrist band information available for nursing staff to use to ensure proper identification of residents. The findings included: During med pass observations of 4 residents on 3/3/15 at approximately 4:00 PM and on 3/4/15 between 10:00 AM and 10:30 AM, the surveyor noted that nursing staff were not identifying residents through the use of wrist bands or through the use of pictures. During med pass observation on 3/3/15 at approximately 4:00 PM, Registered Nurse (RN) #1 was not observed to check a wrist identification band prior to giving Resident #28 his/her medications. (Review of the 1-13-15 Annual Minimum Data Set (MDS) Assessment revealed that Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.) During a med pass observation on 3/4/15 at 10:11 AM, Licensed Practical Nurse (LPN) #1 was asked how s/he identified residents in order to administer their medications. LPN #1 was asked to check for a wrist band for Resident #20 but found none. According to the nurse, the resident was oriented to his/her name and would answer if his/her name was called. (Review of the 2-14-15 5-Day MDS revealed that Resident #20 had a BIMS score of 1, indicating severe cognitive impairment.) During med pass observation on 03/04/2015 at 10:26 AM, LPN #1 stated Resident #7 answered to his/her name and was alert and oriented. (Review of the 1-13-15 Quarterly MDS Assessment revealed that Resident #28 had a BIMS score of 15, indicating the resident was cognitively intact.) LPN #1 verified there was no wrist identification band for the resident. According to the nurse, the residents' pictures didn't show up in their computer system used for med pass. During med pass observation on 3/4/15 at 10:33 AM, LPN #1 stated Resident #44 was alert and oriented. The resident had no wrist band identification. Review of the 1-26-15 MDS Assessment revealed that Resident #44 had a BIMS score of 14, indicating the resident was cognitively intact. During an interview on 03/04/2015 at 10:40 AM, the Director of Nursing (DON) was informed that the residents observed on med pass had no identification bands on and that there were no pictures of the residents in the computerized record for the nurses to use for identification during med pass. The DON stated that residents in the facility did not use armbands for identification. According to the DON, they had previously used picture identification when they used paper charting. The DON stated that when the computerized system rolled out the previous year, there had been a place to add pictures, but they had not been added. S/he stated they would take pictures and upload them. The DON also stated that there was always a staff member at the facility who would be able to identify the residents. During an interview on 3/5/15 at 12:51 PM, the Administrator stated that s/he had been at the facility since August and there had been no medication errors reported related to misidentification of residents since s/he started. The facility admitted Resident #41 with [DIAGNOSES REDACTED]. Resident #41 was observed eating lunch on 3/3/2015 at 12:29 PM. The resident was served foods that had not been mechanically altered and were of a regular consistency and texture. S/he was also served liquids that had not been thickened. Shortly after the resident began eating, s/he was observed coughing, and a staff member took the regular meal from the resident and exchanged it for a meal that consisted of pureed foods and thickened liquids. Record review of a 2/17/2015 Physician order [REDACTED]. During an interview on 3/4/2015 at 3:37 PM, Licensed Practical Nurse (LPN) #1 confirmed that s/he served the resident the wrong tray for lunch on 3/3/2015. LPN #1 stated s/he served the resident another resident's lunch tray that had unaltered foods of a regular consistency and thin liquids. The nurse stated s/he must not have looked closely enough at the name on the ticket on the lunch tray. LPN #1 confirmed the resident was eating from the regular tray and did cough, but was immediately given the correct lunch tray. LPN #1 stated s/he stayed with the resident for the rest of the meal to make sure s/he was ok. The nurse also stated that the Nurse Practitioner had been notified of the incident and ordered a chest x-ray. Review of the chest x-ray results on 3/4/2015 at approximately 3:37 PM revealed no evidence of aspiration.
F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to obtain weekly weights due to significant weight loss per the recommendation of the Registered Dietician (RD) for Resident # 26, 1 of 3 sampled residents reviewed for nutrition. The findings included: The facility admitted Resident #26 with [DIAGNOSES REDACTED]. Record review of the residents Weights and Vitals Summary on 3/5/2015 at 8:39 AM revealed a 9% weight loss in 30 days. The resident's weight on 1/8/2015 was 157.8 pounds. The resident's weight on 2/11/2015 was 145.4 pounds. The last weight documented for the resident was on 2/17/2015 with a result of 95 pounds. Review of a Nutrition Note at approximately 8:39 AM revealed that the RD had identified a significant weight loss on 2/12/2015. Review of the physician's orders [REDACTED]. During an interview on 3/5/2015 at 8:20 AM, the RD stated that after identifying the significant weight loss s/he implemented multiple interventions, including weekly weights. The RD was interviewed again at 9:06 AM and confirmed there was no order for weekly weights and that weekly weights were not noted on the Care Plan. In addition, the RD stated the weight for 2/17/2015 (95 pounds) was incorrect and confirmed the last accurate weight for the resident had been on 2/11/2015. The RD confirmed s/he recommended weekly weights for the resident, but the weekly weights had not been done. When asked how the staff would know to weigh the resident weekly, the RD stated s/he gave the Director of Nursing a list of

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F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) residents s/he recommended for weekly weights. When asked if s/he could show documentation of this list the RD produced a photocopy of a sticky note at 9:25 AM. Written on the sticky note was Weekly Weights and 3 residents' names (including Resident #26 due to significant weight loss). The note did not indicate the author, nor was it signed or dated. During another interview at 9:38 AM, the RD stated Resident #26 had been weighed that morning (3/5/2015). The resident's weight was 143.2 pounds - a loss of 2.2 pounds.
F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to provide oxygen (O2) as ordered for 1 of 2 sampled residents reviewed for respiratory care. Resident #30 was observed with no oxygen on or with 2 liters of oxygen infusing when physician's orders [REDACTED]. The Comprehensive Care Plan for Resident #30 was not updated to include behaviors of removing the Oxygen and/or changing the Oxygen settings. The findings included: The facility admitted Resident #30 with [DIAGNOSES REDACTED]. The resident was admitted to hospice care on 2/9/15 with [DIAGNOSES REDACTED]. Review of the 2-18-15 Readmission Minimum Data Set Assessment revealed that the resident had a Brief Interview for Mental Status Score of 8, indicating moderate cognitive impairment. No rejection of care was documented under the behavior section of the assessment. Record review on 3/5/15 at 10:25 AM revealed 2/9/15 physician's orders [REDACTED]. Observation on 3/3/15 from 10:40 AM to 10:50 AM revealed the resident sitting in his/her wheelchair in the room with Oxygen infusing via nasal cannula at 2 liters per minute by Oxygen concentrator. Observation on 3/4/15 at 8:46 AM revealed the resident sitting at the dining room table feeding her/himself. The resident was on room air. There was no oxygen tank or concentrator present for the 15 minute meal observation. Observation with the Director of Nursing (DON) on 3/5/15 at 10:30 AM revealed Resident #30 sitting in his/her wheelchair in the room with oxygen infusing via nasal cannula by concentrator at 2 liters per minute. According to the DON, hospice had ordered the oxygen at 5 liters upon return from the hospital in early February. S/he stated Resident #30 did not like to wear the oxygen at times, and turned the oxygen down or took it off. Review of the Care Plan with the DON revealed the resident had not been care planned for removing or turning down the oxygen. The DON was informed of previous surveyor observations of the resident without oxygen for a breakfast meal and with the oxygen at 2 liters. A review of the care plan revealed the resident was to have oxygen settings per orders via nasal cannula, and that If the resident is allowed to eat, oxygen still must be given to the resident . During an interview on 3/5/15 at 10:35 AM, Licensed Practical Nurse (LPN) #1 stated that oxygen saturations weren't routinely monitored for Resident #30. LPN #1 reviewed the documentation in the record that showed the resident's oxygen saturation had been taken (with oxygen) on 2/10/15 with a saturation of 99% and on 2/12/15 with a saturation of 92%. Further interview at 11:58 AM with LPN #1 revealed that s/he had been aware that the resident turned down and/or took off his/her oxygen. According to the nurse, the resident got confused and thought the oxygen was his/her nebulizer treatment and the resident would state s/he was only to get this treatment for 15 minutes. During an interview on 3/5/15 at 11:53 AM, the MDS (Minimum Data Set) Coordinator stated s/he had been aware that the resident took off his/her oxygen at times. When asked, the MDS Coordinator stated the care plan probably should have been updated with this information under behaviors.
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and a review of the facility policy entitled [MEDICAL CONDITION] Management, the facility failed to appropriately monitor the use of psychoactive medications for 1 of 5 sampled residents reviewed for unnecessary medications. Facility nursing staff failed to adequately document behaviors and interventions used prior to the administration of As Needed (PRN) [MEDICATION NAME] to justify its use for Resident #24. There were multiple blanks in Behavior Monthly Flow Sheets and there was no Behavior Monthly Flow Sheet in the record for March, 2015. where the nursing staff failed to document whether the resident did or did not have behaviors and/or to indicate what interventions had been used for Resident #24 related to the use of antidepressant and anti-anxiety medications. The findings included: The facility admitted Resident #24 with [DIAGNOSES REDACTED]. A review of the record on 3/4/15 revealed Resident #24 had orders for and/or had received the following psychoactive medications in December 2014, and in January, February, and March of 2015. The medications included [MEDICATION NAME] Oxalate once daily for Depression, [MEDICATION NAME] sprinkles two times a day for Senile Dementia with Depressive Features, [MEDICATION NAME] three times daily for Anxiety, and [MEDICATION NAME] every 24 hours as needed for Anxiety. On 3/4/15, a review of the Behavior Monthly Flow Sheets for December 2014, January 2015, and February 2015 revealed multiple blanks where facility nursing staff had failed to document whether the resident had exhibited behaviors relative to the administration of antidepressant or anti-anxiety medications. The facility was unable to provide a March 2015 Behavior Flow Sheet. A review of the February 2015 Medication Administration Record [REDACTED]. A review of Nursing Progress Notes revealed the PRN doses of [MEDICATION NAME] had been administered for anxiety or agitation. A note dated 2/16/15 at 5:46 PM documented the medication had been given for grabbing at others. A note dated 2/26/15 at 3:59 PM documented the PRN [MEDICATION NAME] had been given for continued grabbing at others. There was no documentation in the record of any behavioral interventions attempted prior to giving the medication or documentation to indicate the duration or intensity of the behavior justified the use of the PRN [MEDICATION NAME]. During an interview on 3/4/15 at approximately 3:45 PM, the Director of Nursing (DON) verified there were blanks on the Behavior Flow Sheets. The DON stated there was no March Behavior Flow Sheet for Resident #24. After reviewing the February Medication Administration Record [REDACTED]As Needed [MEDICATION NAME]. A review of the resident's comprehensive care plan with the DON revealed a care plan had not been developed related to the use or monitoring of psychoactive medications. A review of the facility policy entitled [MEDICAL CONDITION] Management, Copyright 2011, revealed A psychoactive drug is considered a chemical restraint when it is used as the first intervention to control behavior, mood, or mental status .The facility will use psychoactive drug therapy only when appropriate to enhance the quality of life, while maximizing functional potential and well being of the resident. Qualified staff will monitor for potential undesirable side effects that are associated with the use of psychoactive drugs according to CMS .