STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375320	A. BUILDING _____ B. WING _____	03/20/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RAINBOW HEALTH CARE COMMUNITY	111 EAST WASHINGTON BRISTOW, OK 74010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On [DATE] an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to notify the physician when a resident began showing signs and symptoms of increased intracranial pressure. At 4:00 p.m., the Oklahoma State Department of Health verified the existence of the IJ situation. At 4:02 p.m., the administrator was notified of the IJ situation related to the facility's failure to notify the physician when a resident began showing signs and symptoms of increased intracranial pressure. On [DATE] at 4:45 p.m., an acceptable plan of removal was provided. The plan of removal documented, .All nurses will be in-serviced on signs and symptoms of intercranial (sic) hemorrhage, monitoring for head injuries related to fall, notification of physician in change of condition post fall. Nurses will also be inserviced on completing documentation as required. No nurses will be scheduled or allow (sic) to work until education has be (sic) completed. Staff inservice will be completed by 1800 [DATE]. Director of Nursing or Designees will monitor the implementation of the plan and if need to make changes. Daily audits of falls to be done daily for 4 weeks, then if compliance noted, then random audits done weekly for 90 days,until substantial compliance noted. The quality assurance committee will review IDT findings monthly for a period of 3 months then quarterly for 9 months to ensure continued compliance with state and federal regulations The immediate jeopardy was removed on [DATE] at 10:36 a.m., when all components of the plan of removal were carried out. The deficient practice remained at an isolated level of actual harm. Based on interview and record review, it was determined the facility failed to notify the physician for a resident when she began showing signs and symptoms of increased intracranial pressure after a fall for one (#4) of six sampled residents who were reviewed for changes in condition. The resident fell and hit her head on [DATE] at 10:30 a.m. The resident began exhibiting signs and symptoms of increased intracranial pressure at 3:00 p.m. The resident's physician was not notified of the symptoms of increased intracranial pressure until 6:00 p.m., when the resident was transfered by ambulance to the hospital. The resident expired on [DATE] due to a subdural hematoma from [MEDICATION NAME] force trauma of the head. The facility identified 70 residents who resided at the facility. Findings: Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An admission assessment, dated [DATE], documented the resident was cognitively intact for daily decision making; was dependent on staff for bed mobility and transfers; and had limitations in range of motion on one upper and one lower extremity. The care plan, dated [DATE], documented the resident was at high risk for falls related to a fall before admission that resulted in three fractures. The goal was the resident would have minimal risk of injury from falls through the next review date. Interventions included to keep the call light within reach; encourage to participate in activities that promote exercise and physical activity for strengthening and improved mobility; encourage to participate with therapies as ordered; and to maintain a safe environment. Monthly physician orders, dated ,[DATE], documented the resident was to receive apixaban (Eliquis), an anti-coagulant, 2.5 mg twice daily for blood clot prevention. A progress note, dated [DATE] at 8:03 p.m., documented, .resident up to w/c with c/o headache that rates ,[DATE]. Medicated with prn pain meds .Currently resting in bed without s/s of obvious distress . A progress note, dated [DATE] at 1:30 a.m., documented, .resting in bed easily awaken alert oriented x 3 .no (complaints of) pain or discomfort at this time . A skilled daily nurse's note, dated [DATE] at 10:30 a.m., documented, .Resident was ambulating s walker et stated she got dizzy and lost her balance and slid down onto floor. States she hit the right side of her head on wall. Head to toe assessment completed c no R/E observed. No redness observed to any skin. PERL. Alert O x 3. Speech clear. Able to stand c assist. Assisted into w/c. Vital signs taken. Denies Pain. Neuro checks initiated. (Physician name withheld) notified of fall c no new orders .(blood pressure) ,[DATE] (pulse) 96 (respirations) 20. (oxygen) sat 99% on room air .resident c/o of dizziness c ear ache instructed to call for assist before getting up. Verbalizes understanding . Review of the resident's neurological flow sheet, dated [DATE] from 10:35 a.m. until 1:40 p.m. revealed the resident's blood pressure ranged from ,[DATE] to ,[DATE]; her pulse ranged from 53 to 64; and her pupil size and reaction remained at 1 mm and brisk. It was documented the resident was fully conscious and had equal and strong hand grasps during this period. The neurological flow sheet documented, .Notify MD IMMEDIATELY of signs and symptoms of Intracranial Pressure!!! . An internet website, http://www.healthline.com/health/increased-intracranial-pressure, documented: .The signs of increased ICP include: * headache * nausea * vomiting * increased blood pressure * decreased mental abilities * confusion about time, and then location and people as the pressure worsens * double vision * pupils that don't respond to changes in light * shallow breathing * [MEDICAL CONDITION] * loss of consciousness * coma . An internet website, https://medlineplus.gov/ency/article/ 3.htm, documented: .Increased intracranial pressure .Symptoms .adults: * Behavior changes * Decreased consciousness * Headache * Lethargy * Neurological symptoms, including weakness, numbness, eye movement problems, and double vision

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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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) * [MEDICAL CONDITION] * Vomiting . Medication administration records, dated [DATE] at 3:00 p.m., documented, .[MEDICATION NAME] ,[DATE] mg (one) c/o head/shoulder pain (eight) per nurse . This entry was signed by CMA #1. The neurological flow sheet, dated [DATE] at 3:40 p.m., documented the resident's blood pressure had increased to ,[DATE], her pulse rate was 64, and she remained fully conscious with equal and strong hand grasps and pupil sizes of three with a brisk reaction. A progress note, dated [DATE] at 3:44 p.m., documented, .Resident remains on neuro checks for previous fall without further incident. resident does c/o headache that rates ,[DATE], and medicated with prn [MEDICATION NAME]. See MAR. Resident educated on fall prevention per facility policy, and procedure. resident able to use call light button appropriately. Will c/t monitor . Medication administration records, dated [DATE] at 4:00 p.m., documented, .[MEDICATION NAME] 25 mg (one) p/o c/o N/V per nurse . This entry was signed by CMA #1. The neurological flow sheet, dated [DATE] at 4:40 p.m., documented the resident's blood pressure had increased to ,[DATE] and her pulse rate had increased to 90. It was documented there was no change to her level of consciousness, hand grasps, pupil size, or pupil reaction. A progress note, dated [DATE] at 5:32 p.m., documented, .resident in room with c/o 'not feeling well.' refused evening meal d/t nausea without emesis. Medicated for nausea. See MAR. Will c/t to monitor . Review of the clinical record revealed no documentation the facility intervened or that they notified the physician when the resident first began showing signs of increasing intracranial pressure at 3:00 p.m. through 5:32 p.m. The resident had developed a headache, had an increasing blood pressure, and had developed nausea, all symptoms of increased intracranial pressure. The neurological flow sheet, dated [DATE] at 5:40 p.m., documented the resident's blood pressure had increased to ,[DATE] and her heart rate was 92. It was documented the resident had snoring respirations at 14 to 16 per minute. It was also documented the resident was in a stupor, had no movement, had pupil sizes at 2 mm and fixed, and her speech was slurred. A progress note, dated [DATE] at 5:50 p.m., documented, .Resident in room laid back onto bed with increased s/s of decreased loc. resident responded with sub sternal rub, and answered: 'what.' VS: ,[DATE], 70, 98% RA with intermittent snoring respirations. Resident c/t have increased s/s of decreased loc. This nurse had another nurse call 911 while this nurse stayed with resident. Resident awakened intermittently, and palpable pulses to radial, and apical heart. Oxygen applied at 2L/NC/O2 while awaiting transport to (hospital name withheld) . A progress note, dated [DATE] at 6:00 p.m., documented, .ambulance arrival and resident condition stable upon departure . A hospital computerized tomography scan result, dated [DATE], documented, .Findings: There is an extensive right-sided subdural hemorrhage which measures 2.7 cm in thickness .This causes significant midline shift to the left by at least 2.4 cm .Impression: Significant right subdural hematoma casing mass effect and midline shift to the left. Possible small associated subarachnoid hemorrhage in right sylvian fissure . A hospital discharge summary, dated [DATE], documented, .Primary cause of death: [MEDICAL CONDITION]. Contributing cause bilateral subdural hematoma status [REDACTED]. A progress note, dated [DATE] at 12:41 p.m., documented, .I called to check on the resident today and the (family member) informed me that the resident had passed away this morning . A State of Oklahoma Certificate of Death, certified on [DATE], documented, date of death .[DATE] .Time of Death 04:50 .Cause of Death .Immediate Cause .Subdural Hemorrhage .Sequentially list conditions, if any, leading to the cause listed .[MEDICATION NAME] Force Trauma Of The Head .Date of Injury XXX[DATE] .Place of Injury .Nursing Home .Describe How Injury Occurred: Fall . On [DATE] at 2:39 p.m., CMA #1 was asked to describe the process for documenting when as needed medications were given. She stated as needed medications were given only after approval from the resident's nurse. She stated the time documented was the time the medication was given. On [DATE] at 2:49 p.m., LPN #1 was asked what was monitored for if a resident had a fall and hit their head or if a fall was unwitnessed. She stated neurological checks were started, and she monitored for changes in mental status. She was asked what the signs and symptoms of increased intracranial pressure were. She stated confusion, one-sided weakness, and changes in the pupils. On [DATE] at 2:51 p.m., LPN #2 was asked what was monitored for if a resident had a fall and hit their head or if a fall was unwitnessed. She stated she would complete neurological checks, watch for slurred speech, and monitor their hand grasps. She was asked what the signs and symptoms of increased intracranial pressure were. She stated the resident's orientation would be off kilter, the vital signs could be different, their eyes might hurt, and loud noises and lights would bother them. On [DATE] at 2:55 p.m., LPN #3 was asked what the signs and symptoms of increased intracranial pressure were. She stated a change in level of consciousness, vital signs might change a little, and the pupils might change. On [DATE] at 3:30 p.m., the DON was asked what staff was expected to do if a resident had a fall and hit their head or had an unwitnessed fall. She stated staff was to monitor the resident and notify the doctor to see if they wanted to send the resident out for a scan. She was asked if staff was supposed to monitor for increased intracranial pressure. She stated, Yes. The DON was asked what the signs and symptoms of increased intracranial pressure were. She stated a change in the level of condition, change in the reaction to light, change in the consciousness level. She stated any definite change in the normal for the resident. She was asked if headaches, nausea, and vomiting were signs of increased intracranial pressure. She stated, Absolutely. On [DATE] at 4:31 p.m., the DON was asked if there was documentation the physician was notified the resident was showing signs and symptoms of increased intracranial pressure. She reviewed the clinical record and stated, No, there is not. She was asked what the facility's expectation of staff was if a resident began to show those signs and symptoms. She stated staff was expected to notify the physician of any change in condition. On [DATE] at 12:00 p.m., the resident's physician was asked if staff notified him when the resident began showing signs and symptoms of increased intracranial pressure. He stated, I don't have a record one way or another. He was asked what his action would have been if he had been in the building at the time the changes started and he had been notified. He stated he would have evaluated the resident immediately, especially since he knew she had a previous history of an [MEDICAL CONDITION].
F 0224 **Level of harm -** Actual harm **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to prevent and report neglect for one (#6) of six sampled residents whose medications were reviewed. The facility obtained physician orders [REDACTED]. The facility did not attempt to find an alternate source for the medication, and they did not report the family's neglect to the proper authorities. Resident #6; who had [DIAGNOSES REDACTED]. This had the potential to affect nine residents who received medications and whose stay at the facility was paid for privately. Findings: The facility's policy on abuse and neglect prevention, dated 01/2016, documented, .To establish guidelines that prevents (sic), identifies, and report resident abuse and neglect .It is the policy of the facility, to ensure that each resident is treated with dignity and care, free from abuse and neglect and to take swift and immediate action to investigate and adjudicate alleged resident abuse and neglect .it is the facility's responsibilities to prevent not only abuse, but also those practices and omissions, neglect and misappropriation of property, that if left unchecked, lead to abuse .Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff .family members or legal guardians .Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs on an individual basis when a resident does receive a lack of care in one or more areas .It is the responsibility of the Administrator and Nursing Services to identify events such as suspicious bruising of residents;

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F 0224 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) occurrences, patterns, and trends that may constitute abuse/neglect and to determine the direction of the investigation .Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury .be reported, the Administrator will appoint a member of management to investigate the alleged incident. The Administrator will file an initial report .Alleged incidents include occurrences between staff/resident, resident/resident, family .Once the facility administration becomes aware of any of these alleged violations, the home must report immediately to the designated state agency .It is required each employee to be knowledgeable of current abuse and neglect laws and be familiar with procedures for reporting suspected abuse or neglect . The Food and Drug Administration's undated medication guide for [MEDICATION NAME] documented, .To prevent serious side effects, do not stop taking [MEDICATION NAME] suddenly . Drugsdb.com's [MEDICATION NAME] withdrawal webpage, dated 06/28/12, documented, .Stopping [MEDICATION NAME] suddenly can cause withdrawal symptoms that include: [MEDICAL CONDITION] or difficulty sleeping, Recurrence of schizohrenia symptoms (delusions or hallucinations), Recurrence of [MEDICAL CONDITION] disorder symptoms (depression or mania). Some patients may also report nonspecific symptoms such as: Anxiety, Nausea and Vomiting, Sweating, Tremor. Usually, the withdrawal symptoms present as recurrence of the underlying disorder ([MEDICAL CONDITION] disorder, depression, or [MEDICAL CONDITION]) for which the patient is being treated for [REDACTED]. Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, initiated 10/22/14, documented a problem related to impaired cognitive function/dementia with behavioral disturbances. The goal was the resident would be oriented to self and have her needs met through the next review date. Interventions included to administer medications as ordered. A psychiatric progress note, dated 10/03/16, documented the resident was receiving [MEDICATION NAME] 7.5 mg at bedtime. It was documented the resident sometimes thought her family member was present when they were not, but no other behavioral problems were reported. The resident's [DIAGNOSES REDACTED]. It was documented, .no suggested medication change . An annual assessment, dated 10/15/16, documented the resident was severely impaired in cognitive skills for daily decision making, had no behaviors, and received antipsychotic and antidepressant medications on seven of the preceding seven days. A progress note, dated 11/30/16 at 12:34 p.m., documented, .still resides on Hummingbird hall with a roommate . Behavior monitoring sheets, dated 11/2016, revealed documentation the resident had no episodes of behaviors for the month. Physician orders, dated 12/2016, documented the resident was to receive [MEDICATION NAME] 7.5 mg by mouth at bedtime for delusional disorder related other persistent mental disorders. It was documented the resident began receiving the medication in this dose on 05/24/16. Medication administration records, dated 12/04/16, documented, .[MEDICATION NAME] 7.5 mg not administered awaiting pharmacy . A progress note, dated 12/05/16 at 1:36 p.m., documented, .PCP notified that pharmacy is unable to fill meds due to non payment. resident is out of [MEDICATION NAME] 7.5 mg. Asked if med needs to be dc'd. No new order at this time. (Family member) does not return calls . Medication administration records, dated 12/05/16, documented, .[MEDICATION NAME] 7.5 mg not given awaiting fufillment . A progress note, dated 12/06/16 at 9:38 a.m., documented, .DON .notified that at this time med is still not in facility per (pharmacy name withheld) due to non payment by (family member) .instructed to DC med . A note to the physician, dated 12/06/16, documented, .(resident #6) is out of [MEDICATION NAME] 7.5 mg (one) po at HS, (pharmacy name withheld) is unable to fill anymore meds until (family member) pays them, do you want this dc'd? (Family member) will not return calls . The note was signed OK by the physician and dated 12/06/16. A progress note, dated 12/08/16 at 12:12 p.m., documented, .she was moved off of the secured unit due to not being a flight risk anymore . A progress note, dated 12/25/16 at 5:21 p.m., documented, .refusing meals and health shake po fluids encouraged with minimal po intake or fluid intake .Dr office notified . A progress note, dated 01/03/17 at 9:02 p.m., documented, .Resident hollers constantly Redirection unsuccessful Repositioned 1:1 unsuccessful Disruptive to other residents Incont care provided as needed . A progress note, dated 01/04/17 at 4:40 a.m., documented, .resident cont on and off through out night to call out for different things resident was given drinks, changed and repositioned, and given snacks. None of these actions was successful in reducing the calling out . A progress note, dated 01/05/17 at 5:37 a.m., documented, .called out all shift and was unconsoleable (sic). Snacks, drinks, repositioning, incont care offered and taken with no help in resident's calling out . A progress note, dated 01/06/17 at 5:40 a.m., documented, .Resident did not call out as much this 10-6 shift . A progress note, dated 01/06/17 at 6:12 p.m., documented, .resident refused dinner meal this shift . A progress note, dated 01/09/176 at 9:46 p.m., documented, .refused meds. Continuously hollering out Redirection/positioning unsuccessful. (Family member) to nurses station with concerns resident yelling will keep her awake all night . A progress note, dated 01/12/17 at 2:32 p.m., documented, .January wt: 160# .sig wt loss of 6.4% x 1 month. Will notify MD .Meal intake: 63% average. [MEDICATION NAME] in place as appetite stimulant. Encouragement ongoing .rec weekly wt monitoring x 4 weeks. Should wt fail to stabilize consider additional interventions . A progress note, dated 01/30/17 at 1:18 a.m., documented, .laying in bed yelling out different needs, at times wants her knees readjusted, at times her neck, at times c/o feeling like she choking (sic), at times just yelling help, each time these things are done for her she yells out again within minutes of leaving room, res doesn't comprehend or else remember to use her call light, res has been readjusted in bed, checked for incont. and incont care given when needed and flds offered and she takes flds at times, when go to leave room res. voices at times she doesn't want you to leave room and has advised her that we cannot stay in room c her at all times and she will say 'why', situation is explained to her, but res cont to yell out, res does yell out the whole 8 hr shift at times if not the whole 8 hrs then its close to it at other times, res appetite has decreased during day, and fld intake in decreased, cont to check for incont and reposition q 2 hour and offer flds. and snacks. Res did yell out whole 8 hours last night and was reported in report that she did yell out alday (sic) today, call light, flds and personal items . Behavior monitoring sheets, dated 01/2017, documented the resident had behaviors of yelling out, restlessness, or uncooperativeness on 19 out of 31 days. A progress note, dated 02/02/17 at 4:31 a.m., documented, .Resident has continued to call out. CNAs reposition, offer fluids and snacks, change resident and resident cont to call out. Resident denies pain. Resident clean dry and fluids and call light in reach . A progress note, dated 02/03/17 at 4:49 a.m., documented, .Resident has continued to call out all night. All interventions unsuccessful . A progress note, dated 02/04/17 at 6:31 a.m., documented, .Resident called out all night long. Unable to redirect with snacks, drinks, re-positioning or one on one. Resident called out so much that her voice is extremely hoarse . A progress note, dated 02/06/17 at 1:16 a.m., documented, .resident yelling out continuously Redirection unsuccessful Incont care provided Offered snacks/fluids Denies pain or discomfort No distress noted . A progress note, dated 02/08/17 at 1:51 p.m., documented, .February wt: 148# .Sig wt loss of 7.5% x 1 month, 11.9% x 3 months, loss of 14% x 6 months. Will notify MD .Meal intake: 18% average . A progress note, dated 02/13/17 at 7:38 p.m., documented, .Resident continues to decline no po intake this shift. (Physician name withheld) assessed resident .advised resident hosipce (sic) appropriate . A progress note, dated 02/14/17 at 8:48 a.m., documented, .resident seems very lethargic this am and will not eat or drink .(physician name withheld) notified . Behavior monitoring sheets, dated 02/01/17 through 02/14/17, documented the resident had behaviors of yelling out, restless, and uncooperativeness on 12 of 14 days. There was no behavior documentation on two of the 14 days. A progress note, dated 02/14/17 at 1:00 p.m., documented, .resident trying to yell after oral care done unable to form words .orders received (sic) to transfer to .hospital . A progress note, dated 02/17/17 at 3:38 p.m., documented, .Today the family called to let me know that the resident had passed away the night before . Review of the clinical record revealed no documentation the facility contacted Adult Protective Services regarding the family not providing payment for the resident's medication. There was no documentation the facility attempted to find an alternate source for the resident's medication. There was no documentation the facility attempted to assist the resident in

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F 0224 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 3) any way to obtain the medication. On 03/15/17 at 4:14 p.m., the administrator, social services director, and business office manager were interviewed. The administrator was asked if he had knowledge the resident's antipsychotic medication had been discontinued because the pharmacy would not refill the prescription due to lack of payment on the family's part. He stated, No. He stated this had occurred before he came to the facility. He stated the DON at the time was now at a different facility. The social services director was asked if she had been aware of the situation. She stated, No. She stated, If they had brought it to my attention, we could have looked at different avenues. She stated they had never had this type situation before. The social services director was asked if Adult Protective Services had been notified the family was not paying for the resident's medications. She stated, Not on my part. She was asked whose role it would have been to notify Adult Protective Services. She stated, More than likely mine. The business office manager was asked if she had notified Adult Protective Services regarding the family not paying for the resident's medications. She stated, No. She stated the family and OSDH had been notified the family was not paying the bill at the facility, but she had not contacted Adult Protective Services. On 03/20/17 at 12:50 p.m., LPN #4 was asked if she had knowledge of resident #6's medication. She stated she remembered faxing, calling, and speaking with one of the physician's nurses. She was asked to explain what had occurred with the resident's Olanzipine. She stated she had ordered the medication but was informed by the pharmacy they would not deliver it until the resident's charge account had been brought current. She stated she reported the situation to the DON. LPN #4 stated the DON informed her she would speak with the administrator. LPN #4 stated she waited a few more days, and the resident ran out of Olanzipine. She stated she asked the DON what she was to do, and the DON informed her to get an order from the physician to discontinue the medication. LPN #4 stated the DON made a comment at the time that the family member was not paying her bill at the facility either. LPN #4 stated she had made multiple attempts to communicate with the family member over the phone, and the pharmacy consultant had provided information related to medication assistance to the family member in the past. She stated the family member would never complete the paperwork for assistance. LPN #4 stated the pharmacy consultant had not been involved in this particular situation. LPN #4 was asked if the facility contacted Adult Protective Services related to the family member not paying the resident's pharmacy bill. She stated, Not that I am aware of.
F 0226 **Level of harm** - Actual harm **Residents Affected** - Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to implement their abuse and neglect policy and procedure to prevent and report neglect for one (#6) of six sampled residents whose medications were reviewed. The facility obtained physician orders [REDACTED]. to the proper authorities. Resident #6; who had [DIAGNOSES REDACTED]. This had the potential to affect nine residents who received medications and whose stay at the facility was paid for privately. Findings: The facility's policy on abuse and neglect prevention, dated 01/2016, documented, .To establish guidelines that prevents (sic), identifies, and report resident abuse and neglect .It is the policy of the facility, to ensure that each resident is treated with dignity and care, free from abuse and neglect and to take swift and immediate action to investigate and adjudicate alleged resident abuse and neglect .it is the facility's responsibilities to prevent not only abuse, but also those practices and omissions, neglect and misappropriation of property, that if left unchecked, lead to abuse .Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff .family members or legal guardians .Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs on an individual basis when a resident does receive a lack of care in one or more areas .It is the responsibility of the Administrator and Nursing Services to identify events such as suspicious bruising of residents; occurrences, patterns, and trends that may constitute abuse/neglect and to determine the direction of the investigation .Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury .be reported, the Administrator will appoint a member of management to investigate the alleged incident. The Administrator will file an initial report .Alleged incidents include occurrences between staff/resident, resident/resident, family .Once the facility administration becomes aware of any of these alleged violations, the home must report immediately to the designated state agency .It is required each employee to be knowledgeable of current abuse and neglect laws and be familiar with procedures for reporting suspected abuse or neglect . The Food and Drug Administration's undated medication guide for [MEDICATION NAME] documented, .To prevent serious side effects, do not stop taking [MEDICATION NAME] suddenly . Drugsdb.com's [MEDICATION NAME] withdrawal webpage, dated 06/28/12, documented, .Stopping [MEDICATION NAME] suddenly can cause withdrawal symptoms that include: [MEDICAL CONDITION] or difficulty sleeping, Recurrence of schizohrenia symptoms (delusions or hallucinations), Recurrence of [MEDICAL CONDITION] disorder symptoms (depression or mania). Some patients may also report nonspecific symptoms such as: Anxiety, Nausea and Vomiting, Sweating, Tremor. Usually, the withdrawal symptoms present as recurrence of the underlying disorder ([MEDICAL CONDITION] disorder, depression, or [MEDICAL CONDITION]) for which the patient is being treated for [REDACTED]. Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, initiated 10/22/14, documented a problem related to impaired cognitive function/dementia with behavioral disturbances. The goal was the resident would be oriented to self and have her needs met through the next review date. Interventions included to administer medications as ordered. A psychiatric progress note, dated 10/03/16, documented the resident was receiving [MEDICATION NAME] 7.5 mg at bedtime. It was documented the resident sometimes thought her family member was present when they were not, but no other behavioral problems were reported. The resident's [DIAGNOSES REDACTED]. It was documented, .no suggested medication change . An annual assessment, dated 10/15/16, documented the resident was severely impaired in cognitive skills for daily decision making, had no behaviors, and received antipsychotic and antidepressant medications on seven of the preceding seven days. A progress note, dated 11/30/16 at 12:34 p.m., documented, .still resides on Hummingbird hall with a roommate . Behavior monitoring sheets, dated 11/2016, revealed documentation the resident had no episodes of behaviors for the month. Physician orders, dated 12/2016, documented the resident was to receive [MEDICATION NAME] 7.5 mg by mouth at bedtime for delusional disorder related other persistent mental disorders. It was documented the resident began receiving the medication in this dose on 05/24/16. Medication administration records, dated 12/04/16, documented, .[MEDICATION NAME] 7.5 mg not administered awaiting pharmacy . A progress note, dated 12/05/16 at 1:36 p.m., documented, .PCP notified that pharmacy is unable to fill meds due to non payment. resident is out of [MEDICATION NAME] 7.5 mg. Asked if med needs to be dc'd. No new order at this time. (Family member) does not return calls . Medication administration records, dated 12/05/16, documented, .[MEDICATION NAME] 7.5 mg not given awaiting fufillment . A progress note, dated 12/06/16 at 9:38 a.m., documented, .DON .notified that at this time med is still not in facility per (pharmacy name withheld) due to non payment by (family member) .instructed to DC med . A note to the physician, dated 12/06/16, documented, .(resident #6) is out of [MEDICATION NAME] 7.5 mg (one) po at HS, (pharmacy name withheld) is unable to fill anymore meds until (family member) pays them, do you want this dc'd? (Family member) will not return calls . The note was signed OK by the physician and dated 12/06/16. A progress note, dated 12/08/16 at 12:12 p.m., documented, .she was moved off of the secured unit due to not being a flight risk anymore . A progress note, dated 12/25/16 at 5:21 p.m., documented, .refusing meals and health shake po fluids encouraged with minimal po intake or fluid intake .Dr office notified . A progress note, dated 01/03/17 at 9:02 p.m., documented, .Resident hollers constantly Redirection unsuccessful Repositioned 1:1 unsuccessful Disruptive to other residents Incont care provided as needed . A progress note, dated 01/04/17 at 4:40 a.m., documented, .resident cont on and off through out night to call out for

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F 0226 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 4) different things resident was given drinks, changed and repositioned, and given snacks. None of these actions was successful in reducing the calling out . A progress note, dated 01/05/17 at 5:37 a.m., documented, .called out all shift and was unconsoleable (sic). Snacks, drinks, repositioning, incont care offered and taken with no help in resident's calling out . A progress note, dated 01/06/17 at 5:40 a.m., documented, .Resident did not call out as much this 10-6 shift . A progress note, dated 01/06/17 at 6:12 p.m., documented, .resident refused dinner meal this shift . A progress note, dated 01/09/176 at 9:46 p.m., documented, .refused meds. Continuously hollering out Redirection/positioning unsuccessful. (Family member) to nurses station with concerns resident yelling will keep her awake all night . A progress note, dated 01/12/17 at 2:32 p.m., documented, .January wt: 160# .sig wt loss of 6.4% x 1 month. Will notify MD .Meal intake: 63% average. [MEDICATION NAME] in place as appetite stimulant. Encouragement ongoing .rec weekly wt monitoring x 4 weeks. Should wt fail to stabilize consider additional interventions . A progress note, dated 01/30/17 at 1:18 a.m., documented, .laying in bed yelling out different needs, at times wants her knees readjusted, at times her neck, at times c/o feeling like she choking (sic), at times just yelling help, each time these things are done for her she yells out again within minutes of leaving room, res doesn't comprehend or else remember to use her call light, res has been readjusted in bed, checked for incont. and incont care given when needed and flds offered and she takes flds at times, when go to leave room res. voices at times she doesn't want you to leave room and has advised her that we cannot stay in room c her at all times and she will say 'why', situation is explained to her, but res cont to yell out, res does yell out the whole 8 hr shift at times if not the whole 8 hrs then its close to it at other times, res appetite has decreased during day, and fld intake in decreased, cont to check for incont and reposition q 2 hour and offer flds. and snacks. Res did yell out whole 8 hours last night and was reported in report that she did yell out alday (sic) today, call light, flds and personal items . Behavior monitoring sheets, dated 01/2017, documented the resident had behaviors of yelling out, restlessness, or uncooperativeness on 19 out of 31 days. A progress note, dated 02/02/17 at 4:31 a.m., documented, .Resident has continued to call out. CNAs reposition, offer fluids and snacks, change resident and resident cont to call out. Resident denies pain. Resident clean dry and fluids and call light in reach . A progress note, dated 02/03/17 at 4:49 a.m., documented, .Resident has continued to call out all night. All interventions unsuccessful . A progress note, dated 02/04/17 at 6:31 a.m., documented, .Resident called out all night long. Unable to redirect with snacks, drinks, re-positioning or one on one. Resident called out so much that her voice is extremely hoarse . A progress note, dated 02/06/17 at 1:16 a.m., documented, .resident yelling out continuously Redirection unsuccessful Incont care provided Offered snacks/fluids Denies pain or discomfort No distress noted . A progress note, dated 02/08/17 at 1:51 p.m., documented, .February wt: 148# .Sig wt loss of 7.5% x 1 month, 11.9% x 3 months, loss of 14% x 6 months. Will notify MD .Meal intake: 18% average . A progress note, dated 02/13/17 at 7:38 p.m., documented, .Resident continues to decline no po intake this shift. (Physician name withheld) assessed resident .advised resident hosipce (sic) appropriate . A progress note, dated 02/14/17 at 8:48 a.m., documented, .resident seems very lethargic this am and will not eat or drink .(physician name withheld) notified . Behavior monitoring sheets, dated 02/01/17 through 02/14/17, documented the resident had behaviors of yelling out, restless, and uncooperativeness on 12 of 14 days. There was no behavior documentation on two of the 14 days. A progress note, dated 02/14/17 at 1:00 p.m., documented, .resident trying to yell after oral care done unable to form words .orders received (sic) to transfer to .hospital . A progress note, dated 02/17/17 at 3:38 p.m., documented, .Today the family called to let me know that the resident had passed away the night before . Review of the clinical record revealed no documentation the facility contacted Adult Protective Services regarding the family not providing payment for the resident's medication. There was no documentation the facility attempted to find an alternate source for the resident's medication. There was no documentation the facility attempted to assist the resident in any way to obtain the medication. On 03/15/17 at 4:14 p.m., the administrator, social services director, and business office manager were interviewed. The administrator was asked if he had knowledge the resident's antipsychotic medication had been discontinued because the pharmacy would not refill the prescription due to lack of payment on the family's part. He stated, No. He stated this had occurred before he came to the facility. He stated the DON at the time was now at a different facility. The social services director was asked if she had been aware of the situation. She stated, No. She stated, If they had brought it to my attention, we could have looked at different avenues. She stated they had never had this type situation before. The social services director was asked if Adult Protective Services had been notified the family was not paying for the resident's medications. She stated, Not on my part. She was asked whose role it would have been to notify Adult Protective Services. She stated, More than likely mine. The business office manager was asked if she had notified Adult Protective Services regarding the family not paying for the resident's medications. She stated, No. She stated the family and OSDH had been notified the family was not paying the bill at the facility, but she had not contacted Adult Protective Services. On 03/20/17 at 12:50 p.m., LPN #4 was asked if she had knowledge of resident #6's medication. She stated she remembered faxing, calling, and speaking with one of the physician's nurses. She was asked to explain what had occurred with the resident's Olanzipine. She stated she had ordered the medication but was informed by the pharmacy they would not deliver it until the resident's charge account had been brought current. She stated she reported the situation to the DON. LPN #4 stated the DON informed her she would speak with the administrator. LPN #4 stated she waited a few more days, and the resident ran out of Olanzipine. She stated she asked the DON what she was to do, and the DON informed her to get an order from the physician to discontinue the medication. LPN #4 stated the DON made a comment at the time that the family member was not paying her bill at the facility either. LPN #4 stated she had made multiple attempts to communicate with the family member over the phone, and the pharmacy consultant had provided information related to medication assistance to the family member in the past. She stated the family member would never complete the paperwork for assistance. LPN #4 stated the pharmacy consultant had not been involved in this particular situation. LPN #4 was asked if the facility contacted Adult Protective Services related to the family member not paying the resident's pharmacy bill. She stated, Not that I am aware of.
F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to have accurate assessments related to behaviors for one (#6) of six sampled residents whose assessments were reviewed. This had the potential to affect 70 residents who resided at the facility. Findings: Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A progress note, dated 01/09/176 at 9:46 p.m., documented, .refused meds. Continuously hollering out Redirection/positioning unsuccessful. (Family member) to nurses station with concerns resident yelling will keep her awake all night . Behavior monitoring sheets, dated 01/09/17 through 01/15/17, documented the resident had behaviors of yelling out, restlessness, or uncooperativeness on four out of seven days. A quarterly assessment, dated 01/15/17, documented the resident had no behaviors during the previous seven days. On 03/20/17 at 12:05 p.m., the MDS coordinator was shown the resident's clinical record and was asked where she obtained the information to complete her assessments. She stated from charting, morning meetings, and making rounds. She was asked why it was documented the resident had no behaviors during the seven day look-back period. She stated she was unsure why it was

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F 0278 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) coded as such. She stated she obviously missed the information.
F 0309 **Level of harm -** Immediate jeopardy **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** On [DATE] an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to intervene when a resident began showing signs and symptoms of increased intracranial pressure. The resident fell and hit her head on [DATE]. The resident expired on [DATE] due to a subdural hematoma from [MEDICATION NAME] force trauma of the head. At 4:00 p.m., the Oklahoma State Department of Health verified the existence of the IJ situation. At 4:02 p.m., the administrator was notified of the IJ situation related to the facility's failure to intervene when a resident began showing signs and symptoms of increased intracranial pressure. On [DATE] at 4:45 p.m., an acceptable plan of removal was provided. The plan of removal documented, .All nurses will be in-serviced on signs and symptoms of intercranial (sic) hemorrhage, monitoring for head injuries related to fall, notification of physician in change of condition post fall. Nurses will also be inserviced on completing documentation as required. No nurses will be scheduled or allow (sic) to work until education has be (sic) completed. Staff inservice will be completed by 1800 [DATE]. Director of Nursing or Designees will monitor the implementation of the plan and if need to make changes. Daily audits of falls to be done daily for 4 weeks, then if compliance noted, then random audits done weekly for 90 days,until substantial compliance noted. The quality assurance committee will review IDT findings monthly for a period of 3 months then quarterly for 9 months to ensure continued compliance with state and federal regulations The immediate jeopardy was removed on [DATE] at 10:36 a.m., when all components of the plan of removal were carried out. The deficient practice remained at an isolated level of actual harm. Based on interview and record review, it was determined the facility failed to intervene for a resident when they began showing signs and symptoms of increased intracranial pressure after a fall for one (#4) of six sampled residents who were reviewed for changes in condition. The resident fell and hit her head on [DATE] at 10:30 a.m. The resident began exhibiting signs and symptoms of increased intracranial pressure at 3:00 p.m. 911 was called at 5:50 p.m. The resident's physician was not notified of the symptoms of increased intracranial pressure until 6:00 p.m., when the resident was transfered by ambulance to the hospital. The resident expired on [DATE] due to a subdural hematoma from [MEDICATION NAME] force trauma of the head. The facility identified 70 residents who resided at the facility. Findings: Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An admission assessment, dated [DATE], documented the resident was cognitively intact for daily decision making; was dependent on staff for bed mobility and transfers; and had limitations in range of motion on one upper and one lower extremity. The care plan, dated [DATE], documented the resident was at high risk for falls related to a fall before admission that resulted in three fractures. The goal was the resident would have minimal risk of injury from falls through the next review date. Interventions included to keep the call light within reach; encourage to participate in activities that promote exercise and physical activity for strengthening and improved mobility; encourage to participate with therapies as ordered; and to maintain a safe environment. Monthly physician orders, dated ,[DATE], documented the resident was to receive apixaban (Eliquis), an anti-coagulant, 2.5 mg twice daily for blood clot prevention. A progress note, dated [DATE] at 8:03 p.m., documented, .resident up to w/c with c/o headache that rates ,[DATE]. Medicated with prn pain meds .Currently resting in bed without s/s of obvious distress . A progress note, dated [DATE] at 1:30 a.m., documented, .resting in bed easily awaken alert oriented x 3 .no (complaints of) pain or discomfort at this time . A skilled daily nurse's note, dated [DATE] at 10:30 a.m., documented, .Resident was ambulating s walker et stated she got dizzy and lost her balance and slid down onto floor. States she hit the right side of her head on wall. Head to toe assessment completed c no R/E observed. No redness observed to any skin. PERL. Alert O x 3. Speech clear. Able to stand c assist. Assisted into w/c. Vital signs taken. Denies Pain. Neuro checks initiated. (Physician name withheld) notified of fall c no new orders .(blood pressure) ,[DATE] (pulse) 96 (respirations) 20. (oxygen) sat 99% on room air .resident c/o of dizziness c ear ache instructed to call for assist before getting up. Verbalizes understanding . Review of the resident's neurological flow sheet, dated [DATE] from 10:35 a.m. until 1:40 p.m. revealed the resident's blood pressure ranged from ,[DATE] to ,[DATE]; her pulse ranged from 53 to 64; and her pupil size and reaction remained at 1 mm and brisk. It was documented the resident was fully conscious and had equal and strong hand grasps during this period. The neurological flow sheet documented, .Notify MD IMMEDIATELY of signs and symptoms of Intracranial Pressure!!! . An internet website, http://www.healthline.com/health/increased-intracranial-pressure, documented: .The signs of increased ICP include: * headache * nausea * vomiting * increased blood pressure * decreased mental abilities * confusion about time, and then location and people as the pressure worsens * double vision * pupils that don't respond to changes in light * shallow breathing * [MEDICAL CONDITION] * loss of consciousness * coma . An internet website, https://medlineplus.gov/ency/article/ 3.htm, documented: .Increased intracranial pressure .Symptoms .adults: * Behavior changes * Decreased consciousness * Headache * Lethargy * Neurological symptoms, including weakness, numbness, eye movement problems, and double vision * [MEDICAL CONDITION] * Vomiting . Medication administration records, dated [DATE] at 3:00 p.m., documented, .[MEDICATION NAME] ,[DATE] mg (one) c/o head/shoulder pain (eight) per nurse . This entry was signed by CMA #1. The neurological flow sheet, dated [DATE] at 3:40 p.m., documented the resident's blood pressure had increased to ,[DATE], her pulse rate was 64, and she remained fully conscious with equal and strong hand grasps and pupil sizes of three with a brisk reaction. A progress note, dated [DATE] at 3:44 p.m., documented, .Resident remains on neuro checks for previous fall without further incident. resident does c/o headache that rates ,[DATE], and medicated with prn [MEDICATION NAME]. See MAR. Resident educated on fall prevention per facility policy, and procedure. resident able to use call light button appropriately. Will c/t monitor . Medication administration records, dated [DATE] at 4:00 p.m., documented, .[MEDICATION NAME] 25 mg (one) p/o c/o N/V per nurse . This entry was signed by CMA #1. The neurological flow sheet, dated [DATE] at 4:40 p.m., documented the resident's blood pressure had increased to ,[DATE] and her pulse rate had increased to 90. It was documented there was no change to her level of consciousness, hand grasps, pupil size, or pupil reaction. A progress note, dated [DATE] at 5:32 p.m., documented, .resident in room with c/o 'not feeling well.' refused evening meal d/t nausea without emesis. Medicated for nausea. See MAR. Will c/t to monitor .

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) Review of the clinical record revealed no documentation the facility intervened or that they notified the physician when the resident first began showing signs of increasing intracranial pressure at 3:00 p.m. through 5:32 p.m. The resident had developed a headache, had an increasing blood pressure, and had developed nausea, all symptoms of increased intracranial pressure. The neurological flow sheet, dated [DATE] at 5:40 p.m., documented the resident's blood pressure had increased to ,[DATE] and her heart rate was 92. It was documented the resident had snoring respirations at 14 to 16 per minute. It was also documented the resident was in a stupor, had no movement, had pupil sizes at 2 mm and fixed, and her speech was slurred. A progress note, dated [DATE] at 5:50 p.m., documented, .Resident in room laid back onto bed with increased s/s of decreased loc. resident responded with sub sternal rub, and answered: 'what.' VS: ,[DATE], 70, 98% RA with intermittent snoring respirations. Resident c/t have increased s/s of decreased loc. This nurse had another nurse call 911 while this nurse stayed with resident. Resident awakened intermittently, and palpable pulses to radial, and apical heart. Oxygen applied at 2L/NC/O2 while awaiting transport to (hospital name withheld) . A progress note, dated [DATE] at 6:00 p.m., documented, .ambulance arrival and resident condition stable upon departure . A hospital computerized tomography scan result, dated [DATE], documented, .Findings: There is an extensive right-sided subdural hemorrhage which measures 2.7 cm in thickness .This causes significant midline shift to the left by at least 2.4 cm .Impression: Significant right subdural hematoma casing mass effect and midline shift to the left. Possible small associated subarachnoid hemorrhage in right sylvian fissure . A hospital discharge summary, dated [DATE], documented, .Primary cause of death: [MEDICAL CONDITION]. Contributing cause bilateral subdural hematoma status [REDACTED]. A progress note, dated [DATE] at 12:41 p.m., documented, .I called to check on the resident today and the (family member) informed me that the resident had passed away this morning . A State of Oklahoma Certificate of Death, certified on [DATE], documented, date of death .[DATE] .Time of Death 04:50 .Cause of Death .Immediate Cause .Subdural Hemorrhage .Sequentially list conditions, if any, leading to the cause listed .[MEDICATION NAME] Force Trauma Of The Head .Date of Injury XXX[DATE] .Place of Injury .Nursing Home .Describe How Injury Occurred: Fall . On [DATE] at 2:39 p.m., CMA #1 was asked to describe the process for documenting when as needed medications were given. She stated as needed medications were given only after approval from the resident's nurse. She stated the time documented was the time the medication was given. On [DATE] at 2:49 p.m., LPN #1 was asked what was monitored for if a resident had a fall and hit their head or if a fall was unwitnessed. She stated neurological checks were started, and she monitored for changes in mental status. She was asked what the signs and symptoms of increased intracranial pressure were. She stated confusion, one-sided weakness, and changes in the pupils. On [DATE] at 2:51 p.m., LPN #2 was asked what was monitored for if a resident had a fall and hit their head or if a fall was unwitnessed. She stated she would complete neurological checks, watch for slurred speech, and monitor their hand grasps. She was asked what the signs and symptoms of increased intracranial pressure were. She stated the resident's orientation would be off kilter, the vital signs could be different, their eyes might hurt, and loud noises and lights would bother them. On [DATE] at 2:55 p.m., LPN #3 was asked what the signs and symptoms of increased intracranial pressure were. She stated a change in level of consciousness, vital signs might change a little, and the pupils might change. On [DATE] at 3:30 p.m., the DON was asked what staff was expected to do if a resident had a fall and hit their head or had an unwitnessed fall. She stated staff was to monitor the resident and notify the doctor to see if they wanted to send the resident out for a scan. She was asked if staff was supposed to monitor for increased intracranial pressure. She stated, Yes. The DON was asked what the signs and symptoms of increased intracranial pressure were. She stated a change in the level of condition, change in the reaction to light, change in the consciousness level. She stated any definite change in the normal for the resident. She was asked if headaches, nausea, and vomiting were signs of increased intracranial pressure. She stated, Absolutely. On [DATE] at 4:31 p.m., the DON was asked if there was documentation the physician was notified the resident was showing signs and symptoms of increased intracranial pressure. She reviewed the clinical record and stated, No, there is not. She was asked what the facility's expectation of staff was if a resident began to show those signs and symptoms. She stated staff was expected to notify the physician of any change in condition. On [DATE] at 12:00 p.m., the resident's physician was asked if staff notified him when the resident began showing signs and symptoms of increased intracranial pressure. He stated, I don't have a record one way or another. He was asked what his action would have been if he had been in the building at the time the changes started and he had been notified. He stated he would have evaluated the resident immediately, especially since he knew she had a previous history of an [MEDICAL CONDITION].
F 0425 **Level of harm -** Actual harm **Residents Affected -** Some	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to attempt to find an alternate source for medications necessary to meet the needs of one (#6) of six sampled residents whose medications were reviewed. The facility obtained physician orders [REDACTED]. The facility did not attempt to find an alternate source for the medication. Resident #6; who had [DIAGNOSES REDACTED]. This had the potential to affect nine residents who received medications and whose stay at the facility was paid for privately. Findings: The Food and Drug Administration's undated medication guide for Zyprexa documented, .To prevent serious side effects, do not stop taking Zyprexa suddenly . Drugsdb.com's Zyprexa withdrawal webpage, dated 06/28/12, documented, .Stopping Zyprexa suddenly can cause withdrawal symptoms that include: Insomnia or difficulty sleeping, Recurrence of schizohrenia symptoms (delusions or hallucinations), Recurrence of bipolar disorder symptoms (depression or mania). Some patients may also report nonspecific symptoms such as: Anxiety, Nausea and Vomiting, Sweating, Tremor. Usually, the withdrawal symptoms present as recurrence of the underlying disorder (bipolar disorder, depression, or schizophrenia) for which the patient is being treated for [REDACTED]. Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, initiated 10/22/14, documented a problem related to impaired cognitive function/dementia with behavioral disturbances. The goal was the resident would be oriented to self and have her needs met through the next review date. Interventions included to administer medications as ordered. A psychiatric progress note, dated 10/03/16, documented the resident was receiving Zyprexa 7.5 mg at bedtime. It was documented the resident sometimes thought her family member was present when they were not, but no other behavioral problems were reported. The resident's [DIAGNOSES REDACTED]. It was documented, .no suggested medication change . An annual assessment, dated 10/15/16, documented the resident was severely impaired in cognitive skills for daily decision making, had no behaviors, and received antipsychotic and antidepressant medications on seven of the preceding seven days. A progress note, dated 11/30/16 at 12:34 p.m., documented, .still resides on Hummingbird hall with a roommate . Behavior monitoring sheets, dated 11/2016, revealed documentation the resident had no episodes of behaviors for the month. Physician orders, dated 12/2016, documented the resident was to receive Olanzapine 7.5 mg by mouth at bedtime for delusional disorder related other persistent mental disorders. It was documented the resident began receiving the medication in this dose on 05/24/16. Medication administration records, dated 12/04/16, documented, .Olanzapine 7.5 mg not administered awaiting pharmacy . A progress note, dated 12/05/16 at 1:36 p.m., documented, .PCP notified that pharmacy is unable to fill meds due to non payment. resident is out of Olanzapine 7.5 mg. Asked if med needs to be dc'd. No new order at this time. (Family member) does not return calls . Medication administration records, dated 12/05/16, documented, .Olanzapine 7.5 mg not given awaiting fufillment .

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0425 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 7) A progress note, dated 12/06/16 at 9:38 a.m., documented, .DON .notified that at this time med is still not in facility per (pharmacy name withheld) due to non payment by (family member) .instructed to DC med . A note to the physician, dated 12/06/16, documented, .(resident #6) is out of Olanzapine 7.5 mg (one) po at HS, (pharmacy name withheld) is unable to fill anymore meds until (family member) pays them, do you want this dc'd? (Family member) will not return calls . The note was signed OK by the physician and dated 12/06/16. A progress note, dated 12/08/16 at 12:12 p.m., documented, .she was moved off of the secured unit due to not being a flight risk anymore . A progress note, dated 12/25/16 at 5:21 p.m., documented, .refusing meals and health shake po fluids encouraged with minimal po intake or fluid intake .Dr office notified . A progress note, dated 01/03/17 at 9:02 p.m., documented, .Resident hollers constantly Redirection unsuccessful Repositioned 1:1 unsuccessful Disruptive to other residents Incont care provided as needed . A progress note, dated 01/04/17 at 4:40 a.m., documented, .resident cont on and off through out night to call out for different things resident was given drinks, changed and repositioned, and given snacks. None of these actions was successful in reducing the calling out . A progress note, dated 01/05/17 at 5:37 a.m., documented, .called out all shift and was unconsoleable (sic). Snacks, drinks, repositioning, incont care offered and taken with no help in resident's calling out . A progress note, dated 01/06/17 at 5:40 a.m., documented, .Resident did not call out as much this 10-6 shift . A progress note, dated 01/06/17 at 6:12 p.m., documented, .resident refused dinner meal this shift . A progress note, dated 01/09/176 at 9:46 p.m., documented, .refused meds. Continuously hollering out Redirection/positioning unsuccessful. (Family member) to nurses station with concerns resident yelling will keep her awake all night . A progress note, dated 01/12/17 at 2:32 p.m., documented, .January wt: 160# .sig wt loss of 6.4% x 1 month. Will notify MD .Meal intake: 63% average. Megace in place as appetite stimulant. Encouragement ongoing .rec weekly wt monitoring x 4 weeks. Should wt fail to stabilize consider additional interventions . A progress note, dated 01/30/17 at 1:18 a.m., documented, .laying in bed yelling out different needs, at times wants her knees readjusted, at times her neck, at times c/o feeling like she choking (sic), at times just yelling help, each time these things are done for her she yells out again within minutes of leaving room, res doesn't comprehend or else remember to use her call light, res has been readjusted in bed, checked for incont. and incont care given when needed and flds offered and she takes flds at times, when go to leave room res. voices at times she doesn't want you to leave room and has advised her that we cannot stay in room c her at all times and she will say 'why', situation is explained to her, but res cont to yell out, res does yell out the whole 8 hr shift at times if not the whole 8 hrs then its close to it at other times, res appetite has decreased during day, and fld intake in decreased, cont to check for incont and reposition q 2 hour and offer flds. and snacks. Res did yell out whole 8 hours last night and was reported in report that she did yell out alday (sic) today, call light, flds and personal items . Behavior monitoring sheets, dated 01/2017, documented the resident had behaviors of yelling out, restlessness, or uncooperativeness on 19 out of 31 days. A progress note, dated 02/02/17 at 4:31 a.m., documented, .Resident has continued to call out. CNAs reposition, offer fluids and snacks, change resident and resident cont to call out. Resident denies pain. Resident clean dry and fluids and call light in reach . A progress note, dated 02/03/17 at 4:49 a.m., documented, .Resident has continued to call out all night. All interventions unsuccessful . A progress note, dated 02/04/17 at 6:31 a.m., documented, .Resident called out all night long. Unable to redirect with snacks, drinks, re-positioning or one on one. Resident called out so much that her voice is extremely hoarse . A progress note, dated 02/06/17 at 1:16 a.m., documented, .resident yelling out continuously Redirection unsuccessful Incont care provided Offered snacks/fluids Denies pain or discomfort No distress noted . A progress note, dated 02/08/17 at 1:51 p.m., documented, .February wt: 148# .Sig wt loss of 7.5% x 1 month, 11.9% x 3 months, loss of 14% x 6 months. Will notify MD .Meal intake: 18% average . A progress note, dated 02/13/17 at 7:38 p.m., documented, .Resident continues to decline no po intake this shift. (Physician name withheld) assessed resident .advised resident hosipce (sic) appropriate . A progress note, dated 02/14/17 at 8:48 a.m., documented, .resident seems very lethargic this am and will not eat or drink .(physician name withheld) notified . Behavior monitoring sheets, dated 02/01/17 through 02/14/17, documented the resident had behaviors of yelling out, restless, and uncooperativeness on 12 of 14 days. There was no behavior documentation on two of the 14 days. A progress note, dated 02/14/17 at 1:00 p.m., documented, .resident trying to yell after oral care done unable to form words .orders received (sic) to transfer to .hospital . A progress note, dated 02/17/17 at 3:38 p.m., documented, .Today the family called to let me know that the resident had passed away the night before . Review of the clinical record revealed no documentation the facility attempted to find an alternate source for the resident's medication. There was no documentation the facility attempted to assist the resident in any way to obtain the medication. On 03/15/17 at 4:14 p.m., the administrator, social services director, and business office manager were interviewed. The administrator was asked if he had knowledge the resident's antipsychotic medication had been discontinued because the pharmacy would not refill the prescription due to lack of payment on the family's part. He stated, No. He stated this had occurred before he came to the facility. He stated the DON at the time was now at a different facility. The social services director was asked if she had been aware of the situation. She stated, No. She stated, If they had brought it to my attention, we could have looked at different avenues. She stated they had never had this type situation before. The social services director was asked if Adult Protective Services had been notified the family was not paying for the resident's medications. She stated, Not on my part. She was asked whose role it would have been to notify Adult Protective Services. She stated, More than likely mine. The business office manager was asked if she had notified Adult Protective Services regarding the family not paying for the resident's medications. She stated, No. She stated the family and OSDH had been notified the family was not paying the bill at the facility, but she had not contacted Adult Protective Services. On 03/20/17 at 12:50 p.m., LPN #4 was asked if she had knowledge of resident #6's medication. She stated she remembered faxing, calling, and speaking with one of the physician's nurses. She was asked to explain what had occurred with the resident's Olanzipine. She stated she had ordered the medication but was informed by the pharmacy they would not deliver it until the resident's charge account had been brought current. She stated she reported the situation to the DON. LPN #4 stated the DON informed her she would speak with the administrator. LPN #4 stated she waited a few more days, and the resident ran out of Olanzipine. She stated she asked the DON what she was to do, and the DON informed her to get an order from the physician to discontinue the medication. LPN #4 stated the DON made a comment at the time that the family member was not paying her bill at the facility either. LPN #4 stated she had made multiple attempts to communicate with the family member over the phone, and the pharmacy consultant had provided information related to medication assistance to the family member in the past in the past. She stated the family member would never complete the paperwork for assistance. LPN #4 stated the pharmacy consultant had not been involved in this particular situation. LPN #4 was asked if the facility contacted Adult Protective Services related to the family member not paying the resident's pharmacy bill. She stated, Not that I am aware of.