| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165147 | A. Building<br>B. Wing | 07/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Henry County Health Center | 401 South Van Buren<br>Mount Pleasant, IA 52641 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>45338<br><br>Based on clinical record review, staff interview, and facility policy review the facility failed to ensure timely follow-up completed in response to Medication Regimen Review recommendations for 1 of 5 residents reviewed for unnecessary medications (Resident #24). The facility reported a census of 34 residents.<br><br>Findings include:<br><br>1. Review of the Minimum Data Set (MDS) assessment for Resident #24 dated 5/15/24 revealed the resident was rarely to never understood, and took hypnotic medication.<br><br>The Care Plan dated 10/1/23 titled LTC Psychotropic Medication Use revealed the following intervention: Monitor for adverse reactions r/t (related to) temazepam, quetipine, trazodone.<br><br>The Physician Order First Dose Date/Time dated 12/4/2023 at 9:00 PM revealed an order for Temazepam 7. 5 mg (milligram) oral cap at HS (night).<br><br>Review of the Phone Message/Call Note dated 3/31/24 at 3:59 PM revealed, in part, the following: In December, the dose of temazepam was successfully decreased to 7.5 mg daily at bedtime. There have been some behaviors during the day time with agitation and crying and it looks like nursing has successfully utilized non pharmacological measures most of the time with success. Would you like to try reducing the temazepam 7.5 mg HS to PRN (as needed) for 2 weeks and see if the patient still requires this medication? Please indicate one of the following: 1) New dose and directions for medication; or 2) Denial of reduction because resident's function will be impaired, cause increased distress, or exacerbate and underlying psychiatric disorder. 3) Any new medications or behavior interventions to be tried.<br><br>On 7/24/24 at 3:18 PM, the following requested via email from the facility's RN (Registered Nurse) Manager: Physician response to the pharmacist recommendation made on 3/31/24 for Resident #24. On 7/24/24 at 3:38 PM, the RN Manager responded via email that she did not see where he responded to the request.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Phone Message/Call Note dated 5/23/24 at 6:13 PM revealed, I sent a communication about possibly decreasing the temazepam to 7.5mg at bedtime to PRN and see if she still needs it scheduled and I just didn't see a response. Did Dr.[Name Redacted] get back to us? The response per the RN Manager, present in the same note and dated 5/28/24 at 12:51 PM revealed, No we have not.<br><br>During an interview on 7/25/24 at 9:29 AM, the RN Manager when queried about physician response to the recommendation, responded it would ideally be 24 to 48 hours for physician response.<br><br>Review of the Facility Policy titled Drug Regimen Review Policy, origination date 8/19/21, revealed the following: The attending provider will document in the resident record that the identified irregularity has been reviewed and what, if any action has been taken to address it. If the physician chooses not to act upon the pharmacy consultant recommendations, the physician must document rationale as to why the change is not indicated in the resident record. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336<br><br>Based on the clinical record review, interviews, and the facility policy, the facility failed to implement interventions prior to the administration of an antianxiety medication, and failed to attempt a gradual dose reduction for a resident on an antidepressant for 2 of 5 residents reviewed for unnecessary medications (Resident #19 and Resident #21). The facility reported a census 34 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #19 was rarely or never understood. The MDS revealed the resident wandered 4 to 6 days out of the last 14 day look back period. The MDS revealed the resident took antipsychotics, antianxiety, and antidepressants.<br><br>The Care Plan, initiated on 6/10/24, for LTC Behavioral Symptoms IPOC (Interdisplinary Plan of Care) included Interventions to: provide care with smile, gentle touch, voice, reassurance; evaluate for signs of pain during care and intervene prior to giving care; evaluate usual time, duration, and frequency of behavior, evaluate medications for desired and adverse outcomes; offer redirection;diversions as appropriate.<br><br>The Care Plan, initiated on 10/31/23, for LTC Psychotropic Medications Use IPOC included Interventions to: maintain a safe environment; monitor/report side effects; adverse reactions/related to quetiapine use and monitor/report adverse effects related to fluoxetine or lorazepam use.<br><br>A review of the clinical record revealed the following Physician Order:<br><br>a. lorazepam 0.5 mg (milligram) BID (twice daily) PRN anxiety, First Dose: 9/26/23. Diagnosis: unspecified dementia, unspecified severity, with other behavioral disturbance<br><br>A review of the MAR (Medication Administration Record) documented lorazepam 0.5 mg administered on:<br><br>a. 6/23/24 at 8:14 PM<br><br>b. 6/26/24 at 7:09 PM<br><br>c. 6/26/24 at 8:22 PM<br><br>d. 7/4/24 at 7:01 PM<br><br>e. 7/6/24 at 5:19 PM<br><br>f. 7/15/24 at 8:05 AM<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Progress Notes, and the Behaviors and Behavioral Management interactive view lacked documentation for non-pharmalogical interventions used prior to the administration of lorazepam 0.5 mg twice daily as needed for the following:<br><br>a. 6/23/24 at 8:14 PM<br><br>b. 6/26/24 at 7:09 PM<br><br>c. 6/26/24 at 8:22 PM<br><br>d. 7/4/24 at 7:01 PM<br><br>e. 7/6/24 at 5:19 PM<br><br>f. 7/15/24 at 8:05 AM<br><br>During an interview on 7/24/24 at 3:59 PM, Staff A, RN (Registered Nurse) stated before she gave lorazepam for anxiety she went into the computer and documented the interventions she tried prior to administration. Staff A stated the interventions were either documented under the progress notes or a specific tab that she checked the specific interventions tried prior to administration.<br><br>During an interview on 7/24/24 at 4:09 , Staff B, RN stated they needed to try at least 3 interventions prior to administration of lorazepam and documented under a specific tab in the EMR and clicked the interventions they tried. Staff B stated at time Resident #19 displayed behaviors such as arguing with other residents or getting up and sitting down which could be a safety concern.<br><br>During an interview on 7/25/24 at 9:25 AM, the DON (Director of Nursing) stated she expected staff to do 3 interventions and chart them before they gave the medication.<br><br>During an interview on 7/25/24 at 11:06 AM, the DON stated she didn't see any interventions completed on the dates provided to her prior to the lorazepam administered. The DON stated some of the nurses better than others at documenting the interventions and now they had a charge nurse who oversees the process to make sure the interventions are tried and charted prior to the medication being administered. The DON stated it was an ongoing process.<br><br>2. The MDS dated [DATE] revealed Resident #21 scored a 3 out of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. The MDS included a diagnosis of depression. The MDS listed Resident #21 prescribed an antipsychotic and antidepressant.<br><br>The Care Plan, initiated on 10/17/23 for LTC Mood State IPOC included an intervention to monitor for signs and symptoms of depression.<br><br>A review of the clinical record revealed the following Physician Orders:<br><br>a. Escitalopram (antidepressant) 10 mg tablet take every PM, first dose 9/27/23.<br><br>b. Mood/ behavior assessment, ordered on 5/11/24 at 5:00 PM, BID, on psychotropic therapy<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility lacked documentation for the any attempted GDR for escitalopram 10 mg.<br><br>Per an email [from the DON] dated 7/25/24 at 9:07 AM, the DON spoke to the pharmacist and the pharmacist stated she included all antipsychotic medications in the note. The pharmacist stated she attempted to reduce or discontinue the antipsychotic before the antidepressant. The pharmacist stated she must of missed adding the escitalopram to the note in March.<br><br>During an interview on 7/25/24 at 9:23 AM, the DON stated she spoke to the pharmacist and the pharmacist thought she missed putting the escitalopram on the GDR progress note.<br><br>Per an email [from the DON] dated 7/25/24 at 10:28 AM, the DON stated she couldn't locate a request for a dose reduction for Resident #21 for the escitalopram.<br><br>Per an email [from the DON] dated 7/25/24 at 10:46 AM, the DON stated Resident #21 started the escitalopram on 5/8/23.<br><br>During an interview on 7/25/24 at 10:59 AM, the DON stated the thought the GDR were completed every 3 months but she wasn't sure because the pharmacy took care of all that.<br><br>The Facility Psychotropic Medication Policy dated 8/31/23 revealed the following:<br><br>a. Based on individualized assessment, determined non-pharmalogical approaches that could be implemented prior to use of the psychotropic medication. Documentation will reflect attempts to implement care planned, non pharmacological approaches and ongoing effectiveness of these interventions.<br><br>b. Within the first year the resident admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt 2 GDR in the first year in separate quarters (with at least one month between them) unless clinically contraindicated. |