STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245433	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sylvan Court	112 St Olaf Avenue South Canby, MN 56220

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 0758 Level of Harm - Minimal harm or potential for actual harm 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. 39988 Based on interview and record review the facility failed to complete a gradual dose reduction (GDR) attempt annually or document a rationale for no gradual dose reduction (GDR) for 2 of 5 residents (R2 and R11) reviewed for unnecessary medications. Findings include: R2's 1/18/24, annual Minimum Data Set (MDS) identified R2 had adequate hearing, his speech was unclear, and he had some difficulty communicating some words or finishing thoughts, but he was able to make his needs understood. R2 was able to understand others. R2's cognition was moderately impaired. R2 was identified during the assessment period to feel down and depressed. R2 displayed no behaviors. R2 was dependent on staff for assistance with grooming and transfers. R2 had diagnoses of hypertension, neurogenic bladder, dementia, seizure disorder, traumatic brain injury, and depression. R2 took a antipsychotic and antidepressant daily. The assessment identified that a gradual dose reduction had not been attempted and the physician had not documented GDR as clinically contraindicated. R2's 5/1/24, physician orders identified Sertraline 200 milligrams (mg) every day (anti-depressant) with a start date of 2/24/23 and Olanzapine 15 mg (anti-psychotic) at bedtime with a start date of 1/24/19. Interview on 4/29/24 at 6:21 p.m., with licensed practical nurse (LPN)-A reported he used to have behaviors, but he was good now. She stated he used to be aggressive with staff and other residents at one time. H was not the one to provoke but he would hit out if provoked as he used to be a boxer. His medication has helped with his behaviors but also the residents have changed that live here and that also had helped. She identified he did have dementia and he was followed by psychiatry. Interview on 4/30/24 at 10:42 a.m., with nursing assistant (NA)-B who reported that R2 did not have behaviors other than he wanted to call his mom late at night. She reported when another one of the residents first came here that resident used to care for his wife, and he had confusion and accidentally went into R2's room and she said she had to get between them, but she had not witnessed R2 having any other behaviors after that. (continued on next page)

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of 3/8/24, psychiatry visit notes identified the provider had reviewed his medication and made no changes to his Sertraline 200 mg daily (anti-depressant), Olanzapine 15 mg (anti-psychotic) at bedtime daily, or Depakote 500 mg twice a day (anti-convulsant). The note identified that R2 had been compliant with his medications and no side effects had been noted. R2 had no stressors since last visit and R2 reported being happy, he denied feeling sad/down or anxious. Review of 4/10/24, physician visit progress note identified R2 had reported no concerns, he was feeling sad for the loss of his wife and later mentioned his mother had recently passed. No changes to his Sertraline 200 mg, Olanzapine 15 mg at bedtime or his Depakote 500 mg twice a day. Review of the pharmacy recommendations from 4/19/23 through 4/4/24, identified the pharmacist had documented on: 1) 4/19/23, pharmacist results of review that on 4/3/23, psychiatry visit with no change wanted and recheck in 3 months. No other significant findings. 2) 7/3/23, pharmacist results of review identified: resident seen on 4/3/23, by psychiatry with no change wanted. He is currently on olanzapine 15 mg/day, sertraline 200 mg/day (increased 10/22), Depakote 100 mg/day. No other significant findings noted. 3) 1/2/24 pharmacist results of review identified: resident continues of Depakote 100 mg/day, sertraline 200 mg/day, and olanzapine 15 mg/day with next psychiatry visit in March. Provider monitoring blood pressures. 4) 4/4/24, pharmacist results of review identified: psych visit on 3/8/24, waiting on notes. No GDR were recommended during the 12-month period. Interview on 5/1/24 at 9:24 a.m., with pharmacist identified that the psychiatrist followed R2, and they did not always document details about medications. He reported that the primary physician received his recommendations, and the psychiatrist did not receive the recommendations. The primary provider typically did not adjust doses for psych medications if the resident was followed by psychiatry. Pharmacy makes recommendations and the nurse ensures the provider addresses the recommendation during rounds at the facility. Interview on 5/1/24 at 10:21 a.m., with registered nurse (RN)-A who identified as the care coordinator reported she completed rounds with the providers and would present the pharmacy recommendations to the provider at that time. She confirmed that the provider typically did not address psych medication if the residents was being followed by the psychiatrist. She reported that she did not forward pharmacy recommendations for a GDR to the psychiatrist but should be doing so. She was unsure if R2 had any documented rationale for not completing a GDR. Interview on 5/1/24 at 11:37 a.m., with the director of nursing identified that she worked with the pharmacist, and they together would ensure that pharmacy would make a GDR recommendation at a minimum in the months of January and July. She confirmed that the primary providers did not like to make dose adjustments on psych medication if the resident was being followed by psychiatry. She reported that the psychiatrist should be receiving the recommendations for GDR as she typically requested information on the resident prior to their visit. She agreed that a GDR should be attempted annually and if contraindicated that rationale should be documented in his medical record. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/1/24 at 11:45 a.m., with administrator who agreed that if R2 has been on the same dose of his Olanzapine 15 mg since 1/24/19, that should have been addressed and documented in his medical record within the last 5 years if it was contraindicated. He agreed that a GDR should be attempted annually and if not appropriate a rationale should be documented in the medical record. Review of the 5/1/24 1:31 p.m., communication between the pharmacist and the mental health provider identified that the mental health provider was not opposed to a trial of decreasing R2's dose however, R2 had an incident that could not for sure be determined if it was intentional or not so at his last appointment, she had continued his medications as is. She reported she would plan to reassess for potential dose reduction at the next appointment. The mental health provider failed to document in R2's medical record during the last visit the rationale for the continued dose of medications. 49336 R11's 2/29/24, quarterly Minimum Data Set (MDS) identified R11 had a diagnosis of dementia and depression. R11 had severe cognitive impairment and had taken antidepressants. R11's section M assessment, identified that a GDR had not been attempted and the physician had not documented a GDR as clinically contraindicated. R11's undated Physician Order Report, identifed he had taken mirtazapine 15 milligrams (mg) daily and escitalopram (for depression and anxiety) 10 mg daily for depression with a start date of 8/24/22. R11's 1/02/24, Pharmacist Drug Regimen Review Observation identified recommendations for a GDR for escitalopram had no psychiatry services. There was no mention of implementation for escitalopram's GDR recommendation to providers. R11's undated care plan, identified he was on antidepressants. R11's goal would be for him to have a therapeutic effect of the medication. Staff were to adminsitered the medication as ordered and medications were reviewed monthly by the pharmacist, director of nursing (DON), nursing and medial director (MD). Interview on 5/01/24 at 10:07 a.m., with pharmacist stated the facility did not attempt a GDR of R11's antidepressants and had difficulty with the process because of refusals from R11's wife. Interview on 5/01/24 at 11:28 a.m., with medical provider (MD) stated she had discussed with R11's wife of the GDR process with the need for dosage modification. She stated R11 had taken antidepressants for a long time and GDR attempts had been made with no success. She stated R11's wife would refuse the need for GDR attempts and would not allow the facility to implement changes. MD stated R11's treatment plans would need approval from the wife and had been that way for a long time. Interview on 5/01/24 at 12:33 p.m., with registered nurse (RN)-A stated R11 had taken Remeron for his appetitite in the past and was unsure if R11's remeron medication had been address to the medical provider. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R11's undate care plan, identified R11 had diabetes, vitamin D deficienciy, and dysphagia. Goal was for R11 to consume adequate calories to maintain body weight. Interventions were for staff to modify R11's consistency of diet, supplements use at the discretion of dietary supervisor, eats meals in the main dining room and to offer snack and document amount consumed. There was no mention of R11's use of remeron for appetite stimulant.Review of 3/28/24, Psychotropic (Psychoactive) Drug Documentation policy identified the pharmacist reviews use of all medication upon admission and if using psychotropic medications to review monthly for any needed adjustments and at least twice yearly for planned dose reductions. Review of 12/6/23, Psychotropic Medications policy identified that gradual dose reduction was the tapering of a dose to determine whether symptoms or conditions can be managed at a lower dose or if a medication can be discontinued. Gradual dose reductions must be attempted annually unless contraindicated. The physician must document the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function or increase distressed behavior.