STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035264	A. BUILDING _____ B. WING _____	08/16/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUN HEALTH LA LOMA CARE CENTER	14260 SOUTH DENNY BOULEVARD LITCHFIELD PARK, AZ 85340

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on closed clinical record review, staff interviews and policy review, the facility failed to ensure there was adequate indication for the use of an as needed (PRN) antipsychotic medication for one resident (#97) and that there was a 14 day stop date or documentation by the prescribing practitioner that the resident was evaluated for the appropriateness of the medication. The deficient practice could result in residents receiving antipsychotic medications without medical necessity.Findings include: Resident #97 was admitted to the facility on (MONTH) 1, (YEAR) with [DIAGNOSES REDACTED]. Review of the clinical record revealed the resident was receiving hospice services. An annual History and Physical dated (MONTH) 18, (YEAR) revealed the resident had acute [MEDICAL CONDITION] and agitation, although no specific behaviors were addressed. A significant change MDS (Minimum Data Set) assessment dated (MONTH) 10, (YEAR) included a BIMS (Brief interview for Mental Status) score of 3, indicating the resident had severe cognitive impairment. The PHQ-9 (9-Item Patient Health Questionnaire) revealed a total severity score of 0, indicating no depression. The assessment also included the resident did have any hallucinations, delusions or behaviors. The physician progress notes [REDACTED]. It also included the resident had no current anxiety or depression. The note included [DIAGNOSES REDACTED]. The plan included for monitoring mood and behaviors. The Recertification Nurse Visit note dated (MONTH) 2, (YEAR) included the resident had no anxiety or agitation beyond comfort level. The resident was disoriented to place and time and was forgetful. The resident had no behavior problem per se but would roll his wheelchair away from the nurse whenever she tried to interact with him. The note also included that the assessment was limited. Review of a music therapy routine visit note dated (MONTH) 6, (YEAR) revealed the resident had no anxiety or agitation beyond comfort level. Per the note, the resident was more lethargic, did not respond appropriately to questions and was more forgetful and confused. It also included the resident reported feeling well. Further review of the clinical record revealed no specific behaviors that the resident had exhibited from (MONTH) (YEAR) through (MONTH) 6, (YEAR). A hospice IDT (interdisciplinary team) care plan for the certification period of (MONTH) 10, (YEAR) to (MONTH) 7, (YEAR) included a [DIAGNOSES REDACTED]. The social worker visit note dated (MONTH) 7, (YEAR) included the resident was sleeping soundly and had no anxiety or restlessness/agitation beyond comfort level. Despite the lack of documentation regarding specific behaviors, a hospice physician's orders [REDACTED]. The order did not include a 14 day stop date. A care plan dated (MONTH) 7, (YEAR) included the resident was receiving the antipsychotic [MEDICATION NAME] (brand name for [MEDICATION NAME]) on an as needed basis. Interventions included to give medication as ordered, record behaviors on the Behavior Tracking Form and monitor patterns of behavior such as time of day, precipitating factors and specific staff or situations. A Behavior/Intervention Flow Record was initiated on (MONTH) 7, (YEAR). From (MONTH) 7 through 11, (YEAR), the resident was being monitored for behaviors related to agitation, as evidenced by yelling. The documented number of episodes that the resident displayed was marked 0, indicating no behaviors were present. Further review of the flow record revealed that on (MONTH) 12, (YEAR) during the night shift, there were 3 greater episodes of behavior. It also included that interventions such as 1:1, change in position, fluids, redirection and medications were provided to the resident and the outcome improved.According to a Consent for the Use of [MEDICAL CONDITION] Medication dated (MONTH) 12, (YEAR), the resident was being administered [MEDICATION NAME] for agitation. Review of the MAR (medication administration record) for (MONTH) (YEAR) revealed that [MEDICATION NAME] was administered on (MONTH) 12, (YEAR) at 6:20 p.m., during a wound dressing change. The behavior exhibited prior to administering the [MEDICATION NAME] was documented as behavior present, combative, yelling out. The behavior/intervention flow record for (MONTH) 13, (YEAR) revealed that during the day shift, the resident had 3 greater episodes of behavior. The following interventions were implemented which resulted in improved outcome: 1:1, change in position, activity, giving of fluids, toileting and medications. The record also showed that during the night shift, the resident had 2 episodes of behavior. The only intervention which was implemented was the administration of the antipsychotic medication. The documentation also included that the resident manifested a side effect of lip smacking-chewing. Continued review of the clinical record revealed there was no evidence the physician/provider or that hospice were notified the resident had manifested a side effect of lip smacking. Despite documentation that the resident experienced a side effect of lip smacking, the MAR indicated [REDACTED] Further review of the clinical record revealed there was no evidence of adequate indications for the use of an antipsychotic medication for this resident. Per the clinical record, the resident continued on hospice services and expired on (MONTH) 20, (YEAR). During an interview with a licensed practical nurse (LPN/staff #93) conducted on (MONTH) 14, 2019 at 11:13 a.m., she stated the physician orders [REDACTED]. She said the number of episodes of behaviors will be monitored and documented to include interventions provided every shift. An interview with another LPN (staff #24) was conducted on (MONTH) 14, 2019 at 1:51 p.m. Staff #24 stated that the order for an antipsychotic will include the [DIAGNOSES REDACTED]. She said the specific symptom for the target behavior may be different for each resident, so staff is supposed to assess and monitor the specific symptom the resident has. She stated the number of episodes of behavior is monitored every shift and is documented in the behavior sheet. She said it is pretty common for an antipsychotic such as [MEDICATION NAME] to be prescribed and given to residents with agitation, especially when they are under hospice service. In an interview with the Director of Nursing (DON/staff #83) conducted on (MONTH) 15, 2019 at 2:38 p.m., she stated the

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	(continued... from page 1) resident was not alert and oriented and had no psychotic behaviors like delusions and paranoia. She stated that after a family member passed, resident #97 started to decline. She stated there was one time when the resident had hallucinations and this was the reason why [MEDICATION NAME] was prescribed. She stated the resident had periods of agitations and eventually was admitted to hospice, who prescribed the [MEDICATION NAME]. She stated that an antipsychotic such as [MEDICATION NAME] is usually prescribed by hospice for agitation and is okayed by the facility's provider when a resident is under hospice services. A policy on [MEDICAL CONDITION] Medication included the physicians or prescribing practitioners will use [MEDICAL CONDITION] medications appropriately in collaboration with the interdisciplinary team to ensure appropriate use, evaluation and monitoring. The policy included that based on a comprehensive assessment of a resident, the facility will ensure residents who have not used [MEDICAL CONDITION] drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. The facility will identify and document in the clinical record the specific medical [DIAGNOSES REDACTED]. The policy also included that PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.