

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

Accepted by Angela Silverstein 11/19/2015 2:30 PM

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055072 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 10/27/2015 |
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| NAME OF PROVIDER OR SUPPLIER ROSECRANS CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1140 W Rosecrans Ave, Gardena, CA 90247-2664 LOS ANGELES COUNTY |
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| | <p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:</p> <p>CLASS AA CITATION -- PATIENT CARE 91-2562-0011677-F Complaint(s): CA00372825, CA00372825</p> <p>Representing the Department of Public Health: Surveyor ID # 31333, Pharmacy Consultant</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>F309 Quality of Care Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>F 329 §483.25(l) Unnecessary Drugs 1. General. Each resident's drug regimen must be free from unnecessary drugs: (i) In excessive dose (including duplicate therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above. 2. Antipsychotic Drugs. Based on a comprehensive</p> | | <p>Citation # 91-2562-0011677-F</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code 1280 and 42 C.R.F. 405.1907.</p> <p><i>[Signature]</i> (Initials)</p> <p>A) <u>How the Correction will be accomplished, both temporarily and permanently;</u></p> <p>1. <u>Temporarily</u>; on 11-17-15 Licensed nurses assessed all residents receiving a combination of Antipsychotic, Antianxiety, Anticonvulsant, Narcotic, Anticholinergic and Antihypertensive medications that have same side effects which may cause sedation and respiratory depression and hypotension. The monitoring will be every shift for 72 hours.</p> | 11/17/15 |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

ADMINISTRATOR

11/17/15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 19

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. Except for nursing homes, the findings 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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| | <p>assessment of a resident, the facility must ensure that:</p> <p>(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and</p> <p>(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>On October 23, 2013 at 8:15 a.m., an unannounced visit was conducted to investigate a complaint alleging Resident 1 was over-medicated and over-sedated. Resident 1 became unresponsive and the facility called 911 (emergency phone number). Resident 1 passed away in the facility.</p> <p>Based on interview, and record review, the facility failed to:</p> <p>1. Ensure Resident 1, who received Risperdal (antipsychotic), Cogentin (anticholinergic), Depakote (anticonvulsant), and Ativan (antianxiety) was assessed and monitored for medications side effects such as sedation (sedative drug that produce a state of calm or sleep), hypotension (a drop in blood pressure due to a change in body position when a person moves to a more vertical position: from sitting to standing or from lying down to sitting or standing), and drowsiness (sleepiness) as indicated in the plan of care.</p> | | <p><u>Permanent</u>, the licensed nurses will address the care plan and continue daily monitoring the side effects of Antipsychotic, Antianxiety, Anticonvulsant, Narcotic, Anticholinergic and Antihypertensive medications which may cause sedation and respiratory depression, hypotension, and drowsiness as indicated in the plan of care.</p> <p>2. <u>Temporarily</u>, all residents who receive psychotropic medications were reviewed for specific clinical justifications. For residents who exhibiting behaviors, the non-pharmacological approach (NPA) will be utilized, also rule out infections and pain assessment were implemented first before notifying MD for further pharmacological intervention. <u>Permanent</u>, Licensed nurses will do daily behavioral monitoring and medication side effects such as EPS, sedation, drowsiness, Orthostatic hypotension (weekly), respiratory depression. IDT will continue</p> | |

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| | <p>2. Ensure Resident 1, had specific clinical justification for the use of Risperdal.</p> <p>3. Ensure Resident 1 did not received Ativan 2 milligram more often than every six hours as ordered by the physician on September 30, 2013, at 10:30 a.m., and 2:30 p.m., October 4, 2013, at 4:30 a.m., and 8 a.m., October 5, 2013, at 8 p.m., then October 6, 2013, at 1 a.m.</p> <p>4. Ensure Resident 1 received Duoneb (breathing treatment used to relax muscles in the airways and increase air flow to the lungs.) every four hours around the clock as ordered by the physician.</p> <p>The facility failures resulted in Resident 1 receiving Ativan 2 mg on three occasions more often than prescribed from September 30, 2013 through October 6, 2013 concomitantly (together) with Risperdal, Cogentin, and Depakote, without adequate monitoring for additive CNS-depressant effects that included, sedation, respiratory depression, ataxia (loss of voluntary muscle control), drowsiness, and weakness, in which the risk of side effects are increased when two or more CNS depressants are administered concomitantly. Resident 1 was not administered DuoNeb breathing treatments on 16 out of 32 occasions from October 2-7, 2013, which included 2 doses not being administered on October 7, 2013 at 12 a.m. and 4 a.m.</p> <p>These violations resulted in Resident 1 being found on October 7, 2013, at 6:05 a.m., unresponsive and no vital signs (signs of life; specifically: the pulse rate, respiratory rate, body temperature, and often</p> | | <p>to review and evaluate the use of the Antipsychotic, Antianxiety, Anticonvulsant, Narcotic, Anticholinergic and Antihypertensive on monthly then quarterly thereafter.</p> <p>3. <u>Temporarily</u>, Licensed nurses assessed all residents who receive anxiolytic medication for proper dosage and frequency as MD ordered. On 11-2, 4, 5, 6-2015, Licensed nurses were in-serviced on administering the medications as MD ordered. <u>Permanent</u>, DON, RN Supervisor will do weekly random check on med pass observation of 3 licensed nurses to ensure the proper administration of the dosage for accuracy of the dosage and frequency of medication. Pharmacy nurse consultant will do monthly med pass observation on licensed nurses. Pharmacist consultant will do the monthly drug regimen review of Antipsychotic, Antianxiety, Anticonvulsant, Narcotic, Anticholinergic and Antihypertensive.</p> | |

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| | <p>blood pressure of a person), cardiopulmonary resuscitation (CPR) was started, and paramedics were called. At 6:49 a.m., Resident 1 was pronounced dead, in the facility.</p> <p>A review of Resident 1's closed clinical record (Face Sheet) indicated Resident 1 was a 72 year-old female, who was initially admitted to the facility on September 8, 2010, and was readmitted on September 27, 2013 with diagnoses that included acute renal insufficiency (when the kidneys suddenly become unable to filter waste products from the blood) with hemodialysis treatment (a procedure for removing waste products and free water from the blood), diabetes mellitus (high blood sugar), hypertension (high blood pressure), and dementia with psychosis (a decline of mental abilities such as thinking, reasoning, and memory/feature of mental illness typically characterized by radical changes in personality, impaired functioning).</p> <p>Resident 1's Minimum Data Set (MDS, an assessment and care screening tool), dated September 23, 2013, indicated Resident 1 had short term memory problem, cognitive skills for daily decision-making were moderately impaired, and required supervision with transfer and toilet use, limited assistance with walking, dressing, and personal hygiene.</p> <p>A care plan, dated September 25, 2013, for needs of antipsychotic (Risperdal) medication for psychosis manifested by non-compliance to care and stealing other resident's and facility's</p> | | <p>The pharmacist consultant's review and identified irregularities and findings will be reported to the DON for immediate corrections.</p> <p>4. Licensed nurses reviewed all residents who receive respiratory treatment. All had received as prescribed. If the resident refused 3 times the MD will be notified for further clinical intervention.</p> <p>B) <u>The title or position of the person responsible for correction;</u></p> <p>Licensed nurse will assess the resident for any side effects of drowsiness, orthostatic hypotension, sedation and respiratory depression, and report any abnormal vital signs to RN Supervisor for further assessment and notification to MD as needed with proper documentation.</p> <p>DSD is responsible for inservicing the CNAs on reporting the change of the resident behavior, vital signs and ADLs to licensed nurses.</p> | |

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| | <p>belongings, indicated the resident was at risk for side effects from the medication, and risk for falls. The goals included no side effects from the medication every shift. The plan approaches included to monitor side effects from the medication and to notify the physician if side effects were observed. The antipsychotic sticker pasted on the care plan indicated to observe the resident closely for significant side effects, common sedation, drowsiness, dry mouth and postural hypotension.</p> <p>Another care plan dated September 25, 2013, for needs of Depakote (anticonvulsant) medication as mood stabilizer for psychosis manifested by mood swings, indicated the resident was at risk for side effects from the medication and at risk for falls. The plan approaches included to monitor side effects from the medication and to notify the physician if side effects were observed. The Depakote sticker pasted on the care plan indicated the adverse side effects which included drowsiness.</p> <p>Resident 1's physician's medication orders included the following:</p> <ol style="list-style-type: none"> 1. Norvasc 10 milligram by mouth (mg) every day, ordered September 8, 2010, for hypertension. The order did not have blood pressure hold parameters (Taking of vital signs, upon which administration of medication or treatments are conditioned). 2. Aricept 5 mg by mouth every night, ordered September 8, 2010, for dementia 3. Cogentin 1 milligram (mg) by mouth to be given every 12 hours, ordered April 23, 2011, for extrapyramidal symptoms (EPS, involuntary | | <p>CNAs are responsible for reporting changes of the resident vital signs, ADLs and behavior to the licensed nurse.</p> <p>C) <u>A description of the monitoring process to prevent recurrence of the deficiency and include the method and frequency of monitoring;</u></p> <p>Licensed nurses and RN Supervisor will continue to do daily monitoring all residents receiving combined medications Antipsychotic, Antianxiety, Anticonvulsant, Narcotic, Anticholinergic and Antihypertensive which may have the same side effects which may cause sedation, dizziness, drowsiness, excessive sleepiness, low blood pressure and respiratory depression.</p> <p>Administrator to monitor DSD to ensure in-services are given to CNAs regarding to report if the resident exhibits excessive sleepiness,</p> | |

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| | <p>muscle movement.)</p> <p>4. Depakote 500 mg by mouth every 12 hours, ordered April 23, 2011 for mood swings and psychosis.</p> <p>5. Losartan 50 mg by mouth every day, ordered October 24, 2011, for hypertension with a parameter to hold if systolic blood pressure (SBP, is the top number of the blood pressure) is less than 110 millimeters of mercury (mmHg).</p> <p>6. Risperdal 1 mg by mouth every night, ordered July 24, 2013, for resident's non-compliance to care and stealing other residents' and facility's belongings</p> <p>7. Ativan 2 mg by mouth every six hours as needed (PRN) for agitation, ordered September 27, 2013</p> <p>8. Duoneb 3 milliliter (ml) via nebulizer every four hours around the clock (ATC) for shortness of breath and/or wheezing and every two hours PRN, ordered September 27, 2013</p> <p>9. Nicoderm CQ 21 mg per 24 hours transdermal patch daily, apply one patch to upper outer arm or chest for smoke cessation, ordered September 27, 2013.</p> <p>Resident 1 had a physician's order dated September 27, 2013, for hemodialysis treatment on Monday, Wednesday and Friday. A review of Dialysis Record indicated Resident 1 last dialysis treatment was on October 4, 2013.</p> <p>A review of the Medication Administration Record (MAR), and Narcotic and Hypnotic Controlled Record from September 28, 2013 to October 6, 2013, indicated Resident 1 received Ativan 2 mg for</p> | | <p>drowsiness and overly sedated.</p> <p>Pharmacist consultant will continue to do monthly drug regimen review for resident receiving Antipsychotic, Antianxiety, Anticonvulsant, Narcotic, Anticholinergic and Antihypertensive with diagnosis of renal failure to ensure there is no medication interactions and side effects.</p> <p>DON will do monthly review of 5 clinical records to ensure that licensed nurses are accurately assessing the resident and monitoring side effect of Antipsychotic, Antianxiety, Anticonvulsant, Narcotic, Anticholinergic and Antihypertensive such as drowsiness, hypotension and excessive sedation.</p> | |

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| | <p>agitation on the following dates and times:</p> <ol style="list-style-type: none"> 1. September 28, 2013, at 5 a.m., and 6 p.m. 2. September 29, 2013, at 12:15 a.m. and 3:30 p.m. 3. September 30, 2013, at 12:20 a.m., 10:30 a.m., and 2:30 p.m. 4. October 1, 2015, at 3 a.m., 11:30 a.m., and 11:30 p.m. 5. October 2, 2015, at 8 p.m. 6. October 3, 2015, at 2 a.m., 11 a.m., and 5 p.m. 7. October 4, 2013, at 4:30 a.m., 8 a.m., and 6 p.m. 8. October 5, 2013, at 8 a.m., and 8 p.m. 9. October 6, 2013, at 1 a.m., and 3 p.m. <p>The MAR and Narcotic and Hypnotic Controlled Record indicated Resident 1 received 21 doses of Ativan 2 mg in nine days upon readmission. Also, on September 30, 2013, October 4, 5, and 6, 2013, Resident 1 was given three doses of Ativan 2 mg more often than every six hours as needed (PRN) as prescribed by the physician.</p> <p>A review of the Psychotropic Assessment for Ativan, dated September 27, 2013, indicated for the first, second and third day to document non-pharmacological interventions (approaches to care that do not involve medications, such as behavioral interventions, including direct care and activities, that are provided as part of a supportive physical and psychosocial environment, and are</p> | | <p>D) <u>Date the immediate correction of the deficiency(s) will be accomplished.</u></p> <p>The immediate correction was done on 11-17-15.</p> | |

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| | <p>directed toward preventing, relieving, and/or accommodating a resident's distressed behavior), and to indicate effectiveness of the non-pharmacological interventions. There was no written documentation that non-pharmacological interventions for the first, second and third day were attempted.</p> <p>A review of Resident 1's MAR under behavior indicated to monitor episodes of stealing other residents' or facility's belongings every shift, tally by hash marks. A review of behavior hash mark for the months of July, August, September, and October 2013 indicated no behavior episodes except for three hash marks on August 18, 21, and 23, 2013 during the 3 p.m. to 11 p.m. shift. There was no documentation that the resident's level of sedation, drowsiness and dry mouth are being monitored for the use of Risperdal. There was no documented clinical justification and indication for the continued use of Risperdal for Resident 1 who had dementia with psychosis.</p> <p>According to DailyMed, the FDA approved manufacturer's label for Risperdal has a Black Box Warning that indicates, "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death...most of the deaths appeared to be either cardiovascular (e.g. heart failure, sudden death)... Risperdal (risperidone) is not approved for the treatment of patients with dementia-related psychosis...The most common adverse reactions</p> | | | |

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| | <p>were nausea, somnolence (sleepiness), sedation, vomiting, dizziness, and akathisia (agitation and restlessness)...there was a 20% increase in valproate (Depakote) peak plasma concentration (the highest level of drug that can be obtained in the blood usually following multiple doses), after concomitant administration of Risperdal. <http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f2e8b588-fae5-476a-b7c5-f27e72db56e3></p> <p>The Licensed Personnel Weekly Progress notes dated September 28, 2013, at 4:40 a.m., indicated the resident was found in her room, sitting on the floor. The late entry dated September 28, 2013, at 9 a.m., indicated the resident had a skin tear, measured 1.5 centimeters (cm) to 2.0 cm to her left shoulder. There were no vital signs taken, to assess and identify if the resident had low blood pressure at the time of the fall.</p> <p>The Licensed Personnel Weekly Progress notes dated September 29, 2013, at 12 a.m.(Midnight).., indicated certified nursing assistant found Resident 1 in her room sitting on the floor with no injuries. The documentation indicated the resident was agitated and was given Ativan 2 mg, with no effectiveness. Resident 1's vital signs were taken and documented within normal ranges.</p> <p>The Licensed Personnel Weekly Progress notes, dated September 29, 2013, at 11:30 a.m., indicated the facility's maintenance staff reported Resident 1</p> | | | |

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| | <p>was lying on the floor, face down. The documentation indicated the resident was bleeding from her left, inner nostril (nose) due to a skin tear and complained of face pain, and the pain scale was 4/10 (ten being the worst pain a resident can experience). First aid was administered, the physician was notified. The vital signs were taken and documented within normal range.</p> <p>The Interdisciplinary Team (IDT) notes, dated September 30, 2013, indicated Resident 1 recently returned to the facility from the general acute care hospital and was really weak, in addition to starting hemodialysis three times a week. The IDT continued to summarize Resident 1 was at a high risk for repeated falls due to fall history, medications, and diagnoses. The record further indicated the hemodialysis treatment started on September 30, 2013. There was no documentation that the IDT assessed the resident for potential side effects of medications that contributed to her three fall incidents.</p> <p>A review of Resident 1's Licensed Personnel Weekly Progress notes from May 2013 through October 2013 documented falls on: * May 20, 2013 at 12 a.m., * June 6, 2013 at 1:30 a.m., * September 28, 2013 at 4:40 a.m., * September 29, 2013 at 12 a.m. and * September 29, 2013 at 11: 30 a.m. Resident 1's Licensed Personnel Weekly Progress notes indicated a pattern of falls during the night</p> | | | |

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| | <p>and early morning, with no documentation of hourly monitoring or any actions taken to prevent such falls.</p> <p>According to DailyMed, the FDA approved manufacturer's label for Risperdal indicated monitoring of orthostatic vital signs should be considered in patients for whom this is of concern. A dose reduction should be considered if hypotension occurs. Risperidone should be used with particular caution in patients with known cardiovascular disease (history of myocardial infarction or ischemia, heart failure, or conduction abnormalities), cerebrovascular disease, and conditions which would predispose patients to hypotension, e.g., dehydration and hypovolemia. Clinically significant hypotension has been observed with concomitant use of risperidone and antihypertensive medication. <http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f2e8b588-fae5-476a-b7c5-f27e72db56e3></p> <p>The facility undated policy and procedures for Fall Prevention and Interventions indicated monitor the resident frequently especially during the time of day or during circumstances in which resident has established pattern of falls, to assess the medications for side effects such as confusion, dizziness orthostatic hypotension and reduce or change medications as appropriate.</p> <p>The Licensed Personnel Weekly Progress notes, dated October 6, 2013, at 11:30 p.m., indicated</p> | | | | |

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| | <p>that Resident 1 was in bed, sleeping soundly on her back but easily aroused. The notes indicated on October 7, 2013 at 1:30 a.m., certified nursing assistant (CNA) provided care, as tolerated and repositioned the resident. At 3:30 a.m., the notes indicated routine positioning and turning was provided by CNA to the resident, and breathing treatment was offered but the resident was too sleepy to tolerate the treatment. The documentation indicated no labored breathing exhibited. The documentation at 5:00 a.m., indicated last rounds, the resident was visually checked and seen moving her extremities, breathing deep but shallow. The documentation at 6:05 a.m. indicated the resident was unresponsive, vital signs were unappreciable, and cardiopulmonary resuscitation (CPR) was started, paramedics were called. At 6:15 a.m., the paramedics came and continued with CPR. At 6:49 a.m., the documentation indicated the resident expired at the facility.</p> <p>A review of the Los Angeles County Fire Department Emergency Medical Service Report Form, dated October 7, 2013, indicated the paramedics were dispatched to the facility at 6:19 a.m., arrived at 6:24 a.m., at resident by 6:26 a.m. (Eleven minutes discrepancy of the facility's documentation to the time the paramedics took over care of the resident). The documentation indicated cardiac arrest (is the sudden, abrupt loss of heart function), CPR was started right away, and at 6:30 a.m., vital signs indicated blood pressure (BP) zero, pulse rate zero, and respiration zero. The resident was pronounced dead at 6:49 a.m., on</p> | | | | |

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| | <p>October 7, 2013.</p> <p>A review of a death certificate, dated October 7, 2013, indicated Resident 1 died of cardiac arrest, end stage renal disease (ESRD), and hypertensive heart disease.</p> <p>On October 22, 2013, at 3:50 p.m., a telephone interview was conducted with FM1, who stated he and another family member visited Resident 1 on October 2, 2013. FM 1 stated, "She looked knocked out and had just returned from dialysis, her eyes were glassy and she was half out of it, really sedated." FM1 stated he went to the nurse's station to get someone to look at Resident 1, and approximately seven minutes later a nurse came and after looking at Resident 1, she told him Resident 1 looked like that because of receiving dialysis. FM1 stated a facility staff member started to try and feed the resident while she was half asleep. That was the last time he saw the resident alive and was told she was found unresponsive in her bed about 6 a.m. on October 7, 2013. FM1stated, "I didn't understand how that could have happened, if she was being checked often."</p> <p>On October 23, 2013, at 12 p.m., during an interview, the director of nursing (DON) while reviewing Resident 1's clinical records stated Resident 1 was very weak and kept trying to get up, out of the wheelchair, so the resident was moved closer to the nurses' station to be monitored</p> | | | |

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| | <p>more closely. The DON stated the practice was to monitor Resident 1 every hour to prevent falls. However, the DON stated this was done informally, "We have no evidence of monitoring ... We do not document monitoring." The DON stated that there was no reason to monitor Resident 1 if she was not getting out of bed. The DON stated while the resident was in bed, the resident was being checked if she was breathing. The DON was unable to provide documentation that Resident 1 was observe closely for significant medications side effects such as sedation, drowsiness, and postural hypotension as indicated in the Risperdal care plan.</p> <p>On October 23, 2013, at 3:10 p.m., licensed vocational nurse 3 (LVN 3) stated he gave Resident 1 Ativan 2 mg on October 6, 2013 at 3 p.m., because the resident was trying to get out of bed. LVN 3 stated he checked the resident every hour to make sure the resident would not fall because the resident was so weak. LVN 3 stated he was not monitoring Resident 1 for sedation side effects from the medication, and stated he was monitoring the resident to prevent fall.</p> <p>On October 24, 2013 at 6:50 a.m., during an interview, licensed vocational nurse (LVN 2) stated on October 6, 2013, during her rounds at 11:30 p.m., the resident was asleep. LVN 2 stated when she offered the resident her breathing treatment (Duoneb) at midnight, as prescribed every four hours; she stated the resident usually refused.</p> | | | |

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| | <p>LVN 2 stated she marked the MAR that resident refused although the breathing treatment was not offered. LVN 2 stated she noticed Resident 1 was not calling, during the night and in the morning of October 7, 2013, so she went to check the resident at 6:05 a.m., and the resident was found unresponsive. LVN 2 stated she called the certified nursing assistant 1 (CNA 1) for help and she checked the resident's pulse and there was nothing and CODE BLUE (a medical emergency, when a resident's heart stops beating or her lungs stop functioning) was called.</p> <p>A review of Resident 1's MAR revealed no documentation that Resident 1 received Duoneb every four hours as ordered by the physician on October 2, 2013, at 8 a.m., 12 p.m., and 8 p.m.; October 3, 2013, at 8 a.m., 12 p.m., 4 p.m., and 8 p.m.; October 4, 2013, at 8 a.m., and 12 p.m.; October 5, 2013, at 12 a.m., 4 a.m., 8 a.m., 12 p.m., and 4 p.m., then October 7, 2013, at 12 a.m., and 4 a.m. Resident 1 did not receive the DuoNeb 16 out of 32 occasions.</p> <p>During an interview, on October 24, 2013 at 7:40 a.m., CNA 1, who worked on 11 p.m. to 7 a.m. shift stated, "I was here when the resident passed, she was on my assignment on October 6 and 7, 2013. I checked the resident when I first came on duty about 11 p.m. to 11:30 p.m. and passed water about 12 a.m., reposition her and changed her diaper about 3 a.m. to 3:30 a.m. Resident 1 was still sleeping. The next time I saw the resident was</p> | | | |

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| | <p>when LVN 2 called me and a CODE BLUE was called about 6:05 a.m."</p> <p>According to the American Geriatrics Society 2012 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, indicated all benzodiazepines, which includes Ativan (lorazepam), increase risk of cognitive impairment, delirium, falls, fractures...in older adults and should be avoided for the treatment of insomnia, agitation, or delirium. The quality of the evidence is high and the strength of the recommendation is strong.</p> <p>According to DailyMed (the official web-based provider of FDA medication labeling information, or package inserts), indicated Ativan use in elderly or debilitated patients, initial dose should not exceed 2 mg; Over dosage of Ativan, a benzodiazepine is usually manifested by varying degrees of central nervous system depression ranging from drowsiness to coma... In more serious cases, and especially when other drugs...were ingested, symptoms may include...hypotension, cardiovascular depression, respiratory depression, hypnotic state, coma, and, death.</p> <p>According to DailyMed, Clinically Significant Drug Interactions... Ativan (lorazepam), produce increased CNS-depressant effects when administered with other CNS depressants such as antipsychotics (e.g. Risperdal)...anticonvulsants (e.g. Depakote)... Concurrent administration of lorazepam with valproate (Depakote) results in increased plasma concentrations and reduced</p> | | | | |

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| | <p>clearance of lorazepam. Lorazepam dosage should be reduced to approximately 50% when co-administered with valproate. <http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=89057c93-8155-4040-acec-64e877bd2b4c></p> <p>According to DailyMed, the FDA approved manufacturer's label for Depakote (valproate) indicated under, Warnings and Precaution, Somnolence (sleepiness) in the Elderly...other adverse reactions (e.g. tremors, dizziness, hypotension, etc...)... Dose reductions or discontinuation of valproate should be considered in patients... with excessive somnolence. <http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=08a65cf4-7749-4ceb-6895-8f4805e2b01f></p> <p>According to DailyMed for Cogentin (a highly anticholinergic medication associated with mental confusion, delirium, dizziness, sedation, dry mouth and constipation), used in treating drug-induced extrapyramidal disorders (involuntary muscle movement or tremors) ...The drug may cause complaints of weakness and inability to move particular muscle groups <http://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=4b1fca78-1bc0-43cd-be4b-ae118196042b&type=display></p> <p>The facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure Resident 1, who received Risperdal, | | | |

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| | <p>Cogentin, Depakote, and Ativan was assess and monitor for medications side effects that included excessive sleepiness or drowsiness, low blood pressure and respiratory depression as indicated in the plan of care.</p> <p>2. Ensure Resident 1, had a clear indication for the use of Risperdal.</p> <p>3. Ensure Resident 1 did not received Ativan 2 milligram more often on three occasions.</p> <p>4. Ensure Resident 1 received Duoneb on 16 out of 32 occasions from October 2-7, 2013, with two treatments not administered on October 7, 2013 at 12 a.m. and 4 a.m.</p> <p>5. Ensure Resident 1's clinical records were accurately documented, prescribed medications were appropriate for the resident with diagnosis of renal failure, and were consistently monitored to minimize medication interactions.</p> <p>The facility failures resulted in Resident 1 receiving an average of 4.5 mg of Ativan each day (over twice the recommended initial total daily dose of 2 mg for elderly or debilitated patients) from September 28, 2013 through October 6, 2013. The excessive doses of Ativan with the decreased clearance due to renal failure and combined use of Depakote, Risperdal, and Cogentin put the resident at greater risk of Ativan accumulation in the system that increased the sedative side effects and respiratory depression. The breathing treatments were not administered as prescribed which contributed to Resident 1 being found unresponsive with no vital signs on October 7, 2013, at 6:05 a.m., and pronounced dead at 6:49 a.m., after unsuccessful</p> | | | |

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| | <p>CPR.</p> <p>These violations presented an imminent danger to the resident and were a direct proximate cause of the death of the resident.</p> | | | |

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