Below you will find F-tag language excerpted from the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Rev 66, 10-01-10).

F329

(Rev. 127, Issued: 11-26-14, Effective: 11-26-14, Implementation: 11-26-14)

§483.25(l) Unnecessary Drugs

<table>
<thead>
<tr>
<th>All classes, e.g., First generation (conventional) agents, e.g.</th>
<th>Indications for Use:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Chlorpromazine</td>
<td>A. Conditions Other than Dementia</td>
</tr>
<tr>
<td>▪ Fluphenazine</td>
<td>An antipsychotic medication should generally be used only for the following conditions/diagnoses as documented in the record and as meets the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Training Revision (DSM-IV TR) or subsequent editions):</td>
</tr>
<tr>
<td>▪ Haloperidol</td>
<td>▪ Schizophrenia</td>
</tr>
<tr>
<td>▪ Loxapine</td>
<td>▪ Schizo-affective disorder</td>
</tr>
<tr>
<td>▪ Mesoridazine</td>
<td>▪ Schizophreniform disorder</td>
</tr>
<tr>
<td>▪ Molindone</td>
<td>▪ Delusional disorder</td>
</tr>
<tr>
<td>▪ Perphenazine</td>
<td>▪ Mood disorders (e.g. bipolar disorder, severe depression refractory to other therapies and/or with psychotic features)</td>
</tr>
<tr>
<td>▪ Promazine</td>
<td>▪ Psychosis in the absence of dementia</td>
</tr>
<tr>
<td>▪ Thioridazine</td>
<td>▪ Medical illnesses with psychotic symptoms (e.g., neoplastic disease or delirium) and/or treatment related psychosis or mania (e.g., high-dose steroids)</td>
</tr>
<tr>
<td>▪ Thiothixene</td>
<td>▪ Tourette’s Disorder</td>
</tr>
<tr>
<td>▪ Trifluoperazine</td>
<td>▪ Huntington disease</td>
</tr>
<tr>
<td>▪ triflupromazine</td>
<td>▪ Hiccups (not induced by other medications)</td>
</tr>
<tr>
<td>▪ Second generation (atypical) agents, e.g.</td>
<td>▪ Nausea and vomiting associated with cancer or chemotherapy</td>
</tr>
<tr>
<td>▪ Asenapine</td>
<td>BCE-01-14, Effective: 11-26-14, Implementation: 11-26-14</td>
</tr>
<tr>
<td>▪ Aripiprazole</td>
<td>BCE-01-14, Effective: 11-26-14, Implementation: 11-26-14</td>
</tr>
<tr>
<td>▪ Clozapine</td>
<td>BCE-01-14, Effective: 11-26-14, Implementation: 11-26-14</td>
</tr>
<tr>
<td>▪ Iloperidone</td>
<td>BCE-01-14, Effective: 11-26-14, Implementation: 11-26-14</td>
</tr>
<tr>
<td>▪ Lurasidone</td>
<td>BCE-01-14, Effective: 11-26-14, Implementation: 11-26-14</td>
</tr>
<tr>
<td>▪ Olanzapine</td>
<td>BCE-01-14, Effective: 11-26-14, Implementation: 11-26-14</td>
</tr>
<tr>
<td>▪ Paliperidone</td>
<td>BCE-01-14, Effective: 11-26-14, Implementation: 11-26-14</td>
</tr>
<tr>
<td>▪ Quetiapine</td>
<td>BCE-01-14, Effective: 11-26-14, Implementation: 11-26-14</td>
</tr>
<tr>
<td>▪ Risperidone</td>
<td>BCE-01-14, Effective: 11-26-14, Implementation: 11-26-14</td>
</tr>
<tr>
<td>▪ Ziprasidone</td>
<td>BCE-01-14, Effective: 11-26-14, Implementation: 11-26-14</td>
</tr>
</tbody>
</table>
§483.10(d)(2) F154, Right to be informed in advance about care and treatment; F155, Right to refuse treatment; and §483.10(d)(3) F280, Right to participate in planning care and treatment.

Antipsychotic medications are only appropriate for elderly residents in a small minority of circumstances (unless the antipsychotic is prescribed to treat previously diagnosed mental illness such as schizophrenia or possibly other conditions listed above).

All antipsychotic medications carry a Food and Drug Administration (FDA) Black Box Warning. Since June 6, 2008, FDA warned healthcare professionals that both conventional and atypical antipsychotics are associated with an increased risk of death in elderly patients treated for dementia-related psychosis. Additional information is available at: http://www.fda.gov/Drugs/default.htm.

(A black box warning means that medical studies indicate that the drug carries a significant risk of serious or even life-threatening adverse effects. It is the strongest warning that the U.S. Food and Drug Administration can require a pharmaceutical company to place on the labeling of a prescription drug, or in the product literature describing it. The intent of 483.25(I) is that each resident's entire medication regimen be managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being.)

Antipsychotic medications may be considered for elderly residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes have been identified and addressed. Antipsychotic medications must be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review.
Inadequate Indications: Antipsychotic medications in persons with dementia should not be used if the only indication is one or more of the following:

- Wandering
- Poor self-care
- Restlessness
- Impaired memory
- Mild anxiety
- Insomnia
- Inattention or indifference to surroundings
- Sadness or crying alone that is not related to depression or other psychiatric disorders
- Fidgeting
- Nervousness
- Uncooperativeness (e.g. refusal of or difficulty receiving care).

Criteria:
All of the above highlight conditions/diagnoses where antipsychotic medications may possibly be appropriate, but diagnoses alone do not warrant the use of an antipsychotic unless the following criteria are also met:

- The behavioral symptoms present a danger to the resident or others

AND one or both of the following:

- The symptoms are identified as being due to mania or psychosis (such as: auditory, visual, or other hallucinations; delusions, paranoia or grandiosity);

OR

- Behavioral interventions have been attempted and included in the plan of care, except in an emergency.

Additional Criteria:
Acute Situations/Emergency
When an antipsychotic medication is being initiated or used to treat an emergency situation (i.e., acute onset or
exacerbation of symptoms or immediate threat to health or safety of resident or others) related to one or more of the aforementioned conditions/diagnoses, the use must meet the above criteria and all of the following additional requirements:

1. The acute treatment period is limited to seven days or less; AND
2. A clinician in conjunction with the interdisciplinary team must evaluate and document the situation within 7 days to identify and address any contributing and underlying causes of the acute condition and verify the continuing need for an antipsychotic medication.
3. If the behaviors persist beyond the emergency situation, pertinent non-pharmacological interventions must be attempted, unless clinically contraindicated, and documented following the resolution of the acute psychiatric event.

**Additional Criteria: Enduring Conditions**

Antipsychotic medications may be used to treat an enduring (i.e., non-acute; chronic or prolonged) condition, if the clinical condition/diagnosis meets the criteria in Section B above.

In addition, before initiating or increasing an antipsychotic medication for enduring conditions, the target behavior/s must be clearly and specifically identified and documented. Monitoring must ensure that the behavioral symptoms are:

1. Not due to a medical condition or problem (e.g., pain, fluid or electrolyte imbalance, infection, obstipation, medication side effect or polypharmacy) that can be expected to improve or resolve as the underlying condition is treated or the offending medication(s) are discontinued;

AND

1. Not due to environmental stressors alone (e.g.,
alteration in the resident’s customary location or daily routine, unfamiliar care provider, hunger or thirst, excessive noise for that individual, inadequate or inappropriate staff response), that can be addressed to improve the symptoms or maintain safety;

**AND**

2. Not due to psychological stressors alone (e.g., loneliness, taunting, abuse), anxiety or fear stemming from misunderstanding related to his or her cognitive impairment (e.g., the mistaken belief that this is not where he/she lives or inability to find his or her clothes or glasses, unaddressed sensory deficits) that can be expected to improve or resolve as the situation is addressed;

**AND**

3. Persistent. In this case, there must be clear documented evidence in the medical record that the situation or condition continues or recurs over time (persists) and that other approaches that have been attempted have failed to adequately address the behavioral/psychological symptoms and that the resident’s quality of life is negatively affected by the behaviors/symptoms as described above.

**New Admissions:**

Many residents are admitted to a SNF/NF already on an antipsychotic medication. The medication may have been started in the hospital or the community, which can make it challenging for the facility and clinical team to identify the indication for use. However, the facility is responsible for:

- Preadmission screening for mentally ill and intellectually disabled individuals, and;
- Obtaining physician’s orders for the resident’s immediate care.
This PASRR screening (F285) should provide pertinent information including appropriate clinical indications for the use of an antipsychotic.

For residents who do not require PASRR screening and are admitted on an antipsychotic medication, the facility must re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks of admission (at the time of the initial MDS assessment) and consider whether or not the medication can be reduced (tapered) or discontinued.

Dosage:

When dosing an antipsychotic, the treatment should be at the lowest possible dose to improve the target symptoms being monitored. It is important to note that doses for acute indications (e.g. delirium or acute psychosis) may differ from those used for long-term treatment of various conditions.

The table below is provided only as a general guide for residents with dementia who have met all of the criteria outlined above. Orders for doses greater than those that appear in the table warrant closer review for adverse effects and risk/benefit evaluation. However, also note that in some cases, residents may require lower doses than those listed on the table. This is an individual, clinical decision based on a number of complex factors. Surveyors are strongly advised to speak with the practitioner/prescriber and/or consultant pharmacist in cases where an antipsychotic medication is prescribed for an elderly resident with dementia.

Daily Dose Thresholds for Antipsychotic Medications Used to Treat Residents with BPSD

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Maximum Total Dosage (mg) per day</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Generation or Typical Agents</strong></td>
<td></td>
</tr>
<tr>
<td>chlorpromazine</td>
<td>75</td>
</tr>
<tr>
<td>fluphenazine</td>
<td>4</td>
</tr>
<tr>
<td>Drug</td>
<td>Dose</td>
</tr>
<tr>
<td>--------------------</td>
<td>------</td>
</tr>
<tr>
<td>haloperidol</td>
<td>2</td>
</tr>
<tr>
<td>loxapine</td>
<td>10</td>
</tr>
<tr>
<td>molindone</td>
<td>10</td>
</tr>
<tr>
<td>perphenazine</td>
<td>8</td>
</tr>
<tr>
<td>thioridazine</td>
<td>75*</td>
</tr>
<tr>
<td>thiothixene</td>
<td>7</td>
</tr>
<tr>
<td>trifluoperazine</td>
<td>8</td>
</tr>
<tr>
<td><strong>Second Generation or Atypical</strong></td>
<td></td>
</tr>
<tr>
<td>aripiprazole</td>
<td>10</td>
</tr>
<tr>
<td>clozapine</td>
<td>50</td>
</tr>
<tr>
<td>olanzapine</td>
<td>5</td>
</tr>
<tr>
<td>quetiapine</td>
<td>150</td>
</tr>
<tr>
<td>risperidone</td>
<td>2</td>
</tr>
<tr>
<td>ziprasidone</td>
<td>**</td>
</tr>
<tr>
<td>paliperidone</td>
<td>**</td>
</tr>
<tr>
<td>asenapine</td>
<td>**</td>
</tr>
<tr>
<td>iloperidone</td>
<td>**</td>
</tr>
<tr>
<td>lurasidone</td>
<td>**</td>
</tr>
</tbody>
</table>

* Due to additional black box warnings of QTC prolongation, its use should be avoided.

** No studies have been conducted or have results available to assess the drug’s safety or efficacy in older adults with dementia.

**Duration:**
Refer to Section V – Tapering of a Medication Dose/Gradual Dose Reduction (GDR) in the guidance.

**Monitoring:**
When monitoring antipsychotics, it is important to not only evaluate ongoing effectiveness and potential adverse consequences, as discussed below, but also to evaluate the use of any other psychopharmacological medications (e.g. mood stabilizers, benzodiazepines) being given to the resident. Specifically, surveyors should review the record to determine whether the facility can explain the rationale for adding, or switching from an antipsychotic to another category (or categories) of
psychopharmacological agents; otherwise, both may potentially be unnecessary medications. Surveyors should investigate further in cases where more than one antipsychotic agent has been prescribed. Surveyors should investigate further in cases where more than one antipsychotic agent has been prescribed, or where an antipsychotic has been discontinued and a medication such as a mood stabilizer has been added.

**Effectiveness:**
After initiating or increasing the dose of an antipsychotic medication, the behavioral symptoms must be reevaluated periodically (at least during quarterly care plan review, but often more frequently, depending on the resident’s response to the medication) to determine the effectiveness of the antipsychotic and the potential for reducing or discontinuing the dose based on target symptoms and any adverse effects or functional impairment.

**Potential Adverse Consequences:**
The facility assures that residents are being adequately monitored for adverse consequences such as:

- **General:** anticholinergic effects (see Table II), falls, excessive sedation
- **Cardiovascular:** cardiac arrhythmias, orthostatic hypotension
- **Metabolic:** increase in total cholesterol and triglycerides, unstable or poorly controlled blood sugar, weight gain
- **Neurologic:** akathisia, neuroleptic malignant syndrome (NMS), parkinsonism, tardive dyskinesia, cerebrovascular event (e.g., stroke, transient ischemic attack (TIA)) in individuals with dementia

If the antipsychotic medication is identified as probably causing or contributing to adverse consequences as identified above, the facility must act upon this. In some cases, the benefits of treatment will still be considered to outweigh the risks or burdens of treatment, so the medication may be continued; however, the facility and
prescriber must document the rationale for the decision and also that the resident, family member or legal representative is aware of and involved in the decision to continue the medication.

IV. DEFICIENCY CATEGORIZATION (Part IV, Appendix P)
Once the team has completed its investigation, analyzed the data, reviewed the regulatory requirement, and identified any deficient practice(s) that demonstrate that noncompliance with the regulation at F329 exists, the team must determine the severity of each deficiency, based on the resultant harm or potential for harm to the resident.

The key elements for severity determination for F329 are as follows:

1. Presence of potential or actual harm/negative outcome(s) due to a failure related to unnecessary medications.
Examples of actual or potential harm/negative outcomes for F329 may include, but are not limited to:
   - Potential for life-threatening toxicity from excessive dose or lack of indication for the use of digoxin.
   - Complications (such as diarrhea with life threatening fluid loss, nephrotoxicity, hearing loss, or anaphylactic shock) from use of an antibiotic when no clear indication for use has been established or response to the use has not been monitored.
   - Fractures or falls with injury resulting from the continuing use of medications (e.g., hypnotics/sedatives, antipsychotics, antidepressants, antihypertensives) in the presence of predisposing risks or adverse consequences such as persistent dizziness or recurrent falling without intervening or reevaluating the need for and dose of the medication believed to be the cause of the gait instability.

2. Degree of potential or actual harm/negative outcome(s) due to a failure related to unnecessary medications.
Identify how the facility practices caused, resulted in, allowed, or contributed to the actual or potential for harm:
   - If harm has occurred, determine if the harm is at the level of serious injury, impairment, death, compromise, or discomfort; or
   - If harm has not yet occurred, determine how likely is the potential for serious injury, impairment, death, compromise, or discomfort to occur to the resident.

3. The immediacy of correction required.
Determine whether the noncompliance requires immediate correction in order to prevent serious injury, harm, impairment, or death to one or more residents. The survey team must evaluate the harm or potential for harm based upon the following levels of severity for tag F329. First, the team must rule out whether Severity Level 4, Immediate Jeopardy to a resident’s health or safety, exists by evaluating the deficient practice in relation to immediacy, culpability, and severity. (Follow the guidance in Appendix Q.)

**NOTE:** The death or transfer of a resident who was harmed or injured as a result of facility noncompliance does not remove a finding of immediate jeopardy. The facility is required to implement specific actions to remove the jeopardy and correct the noncompliance which allowed or caused the immediate jeopardy.

**Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety**

Immediate Jeopardy is a situation in which the facility’s noncompliance with one or more requirements of participation:

- Has allowed, caused, or resulted in, or is likely to allow, cause, or result in serious injury, harm, impairment, or death to a resident; and
- Requires immediate correction, as the facility either created the situation or allowed the situation to continue by failing to implement preventative or corrective measures.

Examples may include, but are not limited to:

- Failure to assess or respond appropriately for a resident taking warfarin who had an elevated INR of 9 or greater with or without bleeding, or the elevated INR persisted without assessment/follow-up.
- Failure to monitor PT/INR for a resident on anticoagulant therapy in accordance with current standards of practice and to recognize and/or respond to a life threatening adverse consequence related to anticoagulation.
- Failure to recognize developing serotonin syndrome (e.g., confusion, motor restlessness, tremor) in a resident receiving a SSRI, leading to the addition of medications with additive serotonin effect or medication to suppress the symptoms. Failure to recognize and respond to signs and symptoms of neuroleptic malignant syndrome (NMS).
- In the presence of gastrointestinal bleeding, the failure to recognize medication therapies (such as NSAIDs or COX-2 inhibitors, bisphosphonates) as potentially causing or contributing to the gastrointestinal bleed, resulting in the continued administration of the medication, until the resident required hospitalization for severe bleeding.
NOTE: If immediate jeopardy has been ruled out based upon the evidence, then evaluate whether actual harm that is not immediate jeopardy exists at Severity Level 3.

Severity Level 3 Considerations: Actual Harm that is Not Immediate Jeopardy
Level 3 indicates noncompliance that resulted in actual harm, and may include, but is not limited to, clinical compromise, decline, or the resident’s inability to maintain and/or reach his/her highest practicable well-being. Examples may include, but are not limited to:

- Facility failure to take appropriate action (e.g., suspending administration of the anticoagulant) in response to an INR greater than 4 and less than 9 for a resident who is receiving warfarin until spontaneous bruising or frank bleeding occurs, resulting in the need to transfuse or hospitalize the resident.
- Facility failure to evaluate the medication regimen as a potential cause of seizure activity resulting in the addition of anticonvulsants to treat recent-onset seizures that can be adverse consequences of medications.
- Facility failure to implement a GDR that was not contraindicated in a resident receiving prolonged, continuous antipsychotic therapy resulting in functional decline, somnolence, lethargy, tremors, increased falling, or impaired ambulation.

NOTE: If Severity Level 3 (actual harm that is not immediate jeopardy) has been ruled out based upon the evidence, then evaluate as to whether Severity Level 2 (no actual harm with the potential for more than minimal harm) exists.

Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy
Level 2 indicates noncompliance that resulted in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident’s ability to maintain or reach his or her highest practicable level of well-being. The potential exists for greater harm to occur if interventions are not provided. Examples may include, but are not limited to:

- Facility failure to take appropriate action (e.g., change or suspend administration of the warfarin dose) for a resident who has an INR greater than 4 and less than 9 without any bleeding.
- Failure to monitor INR for a resident who has been stabilized on warfarin, but who has not had bleeding.
- Facility failure to identify and act upon minor symptoms of allergic response to medications, such as a rash.
- Facility failure to monitor for response to therapy or for the emergence or presence of adverse consequences before the resident has experienced an adverse consequence or decline in function (e.g., monitoring periodically for symptoms of
behavioral distress in someone receiving psychopharmacological medication; monitoring thyroid function at least annually in an individual receiving thyroid hormone replacement; and monitoring hydration status and basic metabolic profile for a resident receiving diuretics or ACE inhibitors, who had a change in mental status after the onset of diarrhea).

Severity Level 1: No Actual Harm with Potential for Minimal Harm

The failure of the facility to provide appropriate care and services to manage the resident’s medication regimen to avoid unnecessary medications and minimize negative outcome places residents at risk for more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

F329 - Additional Example under Investigative Protocol

The following example illustrates the differences between compliance, and non-compliance at severity levels 4, 3 and 2 related to the use of antipsychotic medication when circumstances and outcomes change:

F329 – Compliance Example

An 89 year old male was re-admitted to the nursing home from the hospital. Upon readmission, diagnoses included pneumonia, CHF, and dementia with moderate cognitive decline and delirium with psychotic features. The history from the hospital indicated the resident was treated with antibiotics, fluid replacement, and was placed on an antipsychotic due to the sudden development, one day after admission, of delirium with psychotic features. The resident had a change in cognition, disorientation and was less alert for prolonged periods and had attempted to remove the IV fluids and crawl out of bed. After the resident’s infection stabilized, he was discharged back to the nursing home.

Upon readmission to the nursing home, the nurse practitioner contacted the hospitalist by telephone to review the case. They agreed that if the resident did not exhibit signs/symptoms of acute delirium over the next week, it would be reasonable to taper and discontinue the antipsychotic medication. The nurse practitioner communicated this information to the nursing staff and consultant pharmacist – the nursing staff included this information in the plan of care.

After a week, no target behaviors were observed. The medication was tapered and discontinued, with ongoing monitoring in place for the potential recurrence of symptoms. The facility has met the criteria for compliance.

F329 - Level 4 Severity Non-compliance Example

An 89 year old male was re-admitted to the nursing home from the hospital. Admitting
diagnoses included pneumonia, CHF, and dementia with moderate cognitive decline and delirium with psychotic features. The history from the hospital indicated the resident was treated with antibiotics, fluid replacement, and was placed on an antipsychotic due to the sudden development, one day after admission, of delirium with psychotic features. The resident had a change in cognition, disorientation and was less alert for prolonged periods and had attempted to remove the IV fluids and crawl out of bed. After the resident’s infection stabilized, he was discharged back to the nursing home.

Approximately 4 months after nursing home readmission, the resident was still receiving the antipsychotic medication. Staff was monitoring for the identified target behaviors; however, documentation revealed that the resident had not exhibited any of the target behaviors for over 3 months. The facility failed to evaluate and/or consider gradual dose reductions, and had not attempted alternative approaches in an effort to discontinue the medication. The consultant pharmacist had recommended gradual dose reductions, but the physician had indicated that the medication was to be continued.

The record indicated that the resident was exhibiting orthostatic hypotension and was at high risk for falling. In addition, he was no longer attending group activities as he was sleeping off and on throughout the day. Staff had identified that the resident, who had been ambulatory with one staff person at admission, was no longer ambulating, was weaker and was in a recliner in his room during the day and evening. The resident had several areas on his hips and coccyx which were identified as Stage III pressure ulcers; he was losing weight due to decreased appetite and was drinking insufficient amounts of fluids.

When interviewed, staff stated that they believed the resident’s decline was related to his dementia. They had not considered reducing or discontinuing the medication and failed to recognize that the medication had been initially ordered for delirium in the hospital, a condition that could potentially be time-limited and in many cases resolves completely.

The facility failed to evaluate for the ongoing indication of use of the antipsychotic after symptoms were no longer present, had not monitored for the presence of adverse consequences, had not attempted gradual dose reductions nor implemented any behavioral interventions. The facility staff had not contacted the medical director to evaluate the resident’s response and consider discussing the case with the attending physician. Following additional investigation, it was determined that the quality assessment and assurance (QAA) committee did not conduct any oversight or monitoring of residents who were receiving antipsychotics to assure that there were appropriate clinical indications for use and that behavioral interventions and gradual dose reductions were attempted.
**Why is this Immediate Jeopardy?**

This resident is now so compromised (he has developed pressure ulcers, has reduced food and fluid intake, is experiencing blood pressure fluctuations and is at risk for falls) that immediate action is required to prevent a serious illness or injury. While immediate jeopardy may exist when only one resident is affected, in this case the lack of systems and processes for review of psychopharmacological medications in residents with dementia indicates that other residents on these medications could potentially be at risk for serious harm as well.

**F329 - Level 3 Severity Non-compliance Example**

An 89 year old male was re-admitted to the nursing home from the hospital. Admitting diagnoses included pneumonia, heart failure, dementia with moderate cognitive decline and delirium with psychotic features. The history from the hospital indicated the resident was treated with antibiotics, fluid replacement, and was placed on an antipsychotic due to the sudden development, one day after admission, of delirium with psychotic features. The resident had a change in cognition, disorientation and was less alert for prolonged periods and had attempted to remove the IV fluids and crawl out of bed. After the resident’s infection stabilized, he was discharged back to the nursing home.

Approximately 3 months after nursing home readmission, the resident was still receiving the antipsychotic medication. The record indicated that the resident was now having difficulty with mobility and was more dependent on staff for ADLs such as bed mobility and transfers. Staff had identified that the resident was in a recliner in his room during the day and evening and was drowsy more often throughout the day. Staff documented that the resident had a small stage II pressure ulcer.

Staff was monitoring the identified target behaviors and documentation revealed the resident had not exhibited the target behaviors for the past 3 months. However, the facility failed to evaluate and/or consider gradual dose reductions, and had not attempted behavioral interventions in an effort to discontinue the medication. Staff failed to recognize that the medication had initially been ordered for delirium in the hospital, a condition that could potentially be time-limited and in many cases resolves completely.

**Why is this level 3 Severity?**

The staff had not identified/evaluated the causal factors for the ongoing use of the medication, nor the potential that the medication could have been contributing to the resident’s decline in ADLs, alertness and skin condition. Staff failed to recognize that the medication had initially been ordered for delirium in the hospital, a condition that could potentially be time-limited and in many cases resolves completely. The facility failed to consider a gradual dose reduction. The resident had actual harm (ADL decline, stage II
pressure ulcer) that could have been related to the medication. However, this is not a level 4 severity because the requirement for immediacy is not met.

**Level 2 Severity**
An 89 year old male was re-admitted to the nursing home sub-acute unit from the hospital. Admitting diagnoses included pneumonia, heart failure, dementia with moderate cognitive decline and delirium with psychotic features. The history from the hospital indicated the resident was treated with antibiotics, fluid replacement, and was placed on an antipsychotic due to the sudden development, one day after admission, of delirium with psychotic features. The resident had a change in cognition, disorientation and was less alert for prolonged periods and had attempted to remove the IV fluids and crawl out of bed. After the resident’s infection stabilized, he was discharged back to the nursing home.

Approximately 3 months after admission, the resident was still receiving the antipsychotic medication and staff was monitoring for target behaviors and for the presence of adverse consequences. The record revealed that the resident had not had any adverse consequences and was no longer exhibiting the target behaviors. However, the facility failed to evaluate and/or consider gradual dose reductions, and had not attempted behavioral interventions in an effort to discontinue the medication. Staff failed to recognize that the medication had been initially ordered for delirium in the hospital, a condition that could potentially be time-limited and in many cases resolves completely.

**Why is this level 2 Severity?**
While the resident is at risk for potential for more than minimal harm from ongoing use of an antipsychotic medication without a clear clinical indication, the staff did not document any actual harm.

This is only one example. Specific evidence may differ in actual situations and surveyors should evaluate each situation individually as no one example applies to every situation.