STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING _____ B. WING _____	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of an onsite complaint investigation survey of 10/17/16 through 10/20/16. Event ID #U7ZJ11.	F 000		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review the facility failed to provide advance notice of a roommate change for 1 of 1 residents (Resident #73) reviewed for admission, transfer, and discharge. The findings included: Resident #73 was admitted to the facility on 7/13/16. The admission Minimum Data Set assessment dated 7/20/16 indicated he had moderate cognitive impairment. An interview with Resident #73 was conducted on 10/17/16 at 11:47 AM. Resident #73 indicated he had a new roommate moved into his room with no notification provided in advance. A record review was conducted for Resident #73. A Social Work (SW) progress note dated 8/10/16 indicated a roommate was moved into Resident #73's room without advance notice. The note reported that as the new roommate was being moved into Resident #73's room, Resident #73 became upset and refused to enter the room. Resident #73 stated he was not informed prior to	F 247	Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. F247 1.) Resident #73 transferred to a private room on 10/21/16. The move was discussed with the resident on 10/21/16 by the Social Worker and documented in the progress notes. The Responsible Party was also notified of the room change on 10/21/16 by the Social Worker and documented in the progress notes. 2.) The Social Worker received an in-service by the Director of Nursing on 10/20/16 to notify residents and Responsible Parties for a planned room change and notify the resident in the room	11/15/16

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

Electronically Signed | 11/11/2016

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F 247	Continued From page 1 the move. The note indicated that the SW and the Marketing Director attempted to explain to Resident #73 the reasons for the change, but Resident #73 continued to be upset. The note additionally reported a family member of Resident #73 was then called with a detailed explanation left on their voicemail. A grievance form dated 8/10/16 was filed by Resident #73. The grievance indicated Resident #73 reported he had not liked the roommate change. The form reported Resident #73 refused to stay in the room with the roommate. A private room was available and Resident #73 was agreeable to moving to a private room. An interview was conducted with the SW on 10/19/16 at 2:00 PM. She reviewed the procedure for room changes and roommate changes. She indicated the procedure included informing the resident and responsible party in advance of the change. The SW note dated 8/10/16 for Resident #73 was reviewed with the SW. She confirmed Resident #73 was not provided advance notification for the 8/10/16 roommate change. She revealed this was an oversight. The SW explained that Resident #73 was initially admitted on 7/13/16 to a semi-private room that he shared with Resident #91, his spouse. She reported Resident #91 passed away on 8/8/16 and Resident #73 remained in the semi-private room alone. She indicated she and the Marketing Director were both out of the facility on 8/10/16 at the time of the move and the other staff had failed to provide advance notification to Resident #73 of the addition of a new roommate to his room. The SW confirmed Resident #73 was upset and had not wanted to remain in the semi-private room with the new roommate. She	F 247	that they will be receiving a new roommate. Room changes will be monitored for all residents moving forward from 10/20/16. The Admissions Coordinator received the in-service on 11/8/16 by the Director of Nursing as back up to the Social Worker in her absence. On weekends, it will be the responsibility of the Charge Nurse on the hall for notification of room changes. Follow-up will be done by a member of administrative nursing to be sure notification took place. Any new Social Worker or Admissions Coordinator will receive the education during orientation. 3.) Utilizing a Room Change Quality Indicator Audit Tool for Residents, the Director of Nursing will review progress notes to assure residents or the Responsible Party were notified of room change and the resident in the room was also notified of receiving a new roommate. Monitoring will occur 5 times weekly x 2 weeks, then 2 times weekly, then weekly x 4 weeks, and monthly x 1 month. The Administrator will review and initial the results of the monitoring for trends and concerns. 4.) The Administrator will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	

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F 247	Continued From page 2 indicated Resident #73 was then moved to a private room. An interview was conducted with the Director of Nursing on 10/19/16 at 3:50 PM. She indicated her expectation was for advance notification to be provided for a roommate and/or room change.	F 247		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to implement non-pharmacological interventions (interventions that do not involve medications) to address a resident's grief reaction (Resident #73), demonstrated by a noted increase in depression, crying outbursts, refusals of treatment, agitation, and combative episodes following the death of his wife (Resident #91) for 1 of 1 residents reviewed for medically related social services. The findings included: Resident #73 was admitted to the facility on 7/13/16 with multiple diagnoses that included depression. The admission Minimum Data Set assessment dated 7/20/16 indicated he had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of an 11. The plan of care for Resident #73, dated 7/26/16,	F 250	Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. F250 1.) Resident #73 was interviewed and assessed by the Social Worker on 10/20/16 for signs and/or symptoms of depression with none present. The Social Worker documented the assessment in the progress notes. Resident #73 was seen and re-evaluated by the Social Worker again on 10/24/16, 10/31/16, and	11/15/16

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F 250	Continued From page 3 included the need for monitoring for evidence of depressive mood while on antidepressant medication. On 8/7/16 the plan of care related to depressive mood and antidepressants was updated and indicated Resident #73's wife passed away increasing the potential for depressive mood. There were no interventions added to this plan of care to address the increased potential for Resident #73's depressive mood. A review of Resident #73's medical record revealed he was initially admitted to a semi-private room that was shared with his wife, Resident #91. Resident #91 passed away on 8/8/16. A Social Work (SW) note dated 8/11/16 indicated a BIMS was conducted yesterday (8/10/16) and Resident #73 had difficulty with the interview scoring a 5, which indicated he had significant cognitive impairment. This revealed a decrease in mental status as Resident #73's previous BIMS score from the 7/20/16 MDS was an 11, which was indicative of only a moderate impairment in cognition. The SW note also indicated Resident #73 reported feeling down due to the recent death of his wife. The SW documented, "We talked about him and his wife for a bit. He stated ...he will miss her tremendously." The SW reported she would continue to monitor for signs and symptoms of depression and grief and would provide resources as appropriate. A review of the Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST) notes for August 2016 revealed Resident #73 had multiple refusals of treatment, noted lethargy,	F 250	11/4/16. The resident will be visited regularly by Clergy, continues to receive services of physical and occupational therapy without refusal, and will receive regular visits by the facility psychiatric services to assure the resident is managing any grief. The resident has been visited weekly by the Social Worker to identify any signs and/or symptoms of grief and is scheduled to meet his son for lunch and visit the cemetery. The resident is invited and assisted to attend activities of choice and the Activity Director completed a new activity interest assessment on 11/8/16 to identify any new interests. The resident has received no prn doses of Ativan since 10/19/16. 2.) A 100% audit was completed by the Social Worker on 10/21/16 to identify any residents with the potential to be affected by grief over the loss of an immediate family member in the past 6 months. No residents were identified. The Social Worker received an in-service by the Director of Nursing on 10/20/16 to address the grieving process for any resident with the loss of an immediate family member. A letter was sent to all Responsible Parties on 11/11/16 to request notification to the facility Administration Staff for any immediate family member losses to assure the facility will assist with the grieving process for the resident. The request will also be presented on each new admission to the facility. Any new Social Workers will receive the in-service during orientation. The facility has a contract with On-Site Care for mental health services with a	

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F 250	Continued From page 4 crying outbursts, episodes agitation, and an increase in confusion. A review of the nursing notes for August 2016 revealed Resident #73 was tearful at times on 8/9/16, 8/10/16, 8/14/16, 8/15/16, and 8/31/16. A Nurse Practitioner (NP) note dated 8/22/16 indicated Resident #73 had slow reactions, a depressed demeanor, and had been very quiet since the death of his wife 2-3 weeks ago. The NP's plan included an increase in Resident #73's Remeron (antidepressant) for his depressed demeanor and sleep. A PT note dated 8/31/16 indicated Resident #73 required frequent rest breaks due to crying outbursts. The note also indicated Resident #73 stated, "...he didn't feel like living anymore and wanted to stop all therapy." An NP note dated 8/31/16 indicated staff had reported Resident #73's episodes of crying and the suspicion it was a grief reaction due to his wife's death. Resident #73 had reported some difficulty sleeping and had been noted to refuse therapy last week. Additionally, Resident #73 was noted to be tearful and sobbing. A diagnosis of "Grief Reaction" was indicated on the NP's note and the plan included a tapering and discontinuation of Remeron and the addition of Zoloft (antidepressant) 50 milligrams (mg) daily for mood and behavior and Ativan (antianxiety) 0.5mg twice daily for 3 days and then as needed (PRN). On 8/31/16 Resident #73's plan of care related to depressive mood and antidepressants was updated and indicated the additional interventions	F 250	start date of 11/14/2016. 3.) Utilizing a Grief Quality Indicator Audit Tool, the Social Worker will monitor any resident, to include Resident #73, identified as having lost a family member for signs and/or symptoms of grief and any new interventions as needed. Monitoring will occur weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 1 month. The Administrator will review and initial the audits weekly x 4, then every 2 weeks x 4 weeks, then monthly x 1 month for trends and concerns. 4.) The Administrator will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	

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of monitoring for evidence of anxiety/restlessness, the administration of Zoloft as ordered for depression, and the administration of Ativan as ordered.

A SW note dated 9/1/16 indicated she had reviewed Resident #73's chart and noted he had stated, "...he did not feel like living anymore and wants to stop all therapy." The note indicated the statement was made by Resident #73 on 8/31/16. Resident #73 was noted to have no plan in place for his suicidal ideations. The note additionally indicated the SW contacted the NP who instructed the nursing staff to do frequent checks on Resident #73. The SW documented an interview she had with Resident #73 on 9/1/16. During the interview, " [Resident #73] mentioned still being upset about his wife's death." The SW note indicated Resident #73 had no signs or symptoms of depression during the interview and she was going to continue to monitor for changes and make appropriate referrals as necessary.

A review of the OT, PT, and ST notes for September 2016 revealed Resident #73 continued to have multiple refusals of treatment, noted lethargy, crying outbursts, episodes of agitation, and an increase in confusion.

Nursing notes dated 9/3/16 through 9/5/16 indicated Resident #73 had episodes of increased agitation and confusion. On 9/3/16 Resident #73 was indicated to have had episodes of increased agitation in intervals, he was removing his clothing, and was yelling at staff. On 9/4/16 Resident #73 was indicated to have had confusion and physically and verbally abusive behaviors toward staff. The nurse indicated multiple attempts were made to reorient and

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redirect Resident #73 without success. On 9/5/16 Resident #73 was indicated to have continued agitation and confusion.

A physician note dated 9/6/16 indicated Resident #73 had recently lost his wife and because of his depression he had been started on Zoloft and Ativan. The physician indicated his plan to treat Resident #73's grief reaction was to continue his current medications as well as the provision of symptomatic support.

OT and ST notes dated 9/7/16 and 9/8/16 indicated the therapists had spoken with staff regarding Resident #73's change in condition. An OT note dated 9/7/16 indicated the Occupational Therapist discussed concerns with nursing staff and the SW regarding Resident #73's depressive behaviors and his decreased therapy participation. The RN had informed the Occupational Therapist that Resident #73 was on an antidepressant and his report was going to be shared with the physician. An ST noted dated 9/8/16 indicated the Speech Therapist spoke with nursing staff regarding Resident #73's current condition, which included lethargy and a notable decline. The nurse on duty had reported to the Speech Therapist that she was aware of his condition.

A SW note dated 9/9/16 indicated Resident #73 had been very sad and has had behaviors. Resident #73 was noted to continue to grieve his wife's death. Resident #73 reported to SW he had little pleasure in doing things, was feeling down, and was feeling tired. The SW indicated Resident #73 mentioned he missed his wife and he had smiled when talking about her.

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A SW note dated 9/12/16 indicated she spoke with Resident #73 and he reported he wasn't having a good day. The note indicated Resident #73 became tearful and he had reported he was missing his wife and was very sad that she passed away. The SW reported she spoke with Resident #73 for "about 10 minutes." Resident #73 was indicated to have been smiling at the end of the conversation with the SW.

A SW note dated 9/15/16 indicated Resident #73 reported feeling down or depressed. The note indicated, "[Resident #73] once again stated missing his wife and having a bad day." The SW reported she spoke with Resident #73 "for a few minutes" about his wife and he was then in a better mood.

A SW note dated 9/23/16 indicated Resident #73 reported he was feeling down or depressed, he had little interest in doing things, and he was feeling tired. The SW indicated, "[Resident #73's] mood fluctuates but mainly, his bad days are attributed to missing his wife." The note additionally indicated that Resident #73 appeared to love to talk about his wife during each SW assessment.

A review of the nursing notes for September 2016 indicated Resident #73 was combative at times on 9/7/16, 9/17/16, 9/18/16, 9/19/16, 9/26/16, 9/28/16, and 9/29/16.

A SW note dated 10/4/16 indicated Resident #73 reported he had little interest or pleasure in doing things, he was feeling down, and he was feeling bad about himself. The note indicated, "[Resident #73] still mentions missing his wife. He has good days and bad days."

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A review of the nursing notes dated 10/5/16, 10/7/16, 10/10/16, 10/11/16, 10/15/16, and 10/16/16 indicated Resident #73 was combative at times.

An interview was conducted with the SW on 10/19/16 at 2:00 PM. She indicated she was familiar with Resident #73. The plan of care for Resident #73 related to the increased potential for depressive mood due to the death of his wife was reviewed with the SW. The interventions that were implemented following the death of Resident #73's wife were reviewed with the SW. The SW reported Resident #73 had been care planned for the monitoring of his depressive behaviors. She stated the monitoring revealed behavioral changes for Resident #73. She indicated Resident #73's behavioral changes included crying episodes, increased depression, increased confusion, and refusals of therapy. The SW reported Resident #73's antidepressant medication was adjusted by the physician and he was also ordered an antianxiety medication as needed to assist with the noted behavioral changes. When the SW was asked what non-pharmacological interventions were implemented to address Resident #73's behavioral changes following the death of his wife she revealed no additional non-pharmacological interventions were implemented.

The SW interview continued. She indicated she had met with Resident #73 on several occasions as required by her scheduled SW assessments. She reported the SW assessments included the BIMS and the mood interview. She indicated that during her interviews she provided Resident #73 some time to talk about his wife. The SW

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reported Resident #73 seemed to enjoy talking about his wife and his mood appeared to improve when he was able to talk about her. The SW note for Resident #73 dated 8/11/16 that indicated she would provide resources as appropriate for signs and symptoms of grief as well the 9/1/16 note that indicated she would monitor for changes and make appropriate referrals as necessary were addressed with the SW. The SW revealed she had not provided additional resources to Resident #73 nor had she referred him to any additional services to address the behavioral changes that occurred following the death of his wife.

An interview was conducted with Nurse #1 on 10/19/16 at 2:30 PM. Nurse #1 reported she worked with Resident #73. She stated Resident #73 was upset after the death of his wife. She indicated Resident #73 had isolated himself in his room on some days by refusing to come out of his room. Nurse #1 stated he also had crying spells and she had tried to console him by letting him talk about his wife. She reported there were days she was able to talk to Resident #73 and he was receptive and smiled, and there were other days he had not wanted to do anything. Nurse #1 indicated she thought social services had gotten involved to assist Resident #73 with the grieving process, but she wasn't sure about any details of the social service involvement.

An interview was conducted with Physical Therapist (PT) #1 on 10/19/16 at 2:45 PM. PT #1 reported she worked with Resident #73. She revealed Resident #73 went through a period of depression when had refused PT treatment on multiple occasions. She stated he had crying spells and they seemed to be when he was

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remembering things about his wife. She reported she had provided Resident #73 education about the importance of PT and why he needed to participate. PT #1 indicated there were days when the education worked and Resident #73 had become agreeable to PT treatment, and there were other days he continued to refuse.

An interview was conducted with the Director of Nursing (DON) on 10/19/16 at 3:50 PM. The DON stated she was familiar with Resident #73 and she had also been familiar with his wife, Resident #91. She indicated after the death of Resident #73's wife he was started on a new antidepressant as well as an antianxiety medication as needed to assist with the grieving process. She stated she was unsure what other non-pharmacological interventions were put into place for Resident #73 to address his grief reaction. The DON indicated she was going look into it for more information.

An interview was conducted with Occupational Therapist (OT) #1 on 10/20/16 at 8:42 AM. OT #1 reported he worked with Resident #73. He stated that when Resident #73 was admitted to the facility he had shared a room with his wife. He indicated that after Resident #73's wife passed away he seemed depressed. OT #1 indicated there were multiple occasions Resident #73 had refused to get out of bed, he participated only minimally in OT treatment, and even when he had participated he was not able to complete the same level of tasks as he had previously been able to complete. He stated Resident #73 had random periods of crying. OT #1 indicated he had tried to distract and redirect Resident #73 when he had these crying spells and sometimes this had worked, but other times it had not

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F 250	Continued From page 11 worked. He additionally indicated Resident #73's concentration and cognition seemed to be affected as well. He stated Resident #73 was not able to answer questions or follow directions as he had been able to do previously. OT #1 indicated he had thought the changes with Resident #73 were signs of grief. He revealed he had discussed his concerns with nursing staff and the SW regarding Resident #73's depressive behaviors and his decreased therapy participation. OT #1 indicated staff had informed him Resident #73 was on an antidepressant. A follow up interview was conducted with the DON on 10/20/16 at 9:00 AM. The DON indicated the interventions for Resident #73 included adjusting his medications. She revealed she was unaware of any non-pharmacological interventions that were implemented to address Resident #73's grief reaction.	F 250		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clean wheelchairs on four of four halls. The findings included: On 10/17/2016 at 11:57AM, an observation of Resident #14's wheelchair revealed the wheelchair had dust and debris on the frame, wheels, and spokes of the wheelchair.	F 253	Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State	11/11/16

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F 253	Continued From page 12 On 10/17/16 at 4:17PM, an observation of Resident #67 ' s wheelchair revealed the frame of the wheelchair was dusty and dirt was noted on the frame of the wheelchair. On 10/17/16 at 2:59PM, an observation of Resident #10 ' s electric wheelchair revealed the frame of the wheelchair was dirty with food particles and was dusty. On 10/18/16 at 3:00PM, an observation of Resident #10 " s electric wheelchair revealed the frame of the wheelchair remained dirty with food particles and was dusty. On 10/19/16 at 8:45AM, an observation of the wheelchairs was conducted and revealed the following: Room 2A--wheelchair frame dusty and dirt noted on frame. Room 4B--wheelchair had dust and dirt on frame. Room 7B--wheelchair had dirt and food particles noted on the wheels/ frame of the chair. Room 14B (Resident #10)--electric wheelchair had dust and dirt on the frame on the chair. Room 20B--dust and dirt noted on the wheels and frame of the wheelchair. Room 25A (Resident #14)--dust and dirt noted on the frame of the wheelchair. Room 25B (Resident #67)--dust noted on the frame of the wheelchair. Room 26-- dirt and dust noted on the frame of the wheelchair. Room 28--dust and dirt noted on the frame of the wheelchair. Room 37--dust and dirt noted on the frame of the wheelchair and the right brake on the wheelchair did not lock.	F 253	and Federal law. F253 1.) Wheelchairs for Residents #14 and #67 were power washed by Housekeeping on 10/21/16; Resident # 10□s motorized wheelchair was cleaned by Housekeeping on 10/21/16; wheelchairs for Room 2A, 4B, 7B, 20B, 25A, 25B, 26, 28, 37, 41, 42, 44B, 47, and 55 were power washed by Housekeeping along with all remaining wheelchairs in the facility by 10/25/16. All remaining motorized wheel chairs were also cleaned by Housekeeping staff by 10/25/16. 2.) The second shift and night shift nursing staff received an in-service from housekeeping on cleaning wheel chairs. The in-service was completed on 11/10/2016. The second and third shift nursing staff will clean standard wheelchairs and Broda chairs weekly ongoing. Housekeeping will clean Geri-chairs and motorized wheel chairs weekly ongoing. Housekeeping will power wash all chairs as needed. 3.) Utilizing a Wheelchair and Broda Chair Cleaning Schedule Audit Tool, the Unit Managers review each morning Monday through Friday to assure wheel chairs and Broda chairs have been cleaned as scheduled and verify cleanliness of 3 random chairs. Housekeeping will utilized a Geri-Chair and Motorized wheel chair Audit tool for weekly cleaning of those chairs. The Unit Managers will review the Geri-Chair and Motorized wheel chair audits once weekly to assure those chairs have been cleaned	

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F 253	Continued From page 13 Room 41--dust and dirt noted on the frame of the wheelchair. Room 42--dust and dirt noted on the frame of the wheelchair. Room 44B--dust and dirt noted on the frame of the wheelchair. Room 47 dust and dirt noted on the frame of the wheelchair. Room 55--dust and dirt noted on the frame of the wheelchair. On 10/19/16 at 10:30AM, an interview was conducted with the Director of Nursing. The Director of Nursing observed several of the wheelchairs. Many of the residents who had dirty and dusty wheelchairs were in an activity and were not disturbed during the activity. She stated there was a cleaning schedule for washing the wheelchairs. The chairs were washed in the shower room by the night shift Monday through Friday. All of the chairs should be washed every week. The Director of Nursing stated she expected the staff to clean the wheelchairs per the schedule and as needed if the wheelchairs had visible food/ dirt on them.	F 253	and verify cleanliness of 2 random chairs weekly. Monitoring will occur Monday through Friday x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1. The Administrator will review and initial the audit tools weekly x 8 weeks, then monthly x 1 for trends and concerns. 4.) The Administrator will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		11/15/16

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F 278	Continued From page 14 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately on prognosis for 1 (Resident #92) of 1 sampled resident receiving hospice care. Finding included: Resident #92 was admitted to the facility on 5/15/15 with multiple diagnoses including Congestive Heart Failure. The quarterly MDS assessment dated 8/29/16 indicated that Resident #92's cognition was intact and she was receiving hospice care while at the facility. The assessment further indicated under the prognosis that Resident #92 had no condition or chronic disease that may result in a life expectancy of less than 6 months. The hospice notes were reviewed and the notes	F 278	Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. F278 1.) The Minimum Data Set of 8/29/16 for Resident #92 was modified by the MDS Nurse on 10/19/16 to reflect the change of the prognosis question to yes. The modification was transmitted to the State Agency on 10/19/16. 2.) The Director of Nursing provided an in-service to the MDS Nurse on 10/20/16	

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F 278	Continued From page 15 indicated that Resident #92 was receiving hospice care since 2/23/16. On 10/19/16 at 1:55 PM, the MDS Nurse was interviewed. She stated that she did not know that if the resident was receiving hospice care, the prognosis should be checked " yes " under life expectancy of less than 6 months. On 10/19/16 at 3:55 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS to be accurate.	F 278	from the R.A. I. Resident Assessment Instrument Version 3.0 Manuel Section J1400 for prognosis coding. A 100% audit for all residents receiving Hospice services was completed by the Director of Nursing on 10/19/16 to identify any residents that may have been affected by the same coding. One other resident was identified and the MDS was made aware for correction. The MDS Nurse corrected the MDS assessment and the modification was transmitted to the State Agency on 10/19/16. Any newly hired MDS nurses will receive the education during orientation. 3.) Utilizing a MDS Hospice/Prognosis Quality Indicator Audit Tool, the ADON will review all physicians orders for new orders for Hospice services to assure the resident s MDS was properly coded correctly for the prognosis question. Monitoring will occur weekly x 4 weeks, then twice monthly x 1 month, then monthly x 1. The Director of Nursing will review the Quality indicator Audit Tool weekly x 4 weeks, then twice monthly x 1 month, then monthly x 1 for trends and concerns. 4.) The Director of Nursing will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		11/15/16

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F 280	Continued From page 16 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to revise the care plan to reflect the diet order of pureed diet as noted on August physician ' s orders for one of three residents reviewed for nutrition (Resident #34). The findings included: Resident #34 was admitted to the facility 6/23/05. Cumulative diagnoses included dysphagia. An Annual Minimum Data Set (MDS) dated 10/7/16 indicated Resident #34 had short term and long term memory impairment and was severely impaired in decision-making skills. Resident #34 required extensive assistance with eating. Her weight was noted at 94 pounds with no weight loss or gain noted. She was on a	F 280	Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. F280 1.) The care plan for Resident #34 was updated to include the resident□s current diet order by the MDS Coordinator on 10/19/16. 2.) The Director of Nursing in-serviced	

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F 280	Continued From page 17 mechanically altered diet. On 10/19/2016 at 8:21AM, Resident #34 was observed eating breakfast. She was being fed by nursing staff. Resident #34 had double portions of a pureed diet. Physician orders for July 2016 indicated Resident #34 had a diet order for pureed foods. A physician ' s order dated 7/7/16 revealed a diet order change to mechanical soft diet with thin liquids. Speech therapy notes reviewed and noted Resident #34 was seen by speech therapy from 6/20/16 through 7/9/16. Resident #34 was discharged from speech therapy on a mechanical soft diet with thin liquids. Physician orders for August and September 2016 were reviewed and revealed a physician ' s order for pureed diet. A review of Resident #34 ' s care plan dated 12/13/16 and reviewed on 10/7/16 revealed Resident #34 had a potential for weight loss and dehydration due to a history of weight loss, dementia and poor food and fluid intake. Approaches added on 7/7/16 indicated a mechanical soft diet with thin liquids. The care plan did not indicate a diet change back to pureed diet. On 10/20/2016 at 8:31AM, an interview was conducted with the Dietary Manager. She stated if speech therapy worked with a resident, speech therapy would send a physician ' s order to the dietary department if a diet was changed. The	F 280	the MDS Nurse on 10/20/16 to include all aspects of residents dietary needs in the residents care plans. A 100% audit of resident diet orders was completed on 10/24/16 by the Director of Nursing to compare with the care plan to assure accuracy. The audit revealed that all physician orders matched the care-planned diets. Any newly hired MDS nurses will receive the education during orientation. 3.) Utilizing a Diet Order Care Plan Quality Indicator Audit Tool, the Assistant Director of Nursing will review all new orders for diet changes to assure the residents care plan was updated. Monitoring will occur Monday through Friday x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month. The Director of Nursing will review and initial the Quality Indicator Audit Tool weekly x 8 weeks, then monthly x 1 month for trends or concerns. 4.) The Director of Nursing will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	

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F 280	Continued From page 18 Dietary Manager stated she remembered that Resident #34 received a mechanical soft diet in July. She said nursing staff notified her sometime after the diet was changed and informed her Resident #34 was holding the food in her mouth and/or spitting it back out. Nursing staff changed the diet consistency back to pureed. She could not remember exactly when the diet change occurred and stated she should have written it in her nutrition notes and should have changed the care plan to reflect the diet change. On 10/20/2016 at 9:20AM, an interview was conducted with the MDS Nurse. She stated she changed the care plan on 7/7/16 to reflect the diet order for mechanical soft diet with thin liquids. She stated she changed the diet order on the care plan because she received a physician ' s order for the diet change. The MDS nurse stated she had not received any further physician ' s orders for a diet change back to a pureed diet. On 10/20/2016 at 9:38AM, an interview was conducted with the Director of Nursing. She stated Resident #34 was unable to tolerate the mechanical soft diet and was holding the food and pocketing food in her mouth. Nursing staff downgraded her diet to pureed and Resident #34 was tolerating that diet very well. She stated the care plan should have reflected the diet that was currently being received by Resident #34.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		11/15/16

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F 282	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow the plan of care for evaluation by a mental health provider as needed for behaviors to address the assaultive behavior of 1 of 1 residents (Resident #8) reviewed for Preadmission Screening and Resident Review (PASRR) Level II. The findings included: Resident #8 was initially admitted to the facility on 7/15/15 with multiple diagnosis that included schizophrenia, anxiety, and depression. A review of Resident #8's medical record revealed he had a current PASRR level II (expiration date 12/22/16) related to a serious mental illness. The quarterly Minimum Data Set (MDS) assessment dated 4/13/16 indicated Resident #8 had moderately impaired cognition. He was coded as having had verbal behaviors 1 to 3 days during the 7 day review period. Resident #8 had been administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period. The plan of care for Resident #8, included the problem/need of monitoring for behaviors associated with schizophrenia and anxiety. This plan of care, initiated on 8/4/15 and most recently updated on 4/30/16, indicated Resident #8 was a level II PASRR. The interventions included referral to a mental health provider as needed for the evaluation of behaviors.	F 282	Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. F282 1.) The Guardian for Resident #8 agreed on 10/25/16 for the resident to be seen by the facility outside psychiatric services. The scheduling of the appointment was discussed with Resident #8 by the Social Worker on 10/25/16. An appointment as a walk-in was scheduled for the resident with the psych services for 10/26/16. The resident was sent by the outside service on 10/26/16. The resident reported he would follow medication evaluation through the nursing home. The facility□s Pharmacist will review the resident□s medications on the November visit and report recommendations to the facility. The resident will be seen by a newly contracted in-house psych service before the end of November. 2.) A 100% audit was completed on 11/8/16 by the Social Worker and Director of Nursing to identify any resident with a psychiatric diagnosis and negative behaviors to include hitting and kicking,	

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F 282	Continued From page 20 A nursing note dated 6/15/16 indicated when Resident #8 was at activities he went up to the preacher after services were over. The note continued on stating the volunteer went to see what was wrong and Resident #8 punched him in the stomach. Resident #8 reportedly stated, "well he should not have come over there." A Nurse Practitioner (NP) note dated 6/15/16 indicated the chief complaint/nature of presenting problem for the visit with Resident #8 was "hit volunteer." The NP indicated Resident #8 had a history of schizophrenia with hallucinations and episodes of being combative. The NP documented, "He was admitted to the hospital last year due to his combative behavior and hallucinations. Staff report that [Resident #8] struck volunteer in the abdomen because he would not let him talk to the preacher after service." The NP's plan indicated a referral for a psychiatric consultation for assaultive behavior. A physician's order dated 6/15/16 indicated a psychiatric referral for assaultive behavior for Resident #8. A nursing note dated 7/9/16 indicated Resident #8 became combative/aggressive and attempted to hit nurse in the face, but had instead hit nurse on the arm. The annual MDS dated 7/12/16 indicated Resident #8 had moderate cognitive impairment. He was coded as having had physical behaviors on 1-3 days during the 7 day MDS review period. The behaviors were indicated to put others at significant risk for physical injury. Resident #8 had been administered antipsychotic medication,	F 282	hallucinations and/or delusions, combative behavior, and paranoia. The audit revealed residents with the potential for behaviors based on diagnoses and referral orders were obtained for those residents. Those residents identified were presented to the Medical Director for orders for psychiatric services by the Social Worker on 11/8/16. Those residents were referred to the in-house psychiatric services provider on 11/8/16 by the Social Worker for evaluation. The Charge Nurse or the Unit Manager on duty will be responsible for MD notification of any needed referrals based on behaviors. The Director of Nursing in-serviced the Social Worker on 10/20/16 to assure resident with new orders for psychiatric services are seen within one week or sooner as possible. 3.) Utilizing a Behavior Quality Indicator Audit Tool, the Unit Managers will read nursing progress notes daily and the Director of Nursing will review progress notes on the weekend x 14 days to identify any behaviors to include hitting and kicking, hallucinations and/or delusions, combative behavior, and paranoia to include Resident #8. The physician will be notified of the need for a psychiatric referral for any newly identified behaviors and repeated behaviors will be referred to the in-house psychiatric services. Monitoring will then occur Monday through Friday x 2 weeks, then weekly x 4 weeks, then monthly x 1. The Administrator will review the audit tool weekly x 8, then monthly x 1 for trends and concerns.	

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F 282	Continued From page 21 antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period. The Care Area Assessment (CAA) of Resident #8's 7/12/16 MDS included, in part, the triggered areas of mood state, behavioral symptoms, and psychotropic drug use. The mood state CAA indicated Resident #8 was receiving mental health (MH) therapy as needed at a community based MH provider. The behavioral symptoms CAA indicated Resident #8 had an episode of hitting staff on 7/9/16 that placed others at risk for injury. Resident #8 was noted with diagnoses of schizophrenia, anxiety, and depression and the potential for fluctuations in behaviors and mood. The psychotropic drug use CAA for Resident #8 indicated the uses of Klonopin (antianxiety medication), Seroquel (antipsychotic medication), Haldol (antipsychotic medication), and Cymbalta (antidepressant medication). Resident #8 was noted to have combative behaviors during the 7/12/16 MDS assessment period and he was also noted to have episodes of delusional behaviors that had not occurred during the assessment period. The psychotropic drug use CAA also indicated Resident #8 was to be referred to mental health as needed for the management of behaviors and the monitoring of appropriateness of current medications. A nursing note dated 8/20/16 indicated she was informed by Speech Therapy (ST) that Resident #8 was yelling at another staff member, refusing to leave the therapy department, was mocking staff, and was hitting himself in the chest. A Patient at Risk (PAR) note dated 8/25/16 indicated Resident #8 continued to receive	F 282	4.) The Administrator will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	

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antipsychotic medications related to a diagnosis of schizophrenia. The note reported Resident #8 continued to have some paranoid behaviors and often accused staff of taking various items.

A nursing note dated 9/25/16 indicated Resident #8 had auditory and visual hallucinations and delusions.

An NP note dated 9/26/16 indicated Resident #8 was seen due to a nursing report that he stated he saw and heard his parents and his dog. This was reported by staff two nights in a row. Resident #8 was indicated to be taking his medications as directed. No changes were indicated for Resident #8.

The quarterly MDS dated 10/5/16 indicated Resident #8 had moderate cognitive impairment. He was coded as having had behavioral symptoms not directed toward others on 1 to 3 days during the 7 day MDS review period. Resident #8 had been administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period.

A nursing note dated 10/10/16 indicated Resident #8 had auditory hallucinations, agitation, and verbal behaviors directed toward staff.

A nursing note dated 10/16/16 indicated Resident #8 had hitting and kicking behaviors as well as agitation.

There was no documentation of a psychiatric consultation as ordered by the physician on 6/15/16 for Resident #8's assaultive behaviors. The medical record additionally revealed

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Resident #8 had not been evaluated by a MH provider since 1/20/16.

An interview was conducted with the Marketing Director on 10/18/16 at 3:20 PM. She indicated she was previously the SW at the facility. She stated Resident #8 was seen by psychiatric services in the past. She indicated the facility used to have a MH provider who came to the facility to see residents. She stated that MH provider ceased their services at the facility several months ago. She indicated she needed to look into the records to find out the actual date the MH provider stopped providing services at their facility.

A follow up interview was conducted with the Marketing Director on 10/18/16 at 4:00 PM. She indicated the MH provider who used to come into the facility discontinued their services at the facility as of 2/29/16. She reported that after 2/29/16 the facility's plan was to utilize the local community MH provider for psychiatric treatment of residents as needed. The physician's order for Resident #8 dated 6/15/16 for a psychiatric consultation for assaultive behaviors was reviewed with the Marketing Director. The medical record that contained no evidence of a psychiatric consultation for Resident #8 following the 6/15/16 physician's order was reviewed with the Marketing Director. She indicated she was responsible for coordination of psychiatric referrals at the time of 6/15/16 physician's order. She reported she remembered this physician's order dated 6/15/16 for a psychiatric consultation for Resident #8. She reported she recalled that there was some type of insurance problem with the local community MH provider and Resident #8 had not been seen for a psychiatric

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consultation. The Marketing Director indicated she was unable to provide additional information.

An interview was conducted with the SW on 10/19/16 at 8:33 AM. She stated she began working at the facility on 7/11/16. She reported she shadowed the previous SW/current Marketing Director when she began working at the facility. The physician's order for Resident #8 dated 6/15/16 for a psychiatric consultation for assaultive behaviors was reviewed the SW. She indicated that although she had not begun to work at the facility at the time of the referral, she was aware of the referral for Resident #8. She reported there were issues with Resident #8's insurance being accepted at the local community MH provider. The SW stated she needed to review her information on Resident #8 to provide additional details.

A second interview was conducted with the SW on 10/19/16 at 9:08 AM. The SW indicated she had obtained additional information regarding Resident #8. She reiterated that there was an issue with Resident #8's insurance being accepted at the local community MH provider. She indicated the local community MH provider agreed to accept Resident #8's insurance as of 8/19/16. The SW indicated that by the time the insurance had been accepted by the local community MH provider that she had assessed Resident #8 as no longer requiring a psychiatric consultation. She revealed Resident #8 had not had a psychiatric consultation as ordered by the physician on 6/15/16. The SW confirmed that as per the medical record, Resident #8 had not had an evaluation by a MH provider since 1/20/16.

An interview was conducted with the Director of

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F 282	Continued From page 25 Nursing (DON) on 10/20/16 at 9:00 AM. She reported her expectation was for the care plan to be followed. The physician's order dated 6/15/16 for a psychiatric consultation for Resident #8's assaultive behavior was reviewed with the DON. The care plan that indicated Resident #8 was to be referred to a MH provider as needed for the evaluation of behaviors was reviewed with the DON. She indicated she thought the psychiatric consultation was never obtained because there were no additional incidents of Resident #8 assaulting anybody else.	F 282		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that 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 residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		11/15/16

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This REQUIREMENT is not met as evidenced by:
Based on medical record review, resident, staff, nurse practitioner, and physician interview, the facility failed to have a clinical indication for the administration of an antipsychotic medication for 1 of 5 residents (Resident #98) reviewed for unnecessary medications. The findings included:

Resident #98 was initially admitted to the facility on 4/3/15 and readmitted on 9/28/16 with multiple diagnoses that included cervical spinal injury and paraplegia (leg paralysis).

The quarterly Minimum Data Set (MDS) assessment dated 10/10/16 indicated Resident #98 had no impairment in cognition. He was assessed as having had no psychosis and no behaviors in the 7 day MDS review period. Resident #98 was indicated to have received antipsychotic medication on 7 of 7 days during the MDS review period. There was no active diagnosis coded on the MDS that justified the use of an antipsychotic medication.

A physician's order dated 9/27/16 indicated Seroquel (antipsychotic medication) 50 milligrams (mg) by mouth each night for Resident #98. There was no diagnosis indicated for the Seroquel on the physician's order.

The plan of care dated 9/27/16 for Resident #98 indicated he was on an antipsychotic medication. There was no diagnosis indicated for the antipsychotic medication on the plan of care.

Disclaimer Clause:
Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law.

F329
1.) The resident #98 received a diagnosis for use of Seroquel and the care plan was updated on 10/19/2016 by the MDS Nurse. The resident #98 was examined and assessed by the attending Physician on 10/25/16 and new orders were received to discontinue the use of Seroquel. The order was carried out and the care plan was updated by the MDS Nurse on 10/25/16.
2.) A 100% audit of all residents receiving psychoactive medications was completed on 11/8/16 by Nursing Administration staff to assure an acceptable diagnosis was documented for use of the medication. The audit revealed that all medications had orders with diagnoses. Clarification orders for appropriate diagnoses were completed as needed. All residents without an acceptable diagnosis were reviewed by the Medical Director for appropriate diagnosis. New orders were written to clarify the use of

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F 329	Continued From page 27 The Nurse Practitioner (NP) progress note dated 9/28/16 indicated Seroquel 50mg each night for Resident #98. The note included no documentation of a clinical indication for the administration of Seroquel. The Medication Administration Record (MAR) from Resident #98's readmission on 9/28/16 through 10/18/16 revealed he had received Seroquel 50mg each night. There was no diagnosis indicated for the Seroquel on Resident 98's MAR. An interview was conducted with the MDS Nurse on 10/19/16 at 4:26 PM. The MDS dated 10/10/16 for Resident #98 was reviewed with the MDS Nurse. She stated she coded the Medications section of the 10/10/16 MDS for Resident #98 as well as the Active Diagnosis section. She indicated she was aware there was no active diagnosis coded on Resident #98's 10/10/16 MDS that related to the antipsychotic medication. The MDS Nurse revealed when she was completing the 10/10/16 MDS for Resident #98 she had been unable to locate documentation of a diagnosis in the medical record for the use of Seroquel. She explained that Resident #98 was discharged from the facility on 9/23/16 and admitted to the hospital. The MDS Nurse reported when Resident #98 was discharged from the hospital and readmitted to the facility on 9/28/16 that he had been ordered the Seroquel. She indicated she documented in the physician's communication book a request for a diagnosis related to the Seroquel, but she had not received a response. She stated that typically the physician responded to a request for a diagnosis for a medication by writing an order that indicated the diagnosis for that medication. She	F 329	the medication on or before 11/10/16 by Nursing Administration. A 100% licensed staff in-service was initiated on 11/9/2016 by ADON to assure all medications to include antipsychotic medications have an appropriate diagnosis and completed by 11/11/16. The in-service included all full-time, part-time and prn (as needed) nurses. Any new orders written on the weekends will be addressed by the Charge Nurse on duty with follow-up by the DON/ADON as needed. The Unit managers will also check to be sure all orders including psychotropic medications have an appropriate diagnosis on the Medication Administration Record. All newly hired licensed staff will receive the education during orientation. 3.) Utilizing a Diagnosis Quality Indicator Audit Tool, the Unit Managers will review all new physicians orders for medication Monday through Friday and the Charge Nurses on weekends, to assure all medications have an appropriate diagnosis for use to include antipsychotic medications. All concerns will be reported to the attending physician for correction. Monitoring will occur weekly x 2 weeks, then twice weekly x 2 weeks, then weekly x 4, then monthly x 1 month. The Director of Nursing will review and initial the audits x 2 weeks, then twice weekly x 2 weeks, then weekly x 4, then monthly x 1 month for trends and concerns. 4.) The Director of Nursing will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	

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again reviewed Resident #98's medical record and reported there was no documentation of a diagnosis for Seroquel.

The interview with the MDS Nurse continued. She explained that when Resident #98 was initially admitted to the facility (4/3/15) he was on Seroquel and she had not known the diagnosis or clinical indication at that time either. She reported Resident #98 had been asked why he was on the Seroquel and had not known. She stated Resident #98's Seroquel was discontinued several months ago. The MDS Nurse indicated when Resident #98 returned from the hospital upon readmission on 9/28/16 he was put back on the Seroquel with no documented diagnosis in the medical record. The MDS Nurse additionally revealed that to her knowledge Resident #98 had displayed no behaviors or signs of psychosis.

An interview was conducted with Registered Nurse (RN) Manager #1 on 10/19/16 at 4:55 PM. She revealed Resident #98 had no known clinical indication for the use of Seroquel. She stated Resident #98 had no behaviors, no psychosis, and no diagnosis documented for Seroquel. RN Manager #1 indicated when Resident #98 was initially admitted to the facility from the hospital (4/3/15) he was on Seroquel. She revealed Resident #98 had no diagnosis for the Seroquel at that time either. RN Manager #1 stated the facility had asked Resident #98 why he was on the Seroquel and he had not known. She indicated the Seroquel was discontinued months ago and Resident #98 had no negative effects.

The interview with RN Manager #1 continued. She indicated Resident #98 was hospitalized on 9/23/16 and was then readmitted to the facility on

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9/28/16. She stated the hospital discharge medication list included Seroquel 50mg at bed. She indicated she thought the hospital had utilized the medication list that was from Resident #98's previous hospital admission rather than utilizing the current medication list that was sent from the facility when Resident #98 was admitted there on 9/23/16. RN Manager #1 revealed this situation had happened on multiple other occasions when residents returned from the hospital with medication lists that were no longer current. She indicated the physician reviewed the medication list after Resident #98's readmission. She revealed there was still no documentation in Resident #98's medical record of a diagnosis for Seroquel.

A phone interview with the NP was conducted on 10/20/16 at 8:57 AM. She indicated she was unable to say what diagnosis the Seroquel was related to or what the clinical indication was for the Seroquel without looking at Resident #98's medical record. The NP suggested the physician be contacted.

An interview was conducted with the Director of Nursing (DON) on 10/20/16 at 9:00 AM. The DON indicated the physician was contacted on 10/19/16 to obtain a diagnosis related to Seroquel for Resident #98. She provided an updated plan of care, dated 10/19/16, that indicated Resident #98 had diagnoses of mood disorder and psychosis for the use of Seroquel. The DON revealed the physician had neglected to provide a diagnosis for the Seroquel previously. She indicated the diagnosis was obtained on 10/19/16.

An interview was conducted with Resident #98 on

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F 329	Continued From page 30 10/20/16 at 10:16 AM. Resident #98 indicated he had not known why he was prescribed Seroquel. He reported he had no mental health issues that required the use of antipsychotics. A phone interview was conducted with the physician on 10/20/16 at 10:25 AM. The physician indicated Resident #98 was initially admitted to the facility (4/3/15) on the Seroquel and had a successful Gradual Dose Reduction (GDR) coordinated by a mental health provider. The physician reported that when Resident #98 was readmitted from the hospital on 9/28/16 that the hospital had reinitiated the Seroquel. He indicated the discharge summary from the hospital had not provided much information as to why the Seroquel was restarted. He stated he had decided to keep Resident #98 on the Seroquel for a little while and then planned on completing another GDR. The physician revealed he added the diagnoses of mood disorder and psychosis on 10/19/16 after the facility had pointed out to him that there was no diagnosis in Resident #98's medical record for Seroquel.	F 329		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	F 406		11/15/16

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This REQUIREMENT is not met as evidenced by:
Based on record review, responsible party interview, and staff interview, the facility failed to obtain a psychiatric consultation as ordered to address the assaultive behavior of 1 of 1 residents (Resident #8) reviewed for Preadmission Screening and Resident Review (PASRR) Level II. The findings included:

Resident #8 was initially admitted to the facility on 7/15/15 with multiple diagnosis that included schizophrenia, anxiety, and depression.

A review of Resident #8's medical record revealed he had a current PASRR level II (expiration date 12/22/16) related to a serious mental illness.

The quarterly Minimum Data Set (MDS) assessment dated 1/15/16 indicated Resident #8's cognition was intact. He was coded as having had physical behaviors 1 to 3 days during the 7 day MDS review period. Resident #8 had been administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period.

Resident #8's most recent mental health consultation was dated 1/20/16. The Psychiatric Mental Health Nurse Practitioner (PMHNP) indicated Resident #8 was diagnosed with schizophrenia, anxiety, and depression. The PMHNP note indicated staff had reported episodes of anxiety/agitation and continued delusions for Resident #8. The PMHNP indicated

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F406
1.) The Guardian for Resident #8 agreed on 10/25/16 for the resident to be seen by the facility outside psychiatric services. The scheduling of the appointment was discussed with Resident #8 by the Social Worker on 10/25/16. An appointment as a walk-in was scheduled for the resident with the psychiatric services for 10/26/16. The resident was seen by the outside service on 10/26/16. The resident reported he would follow medication evaluation through the nursing home. The facility□s Pharmacist will review the resident□s medications on the November visit and report recommendations to the facility. The resident will be seen by a newly contracted in-house psychiatric service before the end of November.
2.) A 100% audit was completed on 11/8/16 by the Admissions Coordinator to identify any resident with a PASRR II (Pre-Admission Screening and Resident Review). No other residents were identified in the facility. The Regional

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F 406	Continued From page 32 her plan for Resident #8's treatment included continued monitoring and notification to her of persistent or worsened behaviors. The plan of care for Resident #8, included the problem/need of monitoring for behaviors associated with schizophrenia and anxiety. This plan of care, initiated on 8/4/15 and most recently updated on 4/30/16, indicated Resident #8 was a level II PASRR. The interventions included, in part, the administration of Haldol (antipsychotic medication) and Seroquel (antipsychotic medication) for the treatment of schizophrenia, the administration of antianxiety medication as ordered for the treatment of anxiety, and referral to a mental health provider as needed for the evaluation of behaviors. The quarterly MDS dated 4/13/16 indicated Resident #8 had moderately impaired cognition. He was coded as having had verbal behaviors 1 to 3 days during the 7 day review period. Resident #8 had been administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period. A nursing note dated 6/15/16 indicated when Resident #8 was at activities he went up to the preacher after services were over. The note continued on stating the volunteer went to see what was wrong and Resident #8 punched him in the stomach. Resident #8 reportedly stated, "well he should not have come over there." A Nurse Practitioner (NP) note dated 6/15/16 indicated the chief complaint/nature of presenting problem for the visit with Resident #8 was "hit volunteer." The NP indicated Resident #8 had a	F 406	Clinical Manager provided an in-service to the Admissions Coordinator to include a resident/Responsible Party consent form for in-house psychiatric services on admission, obtain a physician□s order for treatment, and promptly fax the consent to the in-house psychiatric services provider for treatment in the facility. 3.) Utilizing a PASRR (Pre-Admission Screening and Resident Review) Admission Quality indicator Audit Tool, the Social Worker will review all new admissions. This will identify residents admitted with a PASRR II (Pre-Admission Screening and Resident Review) to assure psychiatric treatment consents are obtained, orders are received for treatment, and the psychiatric provider is notified for treatment. Monitoring will occur Monday through Friday x 2 weeks, then, twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1. The Administrator will review the audit tool weekly x 8, then monthly x 1 for trends and concerns. 4.) The Administrator will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	

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history of schizophrenia with hallucinations and episodes of being combative. The NP documented, "He was admitted to the hospital last year due to his combative behavior and hallucinations. Staff report that [Resident #8] struck volunteer in the abdomen because he would not let him talk to the preacher after service." The NP's plan indicated a referral for a psychiatric consultation for assaultive behavior.

A physician's order dated 6/15/16 indicated a psychiatric referral for assaultive behavior for Resident #8.

There was no documentation of a psychiatric consultation for Resident #8 following the 6/15/16 physician's order for a psychiatric referral.

A nursing note dated 7/9/16 indicated Resident #8 became combative/aggressive and attempted to hit nurse in the face, but had instead hit nurse on the arm.

The annual MDS dated 7/12/16 indicated Resident #8 had moderate cognitive impairment. He was coded as having had physical behaviors on 1-3 days during the 7 day MDS review period. The behaviors were indicated to put others at significant risk for physical injury. Resident #8 had been administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period.

The Care Area Assessment (CAA) of Resident #8's 7/12/16 MDS included, in part, the triggered areas of mood state, behavioral symptoms, and psychotropic drug use. The mood state CAA indicated Resident #8 was receiving mental

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health (MH) therapy as needed at a community based MH provider. The behavioral symptoms CAA indicated Resident #8 had an episode of hitting staff on 7/9/16 that placed others at risk for injury. Resident #8 was noted with diagnoses of schizophrenia, anxiety, and depression and the potential for fluctuations in behaviors and mood. The psychotropic drug use CAA for Resident #8 indicated the uses of Klonopin (antianxiety medication), Seroquel (antipsychotic medication), Haldol (antipsychotic medication), and Cymbalta (antidepressant medication). Resident #8 was noted to have combative behaviors during the 7/12/16 MDS assessment period and he was also noted to have episodes of delusional behaviors that had not occurred during the assessment period. The psychotropic drug use CAA also indicated Resident #8 was to be referred to mental health as needed for the management of behaviors and the monitoring of appropriateness of current medications.

A nursing note dated 7/13/16 indicated Resident #8 was made aware of a scheduled appointment with a community MH provider for 7/21/16.

A SW note dated 7/21/16 indicated she received a call from Resident #8's Responsible Party (RP). The RP indicated the community MH provider located close to the facility was currently unable to see Resident #8 due to his insurance. The RP reported Resident #8's insurance was only accepted at the community MH provider that was located in his home county. The RP informed the SW she was trying to coordinate services with Resident #8's insurance and with the community MH provider so he was able to be seen for psychiatric services at the provider located close to the facility.

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A SW note dated 8/19/16 indicated she received a call from Resident #8's RP indicating that the local community MH provider had made an exception and was going to accept Resident #8's insurance at their location. The note additionally indicated Resident #8 was going to have an appointment set up at the local MH provider by the RP and she was going to inform the facility of the date and time so the facility was able to provide transportation.

A nursing note dated 8/20/16 indicated she was informed by Speech Therapy (ST) that Resident #8 was yelling at another staff member, refusing to leave the therapy department, was mocking staff, and was hitting himself in the chest.

A Patient at Risk (PAR) note dated 8/25/16 indicated Resident #8 continued to receive antipsychotic medications related to a diagnosis of schizophrenia. The note reported Resident #8 continued to have some paranoid behaviors and often accused staff of taking various items.

A nursing note dated 9/25/16 indicated Resident #8 had auditory and visual hallucinations and delusions.

An NP note dated 9/26/16 indicated Resident #8 was seen due to a nursing report that he stated he saw and heard his parents and his dog. This was reported by staff two nights in a row. Resident #8 was indicated to be taking his medications as directed. No changes were indicated for Resident #8.

The quarterly MDS dated 10/5/16 indicated Resident #8 had moderate cognitive impairment.

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He was coded as having had behavioral symptoms not directed toward others on 1 to 3 days during the 7 day MDS review period. Resident #8 had been administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days during the MDS review period.

A nursing note dated 10/10/16 indicated Resident #8 had auditory hallucinations, agitation, and verbal behaviors directed toward staff.

A nursing note dated 10/16/16 indicated Resident #8 had hitting and kicking behaviors as well as agitation.

A SW note dated 10/18/16 indicated she had left a voicemail message for Resident #8's RP reporting he had not had any outbursts or issues lately that were indicative a need for further MH evaluation. The SW note additionally indicated she had informed the RP that if a need for an MH appointment arose that she would inform her.

An interview was conducted with the Marketing Director on 10/18/16 at 3:20 PM. She indicated she was previously the SW at the facility. She stated Resident #8 was seen by psychiatric services in the past. She indicated the facility used to have an MH provider who came to the facility to see residents. She stated that MH provider ceased their services at the facility several months ago. She indicated she needed to look into the records to find out the actual date the MH provider stopped providing services at their facility.

A follow up interview was conducted with the Marketing Director on 10/18/16 at 4:00 PM. She

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indicated the MH provider who used to come into the facility discontinued their services at the facility as of 2/29/16. She reported that after 2/29/16 the facility's plan was to utilize the local community MH provider for psychiatric treatment of residents as needed. The physician's order for Resident #8 dated 6/15/16 for a psychiatric consultation for assaultive behaviors was reviewed with the Marketing Director. The medical record that contained no evidence of a psychiatric consultation for Resident #8 following the 6/15/16 physician's order was reviewed with the Marketing Director. She indicated she was responsible for coordination of psychiatric referrals at the time of 6/15/16 physician's order. She reported she remembered this physician's order dated 6/15/16 for a psychiatric consultation for Resident #8. The nursing note dated 7/13/16 that indicated Resident #8 was made aware of a scheduled appointment with a community MH provider for 7/21/16 was reviewed with the Marketing Director. She reported she recalled that there was some type of insurance problem with the local community MH provider and Resident #8 had not been seen for a psychiatric consultation. She was unable to explain why the physician's order for the psychiatric consultation for Resident #8 was dated 6/15/16 and the first documentation in the medical record regarding the psychiatric appointment was on 7/13/16 when the appointment was indicated to be scheduled for 7/21/16. The Marketing Director indicated that the facility's Receptionist was the person who scheduled all of the appointments. She suggested the Receptionist and current SW be interviewed for additional information.

An interview was conducted with the SW on 10/19/16 at 8:33 AM. She stated she began

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working at the facility on 7/11/16. She reported she shadowed the previous SW/current Marketing Director when she began working at the facility. The physician's order for Resident #8 dated 6/15/16 for a psychiatric consultation for assaultive behaviors was reviewed the SW. She indicated that although she had not begun to work at the facility at the time of the referral, she was aware of the referral for Resident #8. She reported there were issues with Resident #8's insurance being accepted at the local community MH provider. She stated due to Resident #8's insurance an appointment was scheduled for 7/21/16 at the community MH provider located in his home county. The SW was unable to explain why the physician's order for the psychiatric consultation for Resident #8 was dated 6/15/16 and the first documentation in the medical record regarding the psychiatric appointment was on 7/13/16 when the appointment was indicated to be scheduled for 7/21/16. The SW was also unable to explain why there was no progress note in Resident #8's medical record of the 7/21/16 psychiatric appointment. She indicated she never received any records from the community MH provider for Resident #8. She stated she needed to review the medical record and follow up with Resident #8's RP for additional information.

An interview was conducted with the Receptionist on 10/19/16 at 8:45 AM. She indicated she kept an electronic calendar with all appointments that were scheduled for residents. She reviewed the electronic calendar and indicated an appointment for Resident #8 was scheduled at the local community MH provider for 6/17/16. She reported the 6/17/16 appointment had a notation that indicated the appointment was cancelled due

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to the local community MH provider not accepting Resident #8's insurance. The Receptionist indicated the next documentation in the electronic calendar related to the psychiatric appointment for Resident #8 was on 7/13/16 when an appointment was scheduled at a community MH provider in his home county on 7/21/16. The Receptionist was unable to explain why the 6/17/16 psychiatric appointment for Resident #8 was cancelled on 6/17/16 and another appointment was not scheduled until 7/13/16.

A second interview was conducted with the SW on 10/19/16 at 9:08 AM. The SW indicated she had obtained additional information regarding the events that occurred after Resident #8 was ordered the psychiatric consultation on 6/15/16. She stated that on 6/17/16 Resident #8 was transported by the facility to the local community MH provider for a scheduled psychiatric appointment. She stated the local community MH provider was unable to provide Resident #8 with a psychiatric consultation due to his insurance. The local MH provider reported Resident #8 had to go to the community MH provider located in his home county. On 7/13/16 the facility scheduled an appointment for 7/21/16 for Resident #8 at the community MH provider that was located in his home county. On 7/21/16 the facility provided transportation for Resident #8 to attend the appointment at the community MH provider located in his home county. Resident #8's RP met him at the 7/21/16 appointment. This appointment was for an informational intake and a psychiatric consultation was not provided for Resident #8. At this appointment the RP was asked by the provider why Resident #8 was not being seen at the community MH provider that was located closer to the facility. The RP then

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worked to coordinate with the insurance company and the community MH provider for an exception to be made so Resident #8 was able to be seen at the community MH provider located near the facility. This coordination took several weeks according to the SW. She indicated Resident #8's RP had informed her by phone on 8/19/16 that the local community MH provider had agreed to accept his insurance. At the time of phone call on 8/19/16 no psychiatric consultation had been scheduled for Resident #8. The SW stated the RP scheduled Resident #8's appointments so that she was able to attend them. The SW indicated Resident #8 had not had any additional behaviors that required a psychiatric consultation so she had not informed his RP that an appointment needed to be scheduled. The SW confirmed Resident #8 was not seen for a psychiatric consultation as ordered by the physician on 6/15/16.

A phone interview was conducted with Resident #8's RP on 10/19/16 at 9:51 AM. The events that occurred after Resident #8 was ordered the psychiatric consultation on 6/15/16 were reviewed with his RP. She indicated she had not attended the appointment that was scheduled for 6/17/16 at the local community MH provider for Resident #8. She stated she had not known why an appointment was not made until 7/13/16 at the community MH provider located in Resident #8's home county. The RP reported she had met Resident #8 at the 7/21/16 appointment. She confirmed this appointment was for an informational intake and Resident #8 was not seen for a psychiatric consultation. She reported that after the 7/21/16 appointment she coordinated with the insurance company and the community MH provider so Resident #8 was able

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F 406	Continued From page 41 to be seen at the community MH provider located closer to the facility. The RP indicated the coordination took several weeks. She stated she had contacted the SW when coordination was completed. The RP indicated she asked the SW to let her know if a psychiatric appointment needed to be scheduled for Resident #8. She stated the SW had not informed her that Resident #8 needed a psychiatric appointment. The interview with Resident #8's RP continued. She discussed Resident #8's psychiatric history. She reported Resident #8 had combative behavior in the past. She indicated Resident #8 had an inpatient psychiatric hospitalization that lasted about three months that was initiated due to his combative behavior. An interview was conducted with the Director of Nursing (DON) on 10/19/16 at 3:50 PM. She reported her expectation was for physician's orders to be followed. She indicated if a physician wrote an order for a psychiatric consultation that she expected the consultation to be obtained. The physician's order dated 6/15/16 for a psychiatric consultation for Resident #8's assaultive behavior was reviewed with the DON. She stated that was aware there had been issues with Resident #8's insurance and the community MH provider. She indicated she thought the psychiatric consultation was never obtained because there were no additional incidents of Resident #8 assaulting anybody else.	F 406		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		11/15/16

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F 520	Continued From page 42 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 11/19/2015 recertification survey. This was for three recited deficiencies in the areas of Assessment Accuracy/coordination/certified (F278), Right to Participate Planning Care-Revise Care Plan (F280), and Drug Regimen is Free from Unnecessary Drugs (F329). These deficiencies were cited again on the current recertification	F 520	Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. F520 The facility will monitor and evaluate effectiveness of the identified QAPI	

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F 520	Continued From page 43 survey of 10/20/2016. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. F278 - Assessment Accuracy: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately on prognosis for 1 (Resident #92) of 1 sampled resident receiving hospice care. During the recertification survey of 11/19/2015 the facility was cited F278 for failing to accurately code hypnotic medication and therapy services on the MDS. On the current recertification survey of 10/20/16, the facility failed to code accurately on prognosis on the MDS. 2. F280 - Right to Participate Planning Care-Revise Care Plan: Based on medical record review and staff interview, the facility failed to revise the care plan to reflect the diet order of pureed diet as noted on August physician ' s orders for one of three residents reviewed for nutrition (Resident #34). During the recertification survey of 11/19/2015 the facility was cited F280 for failing to review and revise a care plan for range of motion for a resident who had bilateral hand splints discontinued and failing to review and revise a care plan for another resident who was receiving psychotropic medications. On the current recertification survey of 10/20/2016, the facility failed to revise the care plan to reflect the diet order of pureed diet. 3. F329 Drug Regimen is free from unnecessary drugs: Based on medical record review, resident, staff, nurse practitioner, and physician interview, the facility failed to have a clinical indication for	F 520	programs by achieving and maintaining identified thresholds for F tags 278, 280 and 329. F278 1.) The Minimum Data Set of 8/29/16 for Resident #92 was modified by the MDS Nurse on 10/19/16 to reflect the change of the prognosis question to yes. The modification was transmitted to the State Agency on 10/19/16. 2.) The Director of Nursing provided an in-service to the MDS Nurse on 10/20/16 from the R.A. I. Version 3.0 Manuel Section J1400 for prognosis coding. A 100% audit for all residents receiving Hospice services was completed by the Director of Nursing on 10/19/16 to identify any residents that may have been affected by the same coding. One other resident was identified and the MDS was made aware for correction. The MDS Nurse corrected the MDS assessment and the modification was transmitted to the State Agency on 10/19/16. Any newly hired MDS nurses will receive the education during orientation. 3.) Utilizing a MDS Hospice/Prognosis QI Audit Tool, the ADON will review all physicians orders for new orders for Hospice services to assure the resident s MDS was properly coded correctly for the prognosis question. Monitoring will occur weekly x 4 weeks, then twice monthly x 1 month, then monthly x 1. The Director of Nursing will review the QI Audit Tool weekly x 4 weeks, then twice monthly x 1 month, then monthly x 1 for trends and concerns.	

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F 520	Continued From page 44 the administration of an antipsychotic medication for 1 of 5 residents (Resident #98) reviewed for unnecessary medications. During the recertification survey of 11/19/2015 the facility was cited F329 for failing to utilize non pharmacological approaches to address behaviors, failed to evaluate the underlying cause of behaviors either before or during treatment with antipsychotic medication and failing to reassess the ongoing clinical indication for antipsychotic medication in the absence of a clinical indication. On the current recertification survey of 10/20/2016, the facility failed to have a clinical indication for the administration of an antipsychotic medication. An interview was conducted with the Administrator on 10/20/2016 at 11:00 AM. She made me aware, that as the administrator, her role was being the head of the facility ' s QAA Committee. She provided further information that the QAA Committee consisted of the Medical Director, Director of Nursing (DON), Dietary Manager, Recreation Services Manager, Social Worker, Environmental/Laundry Manager, Maintenance Director, Rehabilitation Director, and the Pharmacist. She stated the committee met monthly. The Administrator was aware that assessment accuracy, right to participate in planning care-revise care plan, and that the resident ' s drug regimen was free from unnecessary drugs were repeat deficiencies from the previous recertification survey. She informed me that the facility QAA committee that had developed and implemented appropriate plans of action to correct identified quality deficiencies from the last survey. The QAA committee had reviewed F278-assessment accuracy, F280-right to participate in planning care-revise care plan, and	F 520	4.) The Director of Nursing will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring. F280 1.) The care plan for Resident #34 was updated to include the resident□s current diet order by the MDS Coordinator on 10/19/16. 2.) The Director of Nursing in-serviced the MDS Nurse on 10/20/16 to include all aspects of residents□ dietary needs in the residents□ care plans. A 100% audit of resident diet orders was completed on 10/24/16 by the Director of Nursing to compare with the care plan to assure accuracy. The audit revealed that all physician orders matched the care-planned diets. Any newly hired MDS nurses will receive the education during orientation. 3.) Utilizing a Diet Order Care Plan Quality Indicator Audit Tool, the Assistant Director of Nursing will review all new orders for diet changes to assure the resident□s care plan was updated. Monitoring will occur Monday through Friday x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month. The Director of Nursing will review and initial the Quality Indicator Audit Tool weekly x 8 weeks, then monthly x 1 month for trends or concerns. 4.) The Director of Nursing will present the results of the monitoring to the	

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F 520	Continued From page 45 F329-drug regimen is free from unnecessary drugs. The QA committee reviews all of the deficiencies from the last survey. If there were any issues that were identified then the issue would be addressed.	F 520	Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring. F329 1.) The resident #98 received a diagnosis for use of Seroquel and the care plan was updated on 10/19/2016 by the MDS Nurse. The resident #98 was examined and assessed by the attending Physician on 10/25/16 and new orders were received to discontinue the use of Seroquel. The order was carried out and the care plan was updated by the MDS Nurse on 10/25/16. 2.) A 100% audit of all residents receiving psychoactive medications was completed on 11/8/16 by Nursing Administration staff to assure an acceptable diagnosis was documented for use of the medication. The audit revealed that all medications had orders with diagnoses. Clarification orders for appropriate diagnoses were completed as needed. All residents without an acceptable diagnosis were reviewed by the Medical Director for appropriate diagnosis. New orders were written to clarify the use of the medication on or before 11/10/16 by Nursing Administration. A 100% licensed staff in-service was initiated on 11/9/2016 by ADON to assure all medications to include antipsychotic medications have an appropriate diagnosis and completed by 11/11/16. The in-service included all full-time, part-time and prn (as needed) nurses. Any new orders written on the weekends will be addressed by the Charge Nurse on duty with follow-up by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING _____ B. WING _____	C 10/20/2016

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F 520	Continued From page 46	F 520	the DON/ADON as needed. The Unit managers will also check to be sure all orders including psychotropic medications have an appropriate diagnosis on the Medication Administration Record. All newly hired licensed staff will receive the education during orientation. 3.) Utilizing a Diagnosis Quality Indicator Audit Tool, the Unit Managers will review all new physicians orders for medication Monday through Friday and the Charge Nurses on weekends, to assure all medications have an appropriate diagnosis for use to include antipsychotic medications. All concerns will be reported to the attending physician for correction. Monitoring will occur weekly x 2 weeks, then twice weekly x 2 weeks, then weekly x 4, then monthly x 1 month. The Director of Nursing will review and initial the audits x 2 weeks, then twice weekly x 2 weeks, then weekly x 4, then monthly x 1 month for trends and concerns. 4.) The Director of Nursing will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring. If identified QAPI (Quality Insurance and Performance Improvement) programs drop below identified thresholds, the Quality Insurance and Performance Improvement program will be reevaluated and revised as necessary. All survey related Quality Insurance and Performance Improvement monitoring programs will remain in effect for	

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F 520	Continued From page 47	F 520	monitoring and review for a period of a minimum of 6 months. The Administrator or Department Head responsible for completing identified audits will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for 3 months, then quarterly x1, and then at the need frequency determined by the Committee.	