STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345278	A. BUILDING ______ B. WING ______	02/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN SURRY SNF	830 ROCKFORD STREET MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to maintain residents' dignity by standing over 4 of 4 sample residents (Resident #11, Resident #29, Resident #6, and Resident #21) while assisting them to eat a meal. The findings included: 1) Resident #11 was admitted to the facility on 5/3/13 from the community. Her cumulative diagnoses included dementia. A review of Resident #11 ' s quarterly Minimum Data Set (MDS) assessment dated 11/1/16 revealed the resident had severely impaired cognitive skills for daily decision making. The resident required total assistance from staff for all of her Activities of Daily Living (ADLs), with the exception of requiring limited assistance with personal hygiene. On 2/7/17 at 12:56 PM, Resident #11 was observed as she was fed her noon meal by Nursing Assistant (NA) #1. Resident #11 was lying in bed with the head of the bed elevated. NA #1 was observed standing over the resident next to the bed as she assisted her with the meal. The nursing assistant was observed to be standing above eye level for Resident #11.	F 241	F241 Plan of correction For resident #11 and all residents having potential to be affected. All staff have been educated by DON on assisting with feeding of residents and proper procedures related to positioning and being at eye level beginning 2-10-17 with completion 2-28-17. No negative outcome was identified by the alleged deficient practice. Education to alter practice to ensure that the problem does not reoccur included if unable to sit at eye level to feed the patient and standing staff to raise bed to eye level. Education also included to not sit on a bed while feeding a resident. All new hires will be educated on the proper feeding technique to include feeding the resident at eye level. Corrective action will be monitored to ensure the alleged deficient practice will not re occur. The DON/Designee will complete a daily audit of two feedings (1 at breakfast and l at lunch) daily for 7 days for 2 weeks.	2/28/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/03/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 On 2/9/17 at 8:17 AM, NA #1 was observed as she entered Resident #11 ' s room and assisted Resident #11 with her breakfast meal. NA #1 was observed standing over the resident next to the bed as she assisted her with the meal. The NA was observed to be standing above eye level while assisting Resident #11. An interview was conducted with NA #1 on 2/9/17 at 2:34 PM. During the interview, the NA reported Resident #11 would try to feed herself on occasions, but typically needed assistance from staff to help finish the meal. Upon further inquiry, NA #1 stated she tries to sit in the chair next to the bed and face the resident, but whether or not this worked depended on the position of the resident. The NA reported she usually tried to raise the resident ' s bed to eye level so she was not standing over her. The NA stated, "(The) facility doesn ' t want us to stand over them really." An interview was conducted on 2/10/17 at 10:20 AM with the facility ' s Director of Nursing (DON) in regards to the observations made of staff standing over residents while assisting them with meals. During the interview, the DON reported the beds in the facility were hospital beds (versus standard nursing facility beds). She stated the beds were higher than a standard nursing facility bed and could not be lowered enough to allow staff to sit at eye level while feeding a resident. The DON stated she has recognized this issue and would rather have the staff standing so they can better reach the resident, be eye level to resident, and able to talk and encourage them to eat.	F 241	Then 2x a day for 3 days a week (1 at breakfast and 1 at lunch) for three weeks for a total amount of 46 observations. The DON/Designee will monitor the daily audits for compliance. Monitoring of compliance will be reported at the March 2017 and April 2017 QA meeting. F241 Plan of correction For resident #29 and all residents having potential to be affected. All staff have been educated by DON on assisting with feeding of residents and proper procedures related to positioning and being at eye level beginning 2-10-17 with completion 2-28-17. No negative outcome was identified by the alleged deficient practice. Education to alter practice to ensure that the problem does not reoccur included if unable to sit at eye level to feed the patient and standing staff to raise bed to eye level. Education also included to not sit on a bed while feeding a resident. All new hires will be educated on the proper feeding technique to include feeding the resident at eye level. Corrective action will be monitored to ensure the alleged deficient practice will not re occur: The DON/Designee will complete a daily audit to ensure of proper	

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F 241	Continued From page 2 2) Resident #29 was admitted to the facility on 4/7/14 from the community. His cumulative diagnoses included dementia. A review of Resident #29 ' s quarterly Minimum Data Set (MDS) assessment dated 11/22/16 revealed the resident had severely impaired cognitive skills for daily decision making. Resident #29 required total assistance from staff for all of his Activities of Daily Living (ADLs), with the exception of requiring limited assistance with personal hygiene. On 2/7/17 at 12:55 PM, Resident #29 was observed as he was fed his noon meal by Nursing Assistant (NA) #4. Resident #29 was lying in bed with the head of the bed elevated. NA #4 was observed standing over the resident next to the bed as she assisted him with the meal. The NA was observed to be standing above eye level for Resident #29. On 2/9/17 at 8:18 AM, NA #3 was observed standing over Resident #29 ' s bed as she assisted the resident with his breakfast meal. The NA was observed to be standing above the resident ' s eye level while assisting him. Upon inquiry, the NA reported Resident #29 had a good appetite and was eating well. An interview was conducted with NA #4 on 2/10/17 at 9:11 AM. During the interview, the NA was asked what the facility policy was in regards to standing while assisting a resident with a meal. The NA reported the facility preferred staff to sit when feeding a resident. However, NA #4 reported she had back and shoulder issues so if she sat by the side of the bed, she would experience pain from having to twist around.	F 241	feeing/positioning The DON/Designee will complete a daily audit of two feedings (1 at breakfast and I at lunch) daily for 7 days for 2 weeks. Then 2x a day for 3 days a week (1 at breakfast and 1 at lunch) for three weeks for a total amount of 46 observations. The DON/Designee will monitor the daily audits for compliance. Monitoring of compliance will be reported at the March 2017 and April 2017 QA meeting. F241 Plan of correction For resident #6 and all residents having potential to be affected. All staff have been educated by DON on assisting with feeding of residents and proper procedures related to positioning and being at eye level beginning 2-10-17 with completion 2-28-17. No negative outcome was identified by the alleged deficient practice. Education to alter practice to ensure that the problem does not reoccur included if unable to sit at eye level to feed the patient and standing staff to raise bed to eye level. Education also included to not sit on a bed while feeding a resident. All new hires will be educated on the proper feeding technique to include feeding the resident at eye level. Corrective action will be monitored to ensure the alleged deficient practice will	

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F 241	Continued From page 3 A telephone interview was conducted with NA #3 on 2/10/17 at 10:05 AM. Upon inquiry, the NA stated she "has a habit" of standing when feeding residents. NA #3 reported she was unsure as to what the facility policy was, but thought they encouraged sitting while assisting a resident to eat. An interview was conducted on 2/10/17 at 10:20 AM with the facility ' s Director of Nursing (DON) in regards to the observations made of staff standing over residents while assisting them with meals. During the interview, the DON reported the beds in the facility were hospital beds (versus standard nursing facility beds). She stated the beds were higher than a standard nursing facility bed and could not be lowered enough to allow staff to sit at eye level while feeding a resident. The DON stated she has recognized this issue and would rather have the staff standing so they can better reach the resident, be eye level to resident, and able to talk and encourage them to eat. 3) Resident #6 was admitted to the facility on 8/22/11, with re-entry from the hospital on 1/4/17. The resident was referred and admitted to Hospice on 2/8/17. A review of Resident #6 ' s admission Minimum Data Set (MDS) assessment dated 1/9/17 revealed the resident had intact cognitive skills for daily decision making. The resident was totally dependent on staff for all of her Activities of Daily Living (ADLs), with the exception of requiring extensive assistance with dressing and personal hygiene. She was noted to be independent with eating.	F 241	not re occur: The DON/Designee will complete a daily audit to ensure of proper feeing/positioning. The DON/Designee will complete a daily audit of two feedings (1 at breakfast and l at lunch) daily for 7 days for 2 weeks. Then 2x a day for 3 days a week (1 at breakfast and 1 at lunch) for three weeks for a total amount of 46 observation Monitoring of compliance will be reported at the March 2017 and April 2017 QA meeting. F241 Plan of correction For resident #21 and all residents having potential to be affected. All staff have been educated by the DON on assisting with feeding of residents and proper procedures related to positioning and being at eye level beginning 2-10-17 with completion 2-28-17. No negative outcome was identified by the alleged deficient practice. Education to alter practice to ensure that the problem does not reoccur included if unable to sit at eye level to feed the patient and standing staff to raise bed to eye level. Education also included to not sit on a bed while feeding a resident. All new hires will be educated on the proper feeding technique to include feeding the resident at eye level.	

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F 241	Continued From page 4 A review of Resident #6 ' s Nutrition Care Plan dated 1/9/17 included an intervention for staff to assist the resident with feeding as needed. On 2/7/17 at 12:58 PM, Resident #6 was observed as she was fed her noon meal by Nursing Assistant (NA) #2. Resident #6 was lying in bed with the head of the bed elevated. NA #2 was observed standing over the resident next to the bed as she assisted her with the meal. The NA was observed to be standing above eye level for Resident #6. An attempt was made to interview Resident #6 on 2/8/17 at 10:20 AM. The resident appeared very sleepy and did not verbally respond to questions posed. On 2/9/17 at 8:20 AM, NA #2 was observed as she entered Resident #6 ' s room. At 8:26 AM, the NA was observed standing over the resident next to the bed as she assisted Resident #6 with her breakfast meal. NA #2 was observed to be standing above eye level while assisting the resident to eat. An interview was conducted on 2/9/17 at 9:24 AM with Nurse #2. Nurse #2 had been assigned to care for Resident #6. Upon inquiry, Nurse #2 confirmed the resident was verbal at times but was not interviewable due to her recent decline in health and mental status. An interview was conducted with NA #2 on 2/10/17 at 10:00 AM. When asked if she usually assisted residents with their meals while sitting or standing, the NA stated, "It all depends on the position ...I prefer to sit on the edge of the bed to	F 241	Corrective action will be monitored to ensure the alleged deficient practice will not re occur. The DON/Designee will complete a daily audit of two feedings (1 at breakfast and I at lunch) daily for 7 days for 2 weeks. Then 2x a day for 3 days a week (1 at breakfast and 1 at lunch) for three weeks for a total amount of 46 observations. Monitoring of compliance will be reported at the March 2017 and April 2017 QA meeting.	

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F 241	Continued From page 5	F 241		

feed the resident." The NA reported the facility ' s policy indicated the staff member should be at eye level when assisting residents to eat. However, the NA stated there was not always a place to sit when she assisted a resident at mealtime.

An interview was conducted on 2/10/17 at 10:20 AM with the facility ' s Director of Nursing (DON) in regards to the observations made of staff standing over residents while assisting them with meals. During the interview, the DON reported the beds in the facility were hospital beds (versus standard nursing facility beds). She stated the beds were higher than a standard nursing facility bed and could not be lowered enough to allow staff to sit at eye level while feeding a resident. The DON stated she has recognized this issue and would rather have the staff standing so they can better reach the resident, be eye level to resident, and able to talk and encourage them to eat.

4) Resident #21 was admitted to the facility on 8/16/11 from the community. Her cumulative diagnoses included Alzheimer ' s disease.

A review of Resident #21 ' s quarterly Minimum Data Set (MDS) assessment dated 11/2/16 revealed the resident had severely impaired cognitive skills for daily decision making. Resident #21 required total assistance from staff for all of her Activities of Daily Living (ADLs).

On 2/10/17 at 8:40 AM, Nursing Assistant (NA) #4 was observed standing over Resident #21 next to the bed as she made multiple attempts to assist the resident with her breakfast. The NA was observed to be standing above the resident ' s

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F 241	Continued From page 6 eye level. Resident #21 appeared to be resistant to eating her meal at the time of the observation. An interview was conducted with NA #4 on 2/10/17 at 9:11 AM. During the interview, the NA was asked what the facility policy was in regards to standing while assisting a resident with a meal. The NA reported the facility preferred staff to sit when feeding a resident. However, NA #4 reported she had back and shoulder issues so if she sat by the side of the bed, she would experience pain from having to twist around. An interview was conducted on 2/10/17 at 10:20 AM with the facility ' s Director of Nursing (DON) in regards to the observations made of staff standing over residents while assisting them with meals. During the interview, the DON reported the beds in the facility were hospital beds (versus standard nursing facility beds). She stated the beds were higher than a standard nursing facility bed and could not be lowered enough to allow staff to sit at eye level while feeding a resident. The DON stated she has recognized this issue and would rather have the staff standing so they can better reach the resident, be eye level to resident, and able to talk and encourage them to eat.	F 241		
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		2/10/17

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F 278	Continued From page 7 (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code active diagnoses on the comprehensive assessment tool, the Minimum Data Set (MDS), for 2 of 5 sampled residents reviewed for unnecessary medications (Resident #7 and Resident #27); and, failed to accurately code the MDS to reflect the medications administered during the 7-day look back period for 2 of 5 sampled residents reviewed for unnecessary medications (Resident #7 and Resident #27).	F 278	F278 Corrective action for Resident #7 and all residents having potential to be affected. MDS-RN received education that included that the diagnosis have to be entered each time that a MDS is created on 2-10-17 from Point Click Care vendor representative on software capability related to Section I-diagnosis. DON	

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F 278

Continued From page 8

The findings included:

1a) Resident #7 was admitted to the facility on 5/7/14 with re-entry from the hospital on 9/21/16. Her cumulative diagnoses included Chronic Obstructive Pulmonary Disease (COPD), chronic respiratory failure, dementia, hypertension, Gastro-Esophageal Reflux Disease (GERD), depression, atrial fibrillation (an irregular heartbeat), anemia, and Chronic Kidney Disease Stage 3.

A review of Resident #7 ' s quarterly Minimum Data Set (MDS) assessment dated 12/14/16 revealed Section I (Active Diagnoses) did not identify the presence of any active diagnoses from the check list provided in that section. Also, the option of checking "None of the above active diagnoses within the last 7 days" was not selected. No additional active diagnoses were reported in the space provided at the bottom of Section I.

An interview was conducted on 2/9/17 at 3:33 PM with the MDS Nurse. Upon inquiry, the MDS Nurse reviewed Resident #7 ' s active diagnoses (from the electronic records) and her MDS records. The nurse reported COPD should have been checked as an active diagnosis from the list in Section I of the MDS. The MDS Nurse also stated she should have reported additional diagnoses in the blanks at the bottom of Section I. The additional diagnoses should have included: GERD, unspecified dementia, respiratory failure; dependence on oxygen, kidney disease, and unspecified iron-deficiency anemia.

An interview was conducted on 2/10/17 at 7:40

F 278

educated MDS-RN on completion of the Section I-diagnosis each time MDS entered due to Point Click Care system not automatically populating Section I diagnosis on 2-10-17. To ensure that this deficient practice does not reoccur MDS-RN now understands that the diagnosis will have to be entered each time an MDS is started.

100% audit of MDS entry to be completed by DON with each MDS entry x2 weeks. 50% of MDS entered to be audited x2 weeks by DON. Ongoing there will be a 30% check of all MDS completed monthly by DON.

Monitoring of compliance will be reported to the monthly QA committee meting starting in March 2017 and will continue until September 2017.

F278

Corrective action for Resident #27 and all residents having potential to be affected.

MDS-RN received education that included that the diagnosis have to be entered each time that a MDS is created on 2-10-17 from Point Click Care vendor representative on software capability related to Section I-diagnosis. DON educated MDS-RN on completion of the Section I-diagnosis each time MDS entered due to Point Click Care system not automatically populating Section I diagnosis on 2-10-17. To ensure that this deficient practice does not reoccur

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F 278	Continued From page 9 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated she would expect the MDS assessments to be coded properly. 1b) Resident #27 was admitted to the facility on 7/9/15. Her cumulative diagnoses included Generalized Anxiety Disorder (GAD), anxiety/agitation, insomnia, hypertension, Gastro-Esophageal Reflux Disease (GERD), gout and hypothyroidism. A review of Resident #27 ' s quarterly Minimum Data Set (MDS) dated 1/18/17 revealed Section I (Active Diagnoses) did not identify the presence of any active diagnoses from the check list provided in that section. Also, the option of checking "None of the above active diagnoses within the last 7 days" was not selected. No additional active diagnoses were reported in the space provided at the bottom of Section I. An interview was conducted on 2/10/17 at 7:40 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated she would expect the MDS assessments to be coded properly. An interview was conducted on 2/10/17 at 11:42 AM with the MDS Nurse. During the interview, the nurse reported she had contacted the support service for the facility ' s MDS software earlier that morning. The MDS nurse reported she was told Section I of the MDS was auto-populated so it would show up on the computer screen as if it had been completed. The nurse stated she believed this was the reason why she had missed filling out Section I of the MDS assessment.	F 278	MDS-RN now understands that the diagnosis will have to be entered each time an MDS is started. 100% audit of MDS entry to be completed by DON with each MDS entry x2 weeks. 50% of MDS entered to be audited x2 weeks by DON. Ongoing there will be a 30% check of all MDS completed monthly by DON. Monitoring of compliance will be reported to the monthly QA committee meeting starting March 2017 and will continue September 2017. F278 Corrective action for Resident #7 and all residents having potential to be affected. MDS-RN received education of completion of Section N coding and drug types on 2-10-17 by DON. DON educated on RAI process regarding medication classes. 100% audit of MDS input to be completed by DON on each MDS entered x 2 weeks. Then 30% of MDS entered to be audited x 2 weeks by Director of Nursing. Ongoing there will be a 30% check of all MDS completed monthly by DON. Monitoring of compliance will be reported to the monthly QA committee meeting beginning March 2017 thru September 2017.	

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F 278	Continued From page 10 2a) Resident #7 was admitted to the facility on 5/7/14 with re-entry from the hospital on 9/21/16. Her cumulative diagnoses included depression and atrial fibrillation (an irregular heartbeat). A review of Resident #7 ' s quarterly Minimum Data Set (MDS) assessment dated 12/14/16 revealed Section N (Medications) reported the resident received both antianxiety and hypnotic medications on 7 out of the 7 days during the look back period. Section N did not indicate the resident received an antidepressant, an anticoagulant, nor an antibiotic medication during the 7-day look back period. A review of the resident ' s December 2016 Medication Administration Record (MAR) revealed the resident received the following medications on a daily basis: 100 milligrams (mg) sertraline (an antidepressant) given as one tablet by mouth once daily; 5 mg Eliquis (an anticoagulant) given as one tablet by mouth twice daily; 0.5 mg lorazepam (an antianxiety medication) given as one tablet by mouth every 8 hours as needed; 50 mg trazodone given as 1 tablet by mouth every night at bedtime; 15 mg mirtazapine given as ½ tablet (7.5 mg) by mouth once daily at bedtime; and 100 mg Macrobid (an antibiotic) given as one capsule by mouth every night at bedtime. An interview was conducted on 2/9/17 at 3:33 PM with the MDS Nurse. Upon inquiry, the MDS Nurse reviewed Resident #7 ' s electronic and paper charts. After her review, the nurse confirmed that while Section N of the MDS was coded accurately for the antianxiety medication, other medications were not. The MDS nurse reported Resident #7 did receive an anticoagulant	F 278	F278 Corrective action for Resident # 27 and all residents having potential to be affected. MDS-RN received education of completion of Section N coding and drug types on 2-10-17 by DON. DON educated on RAI process regarding medication classes. 100% audit of MDS input to be completed by DON on each MDS entered x 2 weeks. Then 30% of MDS entered to be audited x 2 weeks by Director of Nursing. Ongoing there will be a 30% check of all MDS completed monthly by DON. Monitoring of compliance will be reported to the monthly QA committee meeting beginning March 2017 thru September 2017.	

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(Eliquis) and antidepressants (sertraline, trazodone, and mirtazapine) on 7 out of 7 days during the look back period. The nurse was uncertain as to why she had reported the resident received a hypnotic medication but believed she may have counted trazodone as a hypnotic instead of an antidepressant medication. Failure to code Macrobid in Section N of the MDS as an antibiotic given 7 out of 7 days was not specifically addressed during the interview.

An interview was conducted on 2/10/17 at 7:40 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated she would expect the MDS assessments to be coded properly.

2b) Resident #27 was admitted to the facility on 7/9/15. Her cumulative diagnoses included Generalized Anxiety Disorder (GAD), anxiety/agitation, and insomnia.

A review of Resident #27 ' s quarterly Minimum Data Set (MDS) dated 1/18/17 revealed Section N (Medications) reported the resident received an antipsychotic, antianxiety and hypnotic medication on 7 out of the 7 days during the look back period. Section N did not indicate the resident received an antidepressant during the 7-day look back period.

A review of the resident ' s January 2017 Medication Administration Record (MAR) revealed the resident received the following medications on a daily basis: 20 milligrams (mg) citalopram (an antidepressant) given as one tablet by mouth once daily; 1 mg haloperidol (an antipsychotic) given as one tablet by mouth twice daily; 1 mg lorazepam (an antianxiety) given as

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F 278	Continued From page 12 one tablet by mouth twice daily; and 15 mg temazepam (a hypnotic medication) given as one capsule by mouth once daily at bedtime. An interview was conducted on 2/10/17 at 7:40 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated she would expect the MDS assessments to be coded properly. An interview was conducted on 2/10/17 at 11:42 AM with the MDS Nurse. Upon inquiry, the MDS Nurse reviewed Resident #27 ' s electronic and paper charts, including the January 2017 MAR. After her review, the nurse confirmed Resident #27 did receive an antidepressant (citalopram) on 7 out of 7 days during the look back period. The MDS Nurse reported use of the antidepressant should have been reported in Section N of the MDS.	F 278		
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights	F 279		3/6/17

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set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

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F 279	Continued From page 14 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to develop a comprehensive care plan for 1 of 3 sampled residents (Resident #30) reviewed for range of motion; and, for 2 of 3 sampled residents (#29 and #30) reviewed for activities. Findings included: 1. Resident #30 was admitted to the facility on 7/23/14 with diagnoses which included: cerebrovascular accident with right sided weakness, rheumatoid arthritis, and osteoarthritis. Review of the annual MDS (minimum data set) dated 11/23/16 indicated Resident #30 was cognitively impaired and had limited range of motion of her bilateral lower extremities. There was no plan of care available with measurable goals and interventions to address the care and treatment related to Resident #30's range of motion needs. During an observation on 2/7/17 at 12:30pm, Resident #30 was sitting up in her bed, feeding herself lunch. The resident was alert but answered questions with confused responses. During an interview on 2/9/17 at 4:39pm, the MDS Nurse revealed Resident #30 had not been	F 279	F279 Corrective action for Resident # 30 and # 29 and residents affected by alleged deficient practice. The care plan for resident #29 was reviewed and updated to reflect the residents needs to include activity preferences.To ensure that the deficient practice dose not reoccur the MDS-RN and Activity Director were educated by the DOn on the requirement that a facility must develop a comprehensive care plan for each resident based on the care needs identified in the comprehensive assessment which includes Activities on 2/13/17. 100 % Audit of current resident care plans was completed by DON on 3-1-17 to determine that care plans reflect the residents needs based on the most recent comprehensive assessment. Any incomplete care plans identified were updated by MDS-RN. 50% audit of care plans to be completed x 2 weeks by DON/Designee. Ongoing there will be a 30% monthly audit completed by DON/Designee.	

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F 279	Continued From page 15 ambulatory since admission. She acknowledged the resident was not, but should have been care planned for ADLs (activities of daily living) which would have included the resident's limited range of motion of her lower extremities. 2. Resident #29 was admitted to the facility on 4/7/14 with diagnoses which included: Alzheimer's disease, dementia, aphasia, and adult failure to thrive. The quarterly MDS (minimum data set) dated 11/22/16 indicated Resident #29 was severely cognitively impaired. There was no plan of care with measurable goals and interventions to address care and treatment related to Resident #29's participation in activities. During an observation on 2/7/17 at 12:55pm, Resident #29 was lying in bed assisted with his meal by a nursing assistant. The resident was not verbal, unable to answer questions. During an interview on 2/10/17 at 2:45pm, the Activity Director indicated Resident #29 was always in bed, sleeping most of time and did not respond to verbal stimuli. She revealed the activity she provided with the resident was one on one talking to the resident once every five days. She also revealed that she did not maintain an Activity Attendance Log for residents. During an interview on 2/10/17 at 5:02pm, the MDS Nurse confirmed there was no Activity Care Plan available for Resident #29, but there should have been.	F 279	Implementation of Activity Attendance Log completed and implemented on 3-1-17 to record attendance of activities for all residents. Monitoring of compliance will be reported to QA committee monthly beginning March 2017 thru September 2017. Corrective action for Resident #30 and residents affected by alleged deficient practice. To ensure that the deficient does not reoccur the MDS-RN and Activity Director were educated by DON on the requirement that a facility must develop a comprehensive care plan for each resident based on the care needs identified in the comprehensive assessment which includes activities and range of motion on 2-13-17 by DON. The care plan for resident #30 was reviewed and updated to reflect the residents needs to include range of motion and activity preferences on 3/6/17. 100 % Audit of current resident care plans was completed by DON on 3-1-17 to determine that care plans reflect the residents needs based on the most recent comprehensive assessment. Any incomplete care plans identified were updated by MDS-RN.	

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F 279	Continued From page 16 3. Resident #30 was admitted to the facility on 7/23/14 with diagnoses which included: cerebrovascular accident with right sided weakness, rheumatoid arthritis, and osteoarthritis. Review of the annual MDS (minimum data set) dated 11/23/16 indicated Resident #30 was cognitively impaired and had activity preferences which included going outside and religious services. There was no plan of care with measurable goals and interventions to address care and treatment related to Resident #30's activity preferences. During an observation on 2/7/17 at 12:30pm, Resident #30 was sitting up in her bed, feeding herself lunch. The resident was alert but answered questions with confused responses. During an interview on 2/9/17 at 10:50am, Resident #30's daughter revealed she volunteered at the facility working with the Activity Director on Monday through Saturday, but still visited the resident on Sundays, after church. She revealed the resident used to get out of bed for group Bingo but currently refused. She also revealed that she visited with the resident every day to talk about current events. During an interview on 2/9/17at 3:00p, the MDS Nurse acknowledged Resident #30 should have been care planned for activities, stating "I missed it".	F 279	50% audit of care plans to be completed x 2 weeks by DON/Designee. Ongoing there will be a 30% monthly audit completed by DON/Designee. Monitoring of compliance will be reported to QA committee at next monthly meeting beginning March 2017 thru September 2017.	
F 280	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO	F 280		3/9/17

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F 280 SS=D	Continued From page 17 PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and	F 280		

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F 280	Continued From page 18 cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 280		

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F 280	Continued From page 19 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews, the facility failed to revise the Care Plan of 1 of 3 residents reviewed for significant weight loss. (Resident #16). Findings included: Resident #16 was admitted to the facility on 5/27/10 with diagnoses which included: congestive heart failure, anemia, hypothyroidism, edema, dysuria, and hypothyroidism. Review of the most recent MDS (minimum data set) dated 11/16/16 indicated Resident#16 was severely, cognitively impaired; was independent with eating; had weight gain; and received a therapeutic diet. The Weights for this resident in six months were: Weight on 1/2/17 was 99 lbs. (pounds); Weight 30 days ago (12/05/2016): 108 lbs. (which is 9 lbs. less than on the first date or a 9.1% loss) Weight 90 days ago (10/06/2016): 99 lbs. (which is 0 lbs. more than on the first date or a 0.0% gain) Weight 180 days ago (08/04/2016): 105 lbs. (which is 6 lbs. less than on the first date or a 6.1% loss) The review of Resident #16's Care Plan was not updated to include the resident's fluctuations in weight status. During an observation and interview on 2/10/17 at 9:00am, Resident #16 was completing her	F 280	F280 Corrective action for residents affected by alleged deficient practice. The care plan for Resident #16 was reviewed and updated to reflect the residents needs to include a dietary care plan. MDS-RN, Dietician, and Pharmacist were educated by DON on 3-1-17 and Social Worker on 3-2-17 of requirement to complete a comprehensive assessment for each resident including dietary. 100 % Audit of current resident care plans was completed by DON on 3-1-17 to determine that care plans reflect the residents needs based on the most recent comprehensive assessment. Any incomplete care plans identified were updated by MDS-RN. 50% audit of care plans to be completed x 2 weeks by DON/Designee. Ongoing there will be a 30% monthly audit completed by DON/Designee. Entry of dietary care plans into Point Click Care will be completed by 3-9-17. Monitoring of compliance will be reported the next quarterly QA meeting.	

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F 280	Continued From page 20 breakfast assisted by NA#2 (nursing assistant). NA#2 indicated the resident was able and would feed herself some of her meal and stop; then she (NA#2) would assist the resident with the remaining meal. During an interview on 2/10/17 at 10:16am, the RD (Registered Dietitian) revealed Resident #16 received a no added salt, lactose free diet with finely chopped meats. The RD stated that the resident's desirable weight range for her height of 52.5 inches was 73-89 lbs. She revealed the resident has had weight variations in the past (three months prior), then her weight would level off between 107 lbs. to 109 lbs. for two months then begin to fluctuate again for a few months. During an interview on 2/10/17 at 5:35pm, the RD confirmed the Nutrition Care Plan was not updated and acknowledged it should have been to include Resident #16's weight fluctuations.	F 280		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F 329		3/6/17

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F 329	Continued From page 21 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff and pharmacist interviews, the facility failed to identify and attempt a Gradual Dose Reduction (GDR) or document the continued need for an antidepressant (citalopram), an antianxiety (lorazepam), and a hypnotic (temazepam) medication ordered for 1 of 5 sampled residents reviewed for unnecessary drugs (Resident #27). The findings included: Resident #27 was admitted to the facility on 7/9/15. Her cumulative diagnoses included Generalized Anxiety Disorder (GAD),	F 329	F329 Plan of Correction Dose reductions for Lorazepam (PRN), Temazepam, and Citalopram were initiated for resident #27 on 02/10/17. Scheduled Lorazepam dose was reduced on 3/6/17. Audit was completed on 2-10-17 by pharmacist for those residents having potential to be affected by the alleged deficient practice.	

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F 329	Continued From page 22 anxiety/agitation, and insomnia. A review of Resident #27 ' s March 2016 Physician ' s Orders revealed her medications included the following orders, in part: 20 milligrams (mg) citalopram given as one tablet by mouth once daily; 1 mg lorazepam given as one tablet by mouth twice daily; 1 mg lorazepam given every two hours as needed for anxiety; and 15 mg temazepam given as one capsule by mouth every night at bedtime. A review of Resident #27 ' s quarterly Minimum Data Set (MDS) dated 1/18/17 revealed the resident had moderately impaired cognitive skills for daily decision making. She was independent with eating, required limited assistance from staff for her bed mobility and personal hygiene, and required extensive assistance for dressing and toileting. Section E of the MDS indicated the resident did not exhibit any behaviors nor rejection of care. A review of Resident #27 ' s February 2017 Physician ' s Orders revealed her medications included the following orders: 20 mg citalopram given as one tablet by mouth once daily; 1 mg lorazepam given as one tablet by mouth twice daily; 1 mg lorazepam given every two hours as needed for anxiety; and 15 mg temazepam given as one capsule by mouth every night at bedtime. Further review of Resident #27 ' s medical record revealed there was no documentation of GDRs having been addressed for the citalopram, lorazepam, or temazepam currently prescribed. An interview was conducted on 2/10/17 at 2:09 PM with the facility ' s consultant pharmacist.	F 329	To protect residents in similar situations and ensure problem does not recur regimens for each resident are reviewed each month by the pharmacist. Pharmacist will recommend gradual dose reduction attempts at this time along with the discontinuation of unnecessary medications. A monitoring tool has been employed by the pharmacist to aid in tracking gradual dose reductions of sedative/hypnotics, anti-anxiety agents, and antipsychotic medications. Pharmacist will attend weekly care-plan meetings and discuss resident's medication therapy with special attention focused on gradual dose reductions of above mentioned medications. Discussion to include, but not limited to 1) medication name and current dose, (2) date of last gradual dose reduction attempt, and (3) whether the dose reduction trial is successful or not. If, at care plan meeting it is found that a gradual dose reduction attempt of any of the above mentioned medications has not occurred in the past quarter, then pharmacist will initiate a request for a dose reduction to the attending physician that day. The MDS Coordinator will determine which residents are scheduled for the weekly care plan meetings, with 100% of residents care planned at least once every 90 days. Pharmacist will also attend monthly Quality Assurance Meetings where gradual dose reduction attempts for the previous month will be reported. Dose reduction recommendations will be made to	

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F 329	Continued From page 23 Upon inquiry, the pharmacist reported he would expect to address GDRs for lorazepam and temazepam every 3-4 months, and an antidepressant such as citalopram "less often" than that. A follow-up interview was conducted on 2/10/17 at 4:30 PM with the consultant pharmacist. At that time, the pharmacist reported he reviewed his records and found GDRs had not been attempted at any time for the citalopram, lorazepam, nor temazepam prescribed for Resident #27. The pharmacist reported he had already telephoned the resident ' s PA and received new medication orders for the GDRs. When asked if the need for addressing Resident #27 ' s GDRs for the citalopram, lorazepam, and temazepam had been missed, the pharmacist stated, "yes." A copy of the Observation and Recommendation Note written by the consultant pharmacist on 2/10/17 for Resident #27 included the following actions taken and new medication orders received from the resident ' s PA: --"Leave scheduled lorazepam as is; --Decrease PRN (as needed) lorazepam to 0.5 mg po (by mouth); --Decrease temazepam to 7.5 mg po q HS (every night at bedtime) PRN sleep; --Decrease citalopram to 10 mg po daily." An interview was conducted on 2/10/17 at 4:45 PM with the facility ' s Director of Nursing (DON). During the interview, failure to address GDRs for the citalopram, lorazepam, and temazepam for Resident #27 ' s was discussed. Upon inquiry, the DON stated she would expect GDRs to be monitored and addressed. She indicated she	F 329	provider and tracked on enclosed form. Documentation of dose reductions will be placed in the resident's medical record. Monitoring of compliance will be reported monthly beginning in March 2017 thru February 2018 to QA Committee. DON will review residents drug regimens for unnecessary drugs and documented attempts at gradual dose reduction on monthly basis.	

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F 329	Continued From page 24 would expect a discussion to be held with the physician and documented attempts for the GDR made or, alternatively, a reason documented as to why the attempt could not be made.	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to have a medication error rate less than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8%, for 2 of 3 residents (Resident #1 and Resident #15) observed during medication pass. The findings included: 1) On 2/8/17 at 4:05 PM, Nurse #1 was observed preparing medications for administration to Resident #1. The medications pulled for administration included a Flovent HFA inhaler with 110 micrograms (mcg) per actuation (puff). The nurse was observed as she administered two puffs of Flovent HFA to the resident. Flovent HFA is a corticosteroid inhaler used for the management of asthma. A review of Resident #1 ' s physician medication orders included a current order for Flovent HFA 110 mcg inhaler to be given as 2 puffs in the morning and 1 puff in the evening (scheduled for	F 332	F332 Corrective Action for resident #1 and all residents having potential to be affected by alleged deficient practice. Resident #1 had no negative outcomes. MD/family notified of medication error. The nurse involved with medication error was educated by DON prior to survey exit on five rights of medication administration. Remaining nurses received education on five rights of medication administration by DON by 3-3-17. Medication pass audit completed by DON with 50% of nurses completed by 2-24-17. To monitor performance the DON will audit a 25 count medication pass 2x each month for 6 months to ensure a less than 5% medication pass error rate. All new nurses will be educated on the 5 rights of medication administration during orientation.	3/3/17

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F 332	Continued From page 25 5:00 PM). An interview was conducted with Nurse #1 on 2/8/17 at 4:30 PM. Nurse #1 reviewed Resident #1 ' s February 2017 Medication Administration Record (MAR) and the administration instructions written on the pharmacy labeling of the Flovent HFA 110 mcg inhaler used. Upon review of the MAR and pharmacy labeling, Nurse #1 acknowledged the directions written on each indicated only 1 puff of the Flovent HFA should have been given to Resident #1 in the evening. The nurse stated she did not notice these directions and acknowledged she administered two puffs of Flovent HFA to the resident during the medication pass observation, instead of one puff as prescribed. An interview was conducted with the facility ' s Director of Nursing (DON) on 2/10/17 at 4:45 PM. Upon inquiry, the DON indicated her expectation was to have a medication error rate of less than 5%. 2) On 2/9/17 at 8:19 AM, Nurse #3 was observed preparing medications for administration to Resident #15. The medications pulled for administration included one - 500 microgram (mcg) Vitamin B12 tablet. The nurse was observed as she administered the medication to the resident. A review of Resident #15 ' s physician medication orders and the resident ' s February 2017 Medication Administration Record revealed there was a current order for two - 500 mcg Vitamin B12 tablets to be given daily. An interview was conducted with Nurse #3 on	F 332	Monitoring of compliance will be reported to the next monthly QA committee meeting beginning in March 2017 thru September 2017. F332 Corrective Action for resident #15 and all residents having potential to be affected by alleged deficient practice. Resident #15 had no negative outcomes. MD/family notified of medication error. The nurse involved with medication error was educated by DON prior to survey exit on five rights of medication administration. Remaining nurses received education on five rights of medication administration by DON. Medication pass audit completed by DON with 50% of nurses completed by 2-24-17. To monitor performance the DON will audit a 25 count medication pass 2x each month fox 6 months to ensure a less than 5% medication pass error rate. All new nurses will be educated 5 rights of medication administration during orientation. Monitoring of compliance will be reported to the next monthly QA committee meeting beginning in March 2017 thru September 2017.	

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F 332	Continued From page 26 2/10/17 at 12:40 PM. During the interview, Nurse #3 reported she made a mistake during the medication pass observation when she gave Resident #15 one Vitamin B12 tablet instead of the two tablets ordered. An interview was conducted with the facility ' s Director of Nursing (DON) on 2/10/17 at 4:45 PM. Upon inquiry, the DON indicated her expectation was to have a medication error rate of less than 5%.	F 332		
F 333 SS=E	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on hospital and facility record reviews, and staff, pharmacist and Physician Assistant (PA) interviews, the facility failed to provide the extended release formulation of an antihypertensive medication as ordered (metoprolol succinate) to a resident over a period of 30 days. This occurred for one of one resident (Resident #33) reviewed who had been recently discharged from the hospital after experiencing a myocardial infarction (heart attack). The findings included: Resident #33 was admitted to the facility on 6/5/14. Her cumulative diagnoses included diabetes and hypertension (high blood pressure).	F 333	F333 Corrective action for Resident #33 and all residents having potential to be affected by alleged deficient practice. Resident #33 had no negative outcomes. MD/family notified of medication error. The nurse involved with transcription of order was educated 2-15-17 on transcribing orders by DON. The remaining nurses received education by 3-3-17 by DON. New nurses will be education on the transcription process to ensure accurate transcription during orientation by DON/Designee. To ensure	3/3/17

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F 333	Continued From page 27 A review of Resident #33 ' s December 2016 and January 2017 Physician Orders (through 1/5/17) revealed her medications included 25 milligrams (mg) metoprolol tartrate (an immediate release formulation of an antihypertensive medication) given as one tablet by mouth twice daily. A review of the resident ' s medical record revealed that on 1/5/17, Resident #33 complained of dizziness and stated, "I ' m fainting." She was lowered to the floor by a Nursing Assistant. The resident ' s vital signs were taken and included an initial blood pressure of 221/88 with a follow up blood pressure of 200/83 (an optimal blood pressure is typically less than 120/80). The resident was transported to the Emergency Department and admitted to the hospital with a diagnosis of a myocardial infarction. Resident #33 was readmitted to the facility on 1/11/17. A review of the resident ' s hospital Discharge Medication list dated 1/11/17 revealed her new medications included 25 mg metoprolol succinate to be given as one tablet by mouth once daily. The hospital Discharge Medication list also noted her discontinued medications included 25 mg metoprolol tartrate given twice daily. According to Lexi-Comp, a comprehensive on-line drug information resource, metoprolol tartrate is an immediate release formulation of an antihypertensive medication. Therefore, the total daily dosage of metoprolol tartrate should be given in 2 - 3 divided doses each day. However, Lexi-Comp indicates metoprolol succinate is an extended release formulation of the antihypertensive medication. The total daily	F 333	that the problem does not reoccur the transcription process has been changed to include verification by two nurses. 100% audit of transcription of new admits medication orders has been completed since 2-13-17 by DON to ensure accuracy of Medication Administration Record. DON will audit 100% of new admit orders within 48 hours of admission to ensure accuracy of transcription and MAR for 6 months. Monitoring of compliance will be reported at the next monthly QA committee meeting beginning in March 2017 thru September 2017.	

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F 333	Continued From page 28	F 333		

dosage of metoprolol succinate is given as one dose daily.

A review of Resident #33 ' s Physician Orders and Medication Administration Record (MAR) dated 1/11/17 revealed the records were handwritten. Both the physician orders and the MAR indicated Resident #33 was to receive, "metoprolol 25 mg po (by mouth) daily" scheduled once a day at 8:00 AM. The 1/11/17 handwritten orders did not specify whether the metoprolol was to be provided as metoprolol tartrate or metoprolol succinate. The handwritten orders were not initialed or signed to identify who transcribed the orders.

Resident #33 ' s Admission Minimum Data Set (MDS) dated 1/16/17 was reviewed and revealed the resident had moderately impaired cognitive skills for daily decision making. She was independent with eating, required limited assistance from staff for transfers, walking in her room, toileting and personal hygiene. The resident was reported as needing extensive assistance for bed mobility and dressing.

A review of the resident ' s type-written February 2017 Physician Orders and MAR indicated Resident #33 was scheduled to receive 25 mg metoprolol tartrate given as 1 tablet twice daily at 8:00 AM and 5:00 PM. However, both the instructions "twice daily" and the 5:00 PM scheduled dose were crossed out on the forms and, a handwritten notation which read "daily" was written next to the medication. The notation was not initialed.

An interview was conducted on 2/10/17 at 2:37 PM with the facility ' s consultant pharmacist.

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F 333	Continued From page 29 During the interview, the pharmacist reviewed the resident's paper and electronic chart. Upon inquiry, the pharmacist confirmed the resident had received the metoprolol tartrate formulation (instead of metoprolol succinate) since she was readmitted to the facility on 1/11/17 and reported this was apparently an error. The pharmacist indicated he would need to contact the physician to determine whether the metoprolol tartrate dosing should be changed to twice daily or the medication changed to metoprolol succinate given once daily. At the time of the interview on 2/10/17 at 2:37 PM, the consultant pharmacist was observed as he wrote a note to the resident ' s physician, explaining the situation. The note indicated Resident #33 was discharged from acute care on 1/11/17 after experiencing a myocardial infarction. He noted the discharge physician had discontinued the 25 mg metoprolol tartrate given twice daily and ordered 25 mg metoprolol succinate to be given once daily. The pharmacist also noted the pharmacy had continued to provide 25 mg metoprolol tartrate given once daily since the resident ' s discharge from the hospital. On 2/10/17 at 2:55 PM, the Director of Nursing (DON) and consultant pharmacist contacted Resident #33 ' s Physician Assistant (PA) by telephone to clarify the metoprolol order and dosing. A telephone interview was conducted on 2/10/17 at 3:00 PM with the PA. During the telephone interview, the PA confirmed he had just clarified the order and reported the resident should receive 25 mg metoprolol succinate to be given	F 333		

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F 333	Continued From page 30 as one tablet by mouth once daily. Upon inquiry as to whether or not the resident may have had an adverse effect from receiving metoprolol tartrate only once daily for the past month, the PA stated the answer would be based on the resident ' s symptomology. He reported the resident seemed to be doing okay, and therefore the error did not appear to have caused harm to the resident. An interview was conducted on 2/10/17 at 4:45 PM with the facility ' s DON. Upon inquiry, the DON stated she would expect medication orders to be transcribed correctly from the hospital discharge summary.	F 333		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides.	F 356		2/10/17

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F 356	Continued From page 31 (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to include all of the required information on the daily nursing staff postings, including the name of the facility, for 60 of the past 60 days reviewed (12/9/16 through 2/9/17). The findings included: An observation made on 2/7/17 at 11:15 AM revealed the nurse staffing information dated	F 356	F356 Corrective action by placing logo with name was completed on 2-9-17 at 4pm when notified by surveyor of deficient practice. Copies of staffing sheets will be supplied to Robin Hodgin, VP of Patient Services, daily 5 days a week x4 weeks to show correction of deficient practice. Ongoing	

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F 356	Continued From page 32 2/7/17 was posted in the hallway near the nursing station. The name of the facility was not included on the nursing staff posting. An observation made on 2/8/17 at 8:30 AM revealed the nurse staffing information dated 2/8/17 was posted in the hallway near the nursing station. The name of the facility was not included on the nursing staff posting. An observation made on 2/9/17 at 9:10 AM revealed the nurse staffing information dated 2/9/17 was posted in the hallway near the nursing station. The name of the facility was not included on the nursing staff posting. An interview was conducted with facility ' s Director of Nursing (DON) on 2/9/17 at 3:21 PM. The DON reported she was not aware it was required to include the facility name on the nursing staff posting. On 2/10/17 at 7:58 AM, a review of the nursing staff postings from the past 60 days was completed. None of the nursing staff postings reviewed included the name of the facility.	F 356	random audits will be completed once a month by VP of Patient Services. Monitoring will be reported to the monthly QA committee meeting beginning March 2017 thru September 2017.	
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 371		3/1/17

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F 371	Continued From page 33 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain sanitary conditions in the kitchen by not ensuring pans, and food slicing knives were stored/stacked clean and dry; and, by not ensuring food service equipment were maintained clean and free from debris. Findings included: 1. During the observation of the meal tray line service in the kitchen on 2/10/17 at 12:15pm, 2 of 2-plate warmers located next to the meal serving line contained stained, dried brown debris on the inside where clean plates were stacked. Also observed in the kitchen was a table top meat slicer. There were brown crumbs noted beneath the meat slicer. The DM revealed that the plate warmers were cleaned weekly by the dietary staff and acknowledged the inside of both plate warmers were dirty.	F 371	F-371 In-Services were held from 2/13/17-3/1/17 for all dietary staff on proper cleaning procedures, including a review of the policy, with emphasis on cleaning knives, meat slicer, grill, pots and pans, plate and base warmer. To monitor the performance and to make sure solutions were sustained, the dietary coordinator will conduct daily visual inspections of equipment prior to leaving each day. The dietary supervisor will conduct weekly inspections of the kitchen equipment and utensils to include knives, meat slicer, grill, pots/pans, plate warmer and base warmer for adequacy of cleaning. The weekly inspection will be once every seven days on a random schedule for three months. Monitoring will be documented and reported to the QA	

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F 371	Continued From page 34 2. During the kitchen observation with the DM (Dietary Manager) on 2/10/17 at 12:20pm 4-large muffin tins and 2-large pans containing dried brown stains were stacked on the storage rack. Also, the knife rack contained 4-slicing knives that were stained with dried debris. The DM removed these items from storage to the three compartment sink, instructing staff to re-wash them.	F 371	Committee at the next scheduled meeting following the conclusion of the three month monitoring.	
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 428		3/6/17

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F 428	Continued From page 35 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff and pharmacist interviews, the consultant pharmacist failed to identify and address a Gradual Dose Reduction (GDR) for an antidepressant (citalopram), an antianxiety (lorazepam), and a hypnotic (temazepam) medication ordered for 1 of 5 sampled residents reviewed for unnecessary drugs (Resident #27). The findings included: Resident #27 was admitted to the facility on 7/9/15. Her cumulative diagnoses included Generalized Anxiety Disorder (GAD),	F 428	F428 Plan of Correction Dose reductions for Lorazepam (PRN), Temazepam, and Citalopram were initiated for resident #27 on 02/10/17. Scheduled Lorazepam dose was reduced on 3/6/17. Audit was completed on 2-10-17 by pharmacist for those residents having potential to be affected by the alleged deficient practice.	

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F 428	Continued From page 36 anxiety/agitation, and insomnia. A review of Resident #27 ' s March 2016 Physician ' s Orders revealed her medications included the following orders, in part: 1 milligram (mg) haloperidol (an antipsychotic medication) given as two tablets by mouth every 6 hours for anxiety/agitation; 20 milligrams (mg) citalopram given as one tablet by mouth once daily; 1 mg lorazepam given as one tablet by mouth twice daily; 1 mg lorazepam given every two hours as needed for anxiety; and 15 mg temazepam given as one capsule by mouth every night at bedtime. A review of Resident #27 ' s medical record revealed the facility ' s consultant pharmacist completed monthly Medication Regimen Reviews on the following dates: --On 3/22/16, the resident was noted to receive the following medications, in part: haloperidol and lorazepam for anxiety/agitation, citalopram for Generalized Anxiety Disorder (GAD), and temazepam for insomnia. The pharmacist noted mirtazapine (an antidepressant) had been recently discontinued. No other changes related to psychotropic medications were noted at that time. No recommendations regarding psychotropic medications were made. A psychotropic medication is any drug that affects brain activities associated with mental processes and behavior. Psychotropic medications include antipsychotic, antidepressant, antianxiety, and hypnotic medications. --On 4/18/16, no changes related to psychotropic medications were noted. No recommendations regarding psychotropic medications were made. --On 5/12/16, no maintenance medication changes were noted. There were no recommendations made at this time.	F 428	To protect residents in similar situations and ensure problem does not recur regimens for each resident are reviewed each month by the pharmacist. Pharmacist will recommend gradual dose reduction attempts at this time along with the discontinuation of unnecessary medications. A monitoring tool has been employed by the pharmacist to aid in tracking gradual dose reductions of sedative/hypnotics, anti-anxiety agents, and antipsychotic medications. Pharmacist will attend weekly care-plan meetings and discuss resident's medication therapy with special attention focused on gradual dose reductions of above mentioned medications. Discussion to include, but not limited to 1) medication name and current dose, (2) date of last gradual dose reduction attempt, and (3) whether the dose reduction trial is successful or not. If, at care plan meeting it is found that a gradual dose reduction attempt of any of the above mentioned medications has not occurred in the past quarter, then pharmacist will initiate a request for a dose reduction to the attending physician that day. The MDS Coordinator will determine which residents are scheduled for the weekly care plan meetings, with 100% of residents care planned at least once every 90 days. Pharmacist will also attend monthly Quality Assurance Meetings where gradual dose reduction attempts for the previous month will be reported. Dose reduction recommendations will be made to	

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F 428	Continued From page 37 --On 6/21/16, no maintenance medication changes were noted. There were no recommendations made at this time. --On 7/20/16, no changes related to psychotropic medications were noted. There were no recommendations made at this time. --On 8/19/16, the consultant pharmacist noted haloperidol was added at 2 mg scheduled twice daily during the past month. No other medication changes were noted to have been made within the last 60 days. No recommendations were made at this time. --On 9/26/16, the consultant pharmacist notes indicated no maintenance medication changes had been made in the past 30 days. No recommendations were made at this time. --On 10/18/16, no medication changes were noted to have been made within the last 60 days. No recommendations were made at this time. On 10/26/16, the consultant pharmacist wrote an Observation/Recommendation Note for Resident #27 ' s physician which read: "CMS (Centers for Medicare & Medicaid Services) requires gradual dose reduction trials for antipsychotic medications. (Resident #27) is currently getting haloperidol 2 mg po (by mouth) BID (twice daily) (scheduled). She has been on this dose since July. Can a dose reduction trial of 1 mg po BID be initiated or if not could you please provide a clinical note as to why?" A review of the resident ' s medical record revealed the physician agreed with the pharmacist ' s recommendation and reduced the dose of haloperidol from 2 mg to 1 mg given twice daily. Further review of Resident #27 ' s medical record revealed the facility ' s consultant pharmacist completed additional monthly Medication	F 428	provider and tracked on enclosed form. Documentation of dose reductions will be placed in the resident's medical record. Monitoring of compliance will be reported monthly beginning in March 2017 thru February 2018 to QA Committee. DON will review residents drug regimens for unnecessary drugs and documented attempts at gradual dose reduction on monthly basis.	

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Regimen Reviews on the following dates:
--On 11/15/16, the consultant pharmacist noted Resident #27 ' s haloperidol dose was reduced from 2 mg to 1 mg by mouth twice daily with no adverse behaviors noted since the dose reduction. No other medication changes were made in the past 30 days. No recommendations were made at this time.
--On 12/26/16, no adverse behaviors were noted since the haloperidol dose reduction. No maintenance medication changes were made in the past month and no recommendations were made at this time.
--On 1/18/16, no adverse behaviors were noted since the haloperidol dose reduction. No maintenance medication changes were made in the past month and no recommendations were made at this time.

A review of Resident #27 ' s quarterly Minimum Data Set (MDS) dated 1/18/17 revealed the resident had moderately impaired cognitive skills for daily decision making. She was independent with eating, required limited assistance from staff for her bed mobility and personal hygiene, and required extensive assistance for dressing and toileting. Section E of the MDS indicated the resident did not exhibit any behaviors nor rejection of care.

A review of Resident #27 ' s February 2017 Physician ' s Orders revealed her medications included the following orders: 1 mg haloperidol to be given as one tablet by mouth twice daily; 20 mg citalopram given as one tablet by mouth once daily; 1 mg lorazepam given as one tablet by mouth twice daily; 1 mg lorazepam given every two hours as needed for anxiety; and 15 mg temazepam given as one capsule by mouth every

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F 428	Continued From page 39	F 428		

night at bedtime.

Further review of Resident #27 ' s medical record revealed there was no documentation of GDRs having been addressed for the citalopram, lorazepam, or temazepam currently prescribed.

An interview was conducted on 2/10/17 at 2:09 PM with the facility ' s consultant pharmacist. Upon inquiry, the pharmacist reported he would expect to address GDRs for lorazepam and temazepam every 3-4 months, and an antidepressant such as citalopram "less often" than that.

A follow-up interview was conducted on 2/10/17 at 4:30 PM with the consultant pharmacist. At that time, the pharmacist reported he reviewed his records and found GDRs had not been attempted at any time for the citalopram, lorazepam, nor temazepam prescribed for Resident #27. The pharmacist reported he had already telephoned the resident ' s PA and received new medication orders for the GDRs. When asked if the need for addressing Resident #27 ' s GDRs for the citalopram, lorazepam, and temazepam had been missed, the pharmacist stated, "yes."

A copy of the Observation and Recommendation Note written by the consultant pharmacist on 2/10/17 for Resident #27 included the following actions taken and new medication orders received from the resident ' s PA:
--"Leave scheduled lorazepam as is;
--Decrease PRN (as needed) lorazepam to 0.5 mg po (by mouth);
--Decrease temazepam to 7.5 mg po q HS (every night at bedtime) PRN sleep;

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F 428	Continued From page 40 --Decrease citalopram to 10 mg po daily." An interview was conducted on 2/10/17 at 4:45 PM with the facility ' s Director of Nursing (DON). A review of Resident #27 ' s history of psychotropic medications without GDRs addressed was discussed. Upon inquiry, the DON stated she would expect GDRs to be monitored and addressed. She indicated she would expect a discussion to be held with the physician and documented attempts for the GDRs made, or alternatively, a reason documented as to why the attempts could not be made.	F 428		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		3/3/17

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F 431	Continued From page 41 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to date a medication when opened to allow for the determination of its shortened expiration date in 1 of 1 medication storage room and 1 of 2 medication carts (Cart 2 for Rooms 337-352); and, failed to store medications as specified by the drug manufacturer in 2 of 2 medication carts (Cart 1	F 431	F431 Corrective action for the residents affected by the alleged deficient practice. Resident #4 had no negative outcomes related to deficient practice. Nursing staff educated on labeling foil	

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F 431 Continued From page 42
for Rooms 320-336 and Cart 2 for Rooms 337-352).

The findings included:

1) Accompanied by Nurse #2, an observation of the medication store room was made on 2/9/17 at 5:00 PM. The observation revealed a carton of 0.25 mg / 2 ml budesonide inhalation suspension (a corticosteroid medication to be inhaled via use of a nebulizer) dispensed for Resident #4 was stored on a shelf in the medication room. The carton included an opened foil pouch containing 4 vials of inhalation suspension. The manufacturer labeling of the budesonide inhalation suspension included storage instructions which read, in part: "Once the foil envelope is opened, use the vials within 2 weeks." The foil pouch was not dated.

A review of Resident #4 ' s Physician Orders revealed there was a current order for budesonide 0.25 mg / 2 ml inhalation suspension to be given as one vial via nebulizer twice daily.

An interview was conducted on 2/9/17 at 5:05 PM with Nurse #2. When asked how she would know when the foil pouches of budesonide inhalation suspension had been opened, Nurse #2 stated she would not know.

An interview was conducted on 2/10/17 at 4:45 PM with the Director of Nursing (DON). During the interview, the DON reported she would expect pharmacy to make nursing staff aware of any special storage needs for medications.

2) An observation of the medication cart for Rooms 337-352 was made on 2/9/17 at 4:50 PM. The observation revealed one vial of 0.25 mg / 2

F 431

packages with date when opened and storing budesonide inhalation suspension in upright position was completed by DON on 3/3/17. New nurses will be educated on the opening and storage of budesonide inhalation suspension in upright position by DON/Designee. Pharmacy was notified of medication not being stored properly prior to survey team exit.

Audit of medication cart for packages opened that require opened date to be completed daily x2 weeks then 3x a week for 6 weeks for a total of 8 weeks to be completed by DON/Designee.

Audit of medication cart for medications that are required to be stored in a standing position will be completed daily x2 weeks and then 3x a week for 6 weeks for a total of 8 weeks to be completed by DON/Designee

Monitoring of compliance will be reported to the next monthly QA committee meeting beginning on March 2017 thru May 2017.

F431

Corrective action for the residents affected by the alleged deficient practice. Resident #30 had no negative outcomes related to deficient practice.

Nursing staff educated on proper storage of Pred Forte 1% ophthalmic suspension was completed by DON. New nurses will be educated on the storage of Pred Forte

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F 431	Continued From page 43 ml budesonide inhalation suspension (a corticosteroid medication to be inhaled via use of a nebulizer) was stored in an opened foil pouch laying on its side in the medication cart drawer labeled for Resident #4. The manufacturer labeling of the budesonide inhalation suspension included storage instructions which read, in part: "Store unopened vials in the foil envelope placed upright in the carton ...Once the foil envelope is opened, use the vials within 2 weeks." The foil pouch was not stored upright; and, the foil pouch was not dated to indicate when it had been opened. A review of Resident #4 ' s Physician Orders revealed there was a current order for budesonide 0.25 mg / 2 ml inhalation suspension to be given as one vial via nebulizer twice daily. An interview was conducted on 2/9/17 at 5:05 PM with Nurse #2 after observations of both the medication cart (Rooms 337-352) and medication storage room were conducted. When asked how she would know when the foil pouches of budesonide inhalation suspension had been opened, Nurse #2 stated she would not know. Nurse #2 also indicated she was not aware the vials of budesonide inhalation suspension needed to be stored upright. An interview was conducted on 2/10/17 at 4:45 PM with the Director of Nursing (DON). During the interview, the DON reported she would expect pharmacy to make nursing staff aware of any special storage needs for medications. 3) An observation of the medication cart for Rooms 320-336 was made on 2/9/17 at 4:25 PM. The observation revealed 1 - 10 milliliter (ml)	F 431	1% ophthalmic suspension. Pharmacy was notified of medication not being stored properly prior to survey team exit. Audit of medication cart for medications that are required to be stored in a standing position will be completed daily x2 weeks and then 3x a week for 6 weeks for a total of 8 weeks to be by DON/Designee. Monitoring of compliance will be reported to the next monthly QA committee meeting beginning March 2017 thru May 2017.	

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F 431	Continued From page 44 bottle of Pred Forte 1% ophthalmic suspension (a corticosteroid suspension used as an eye drop) dispensed for Resident #30 was stored laying down on its side in a drawer of the medication cart. The manufacturer ' s instructions for storage were covered by the pharmacy labeling. Upon peeling back the pharmacy label, the manufacturer ' s labeling on the bottle of the Pred Forte 1% ophthalmic suspension became visible and read, in part: "Store in upright position." A review of Resident #30 ' s Physician Orders revealed there was a current order for Pred Forte 1% ophthalmic suspension to be given as one drop in the right eye once daily. An interview was conducted on 2/9/17 at 4:30 PM with Nurse #3. Nurse #3 was assigned to the medication cart for Rooms 320-336. During the interview, Nurse #3 reviewed the labeling on the Pred Forte eye drops and reported she would need to find an alternative way to store these eye drops. An interview was conducted on 2/10/17 at 4:45 PM with the Director of Nursing (DON). During the interview, the DON reported she would expect pharmacy to make nursing staff aware of any special storage needs for medications.	F 431		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:	F 520		3/3/17

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F 520	Continued From page 45 (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 and interviews with the facility staff, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these	F 520	F520 Deficiencies in the areas of comprehensive care plan development,	

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F 520	Continued From page 46 interventions that the committee put into place in March of 2016. This was for five recited deficiencies which were originally cited in February of 2016 on a recertification survey and subsequently recited on the current recertification survey. The deficiencies were in the areas of comprehensive care plan development (F279), care plan revision (F280), unnecessary drugs (F329), medication regimen review (F428), and labeling/storage of medications (F431). 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 Assurance Program. The findings included: This tag is cross referred to: a) F279: Develop Comprehensive Care Plans. Based on observations, record reviews, and staff interviews, the facility failed to develop a comprehensive care plan for 1 of 3 sampled residents (Resident #30) reviewed for range of motion; and, for 2 of 3 sampled residents (#29 and #30) reviewed for activities. During the recertification survey of 2/19/16, the facility was cited for F279 for failure to develop a care plan with critical interventions, including monitoring target behaviors and non-pharmacological interventions, for 1 of 6 residents receiving psychotropic medications (Resident #12). On the current recertification survey, the facility was recited for failing to develop a care plan to address range of motion for 1 of 3 sampled residents and activities for 2 of 3 sampled residents reviewed.	F 520	care plan revision, unnecessary drugs, medication regimen review, and labeling/storage of medications was discussed at length with members of the QA committee on 3-3-17. A compliance monitoring tool has been developed to assure these items are monitored and addressed in a timely fashion with immediate follow up as needed. These items will be a standing agenda item at each QA meeting. Frequency of QA meetings will be changed from quarterly to monthly beginning in March 2017 continuing thru February 2018 and will be reassessed at that time regarding continuation of monthly versus quarterly meetings. Weekly assessment of compliance in the areas of comprehensive care plan development, care plan revision, unnecessary drugs, medication regimen review, label/storage of medications will be assessed weekly by the VP of Patient Services.	

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	345278	A. BUILDING ______ B. WING ______	**02/10/2017**

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F 520	Continued From page 47 An interview was conducted on 2/10/17 at 5:30 PM with the facility ' s Director of Nursing (DON) and Vice President (VP) of Patient Services. The areas of recited deficiencies identified by the current recertification survey were discussed during the interview. The DON reported the QAA Committee has been working on the area of care plans since 11/7/16, with care plans being reviewed on a quarterly basis. The DON stated the last staff meeting (held on 1/5/17 with 90% attendance) emphasized the need for staff input on care plans. Additionally, the DON noted residents ' care plans completed in October, November and December of 2016 were reviewed at the QAA meeting on 1/19/17. Upon inquiry, the DON stated the care plan QAA project did not specifically address a timeline and the action plan itself was described as, "ongoing." b) F280: Care Plan Revision. Based on observation, record reviews and staff interviews, the facility failed to revise the care plan of 1 of 3 residents reviewed for significant weight loss (Resident #16). During the recertification survey of 2/19/16, the facility was cited for F280 for failure to update a care plan with the current psychotropic medications and dosages for 1 of 6 residents receiving psychotropic medications (Resident #16). On the current recertification survey, the facility was recited for failing to revise the care plan for a resident reviewed for significant weight loss. An interview was conducted on 2/10/17 at 5:30 PM with the facility ' s Director of Nursing (DON) and Vice President (VP) of Patient Services. The areas of recited deficiencies identified by the	F 520		

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F 520	Continued From page 48	F 520		

current recertification survey were discussed during the interview. The DON reported the QAA Committee has been working on the area of care plans since 11/7/16, with care plans being reviewed on a quarterly basis. The DON stated the last staff meeting (held on 1/5/17 with 90% attendance) emphasized the need for staff input on care plans. Additionally, the DON noted residents ' care plans completed in October, November and December of 2016 were reviewed at the QAA meeting on 1/19/17. Upon inquiry, the DON stated the care plan QAA project did not specifically address a timeline and the action plan itself was described as, "ongoing."

c) F329: Drug Regimen is Free From Unnecessary Drugs. Based on record reviews, and staff and pharmacist interviews, the facility failed to identify and attempt a Gradual Dose Reduction (GDR) or document the continued need for an antidepressant (citalopram), an antianxiety (lorazepam), and a hypnotic (temazepam) medication ordered for 1 of 5 sampled residents reviewed for unnecessary drugs (Resident #27).

During the recertification survey of 2/19/16, the facility was cited for F329 for failure to ensure that Resident #12's drug regimen was free of unnecessary drugs, as they failed to identify and monitor target behaviors and failed to attempt a dose reduction of an antipsychotic medication for 1 of 6 residents. On the current recertification survey, the facility was recited for failing to identify and attempt a GDR, or document the resident ' s continued need for an antidepressant, antianxiety, and hypnotic medication.

An interview was conducted on 2/10/17 at 5:30

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PM with the facility ' s Director of Nursing (DON) and Vice President (VP) of Patient Services. The areas of recited deficiencies identified by the current recertification survey were discussed during the interview. Upon inquiry, the DON reported a spread sheet was developed and put into place by the consultant pharmacist after the facility ' s last recertification to address the areas of unnecessary medications and gradual dose reductions. Data from the information collected was reviewed by the DON and reported to the QAA committee quarterly.

d) F428: Medication Regimen Review. Based on record reviews, and staff and pharmacist interviews, the consultant pharmacist failed to identify and address a Gradual Dose Reduction (GDR) for an antidepressant (citalopram), an antianxiety (lorazepam), and a hypnotic (temazepam) medication ordered for 1 of 5 sampled residents reviewed for unnecessary drugs (Resident #27).

During the recertification survey of 2/19/16, the facility was cited for F428 for failure of the consultant pharmacist to recommend a gradual dose reduction and/or a risk versus benefit rationale for the continued use of an antipsychotic medication for 1 of 6 residents reviewed for unnecessary medications (Resident #12). On the current recertification survey, the facility was recited for the consultant pharmacist failing to identify and address a GDR for a resident continuing to receive an antidepressant, antianxiety, and hypnotic medication.

An interview was conducted on 2/10/17 at 5:30 PM with the facility ' s Director of Nursing (DON) and Vice President (VP) of Patient Services. The

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F 520	Continued From page 50 areas of recited deficiencies identified by the current recertification survey were discussed during the interview. Upon inquiry, the DON reported a spread sheet was developed and put into place by the consultant pharmacist after the facility ' s last recertification to address the areas of unnecessary medications and gradual dose reductions. Data from the information collected was reviewed by the DON and reported to the QAA committee quarterly. e) F431: Labeling and Storage of Drugs. Based on observation, record review and staff interviews, the facility failed to date a medication when opened to allow for the determination of its shortened expiration date in 1 of 1 medication storage room and 1 of 2 medication carts (Cart 2 for Rooms 337-352); and, failed to store medications as specified by the drug manufacturer in 2 of 2 medication carts (Cart 1 for Rooms 320-336 and Cart 2 for Rooms 337-352). During the recertification survey of 2/19/16, the facility was cited for F431 for failure to remove an expired medication from one of two medication carts and failure to date a multi dose insulin vial when opened in one of one medication rooms. On the current recertification survey, the facility was recited for failing to date medications when opened to allow for the determination of a shortened expiration date; and, for failing to store medications as specified by the drug manufacturer. An interview was conducted on 2/10/17 at 5:30 PM with the facility ' s Director of Nursing (DON) and Vice President (VP) of Patient Services. The areas of recited deficiencies identified by the	F 520		

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F 520	Continued From page 51 current recertification survey were discussed during the interview. Upon inquiry, the DON reported the deficiency related to medication labeling and storage from the facility ' s last recertification had more to do with expired medications. She indicated the medication labeling/storage concerns identified during the current recertification survey were different from the previous survey.	F 520		