STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to establish and maintain a comprehensive emergency preparedness. (EP) plan which described the facility's comprehensive approach to meeting health, safety and security needs for their staff and resident population during an emergency or disaster situation. The facility failed to address the following: -Maintain and review the EP plan annually -Address the resident population and delegation of authority	E 001	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.	7/19/18

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

Electronically Signed | 07/08/2018

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E 001	Continued From page 1 -Collaborate with local, state and Federal EP officials -Assess Subsistence needs for staff and residents -Develop a procedure for tracking staff and residents -Safe evacuation -Primary and alternate means of communication -Plan to shelter in place -System of sharing of medical documentation, securement and availability -Policy and procedure for emergency volunteers -Emergency official Contact information -Method of sharing the EP plan with families or representatives -Evidence of staff training on the EP plan -Emergency power and stand-by power system and fuel needs The findings included: Review of the facility EP plan manual provided by the facility with policies and procedures was conducted. The manual did not contain a written established comprehensive EP program that met the federal requirements. Interview on 06/21/18 at 8:00 AM, the Administrator stated she was aware of the missing elements in the facility EP plan. Interview on 06/21/18 at 10:00 AM, the Maintenance Director stated he was new to long-term care and his position. He stated he was having trouble obtaining assistance and input from local officials.	E 001	1. The Facility Safety Committee (comprised of the facility Administrator, Maintenance Director, Director of Health Services, Clinical Competency Coordinator, Housekeeping Supervisor, and Dietary Manager met on July 6, 2018 for the annual review and maintenance of the facility Emergency Preparedness (EP) Plan. During the meeting the following areas of the plan were updated and discussed by the Committee Members with documentation added to the EP plan binder: Resident Population and delegation of authority, Subsistence needs for the staff and residents, procedure for tracking staff and residents, safe evacuation, primary and alternate means of communication, shelter in place plan, system of sharing medical documentation along with securement and availability, policy and procedure for emergency volunteers, method of sharing EP plan with families and representatives, evidence of staff training on EP plan, as well as Emergency power and stand by power system and fuel needs. The facility Administrator met with the local Fire Marshall & Fire Chief on 7/5/2018 to review the facility EP plan as well as collaborate with local, state, and federal EP officials. Facility Administrator added the emergency official contact information from this meeting to the facility EP plan on 7/6/2108. Processes that lead to the deficiency cited were changes in facility personnel and need for increased education regarding facility EP plan preparedness	

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E 001	Continued From page 2	E 001	2. The procedure for implementing the acceptable Plan of correction for the deficiency cited is as follows: Meetings held on 7/5/2018 with local EP officials as well as the annual review of the plan on 7/6/2018 ensure facility residents are covered with an effective EP plan. Facility Safety Committee met 7/6/2018 for annual review of EP plan and will meet monthly thereafter to discuss EP plan effectiveness and make revisions as needed. Current Facility employees received EP plan training on 7/6/2018 from facility Administrator. Facility employees will be trained at time hire and quarterly regarding the facility EP plan. Facility will collaborate with local officials yearly to ensure facility EP plans include current contact information for local, state, and federal officials. Facility mailed EP plan information to current resident families and responsible parties on 7/5/2018. Facility will mail out information yearly to resident families and representatives regarding emergency preparedness plan. 3. Facility Safety Committee will audit EP plan monthly during Safety Committee meetings for accuracy and training opportunities. Findings of the audits will be discussed by facility Administrator at facility Quality Assurance Performance Improvement Committee (QAPI) meeting monthly. 4. Facility Administrator and Safety Committee Members will be responsible	

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E 001	Continued From page 3	E 001	for implementing this plan of correction. 5. 7/19/2018	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		7/19/18

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F 584	Continued From page 4 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a clean bathroom as evidenced by a brown ring, soil stain at the base of the toilet in 4 of 8 bathrooms observed for environment (Room #s 140, 144, 145, and 148). On 6/18/18 at 9:30 am, 6/19/18 at 3:30 pm, and 6/20/18 at 2:00 pm an observation was conducted of 8 bathrooms on C Hall. Rooms 140, 144, 145 and 148 were observed to have a brown soil-stain ring at the base of the toilet and the tile was noted to be decaying. There was also an odor that resembled mold. On 6/19/18 at 11:00 am the oriented resident in room #144 stated that she thought the base of her toilet was dirty and had an odor. There was a brown ring around the base of the toilet and part of the tile was missing. On 6/20/18 at 11:45 am an interview was conducted with the Hall C housekeeper who stated the floors in the bathroom were cleaned, the brown ring was from soil staining. The caulking was missing and the tile was decaying possibly allowing moisture. The housekeeper stated she did not know if the brown was from rust. The housekeeper had cleaned the floor with several different types of cleaners and it appeared that the soiling was stained into the tile	F 584	1. The bathroom floors in rooms 140, 144, 145, and 148 were deep cleaned by the housekeeping supervisor on 6/20/2018 with the caulking around the base of the commode in each room replaced by the facility Maintenance Director on 6/20/2018. Rooms 140, 144, 145, and 148 had plumbing work done to commode to ensure proper function and caulking was not replaced which exposed the ring left by previous caulking. Processes that lead to the deficiency cited were changes to facility monitoring of resident environment areas. 2. The procedure for implementing the acceptable Plan of correction for the deficiency cited is as follows: Facility bathrooms in residents□ rooms were inspected by the housekeeping supervisor starting 6/21/2018 and ending 7/6/2018. Resident bathroom floors on each of the facility units found by the Housekeeping Supervisor to need deep cleaning were cleaned at the time of the inspection. Resident bathroom floors in need of caulking on each of the facility units had work orders placed by the Housekeeping supervisor to the Maintenance Director. The Maintenance Director reviewed and	

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F 584	Continued From page 5 and unable to be removed. On 6/20/18 at 11:55 am an interview was conducted with the Housekeeping Supervisor who stated that the caulking was removed due to soiling and decay and not replaced. The supervisor had tried several types of cleaning products and had cut away parts of the soiled tile to improve the soil staining. The floor surrounding the toilet had been soil stained for several years. The supervisor felt the tile around the base of the toilet needed to be replaced to remove the soiling stain and improve the appearance. On 6/20/18 at 2:00 pm an interview was conducted with the Administrator who stated the facility does not currently have a plan to correct the decaying tile and soiling at the base of the resident's toilets. The Administrator was not aware that the caulking had been removed and the soiling remained after cleaning at the base of the toilet. On 6/20/18 at 3:15 pm an interview was conducted with maintenance who stated that the caulking was missing from the base of the toilet and there was brown staining from soiling in several of the resident's bathrooms. Maintenance was aware that the soiling was not removed when housekeeping cleaned the bathroom floor.	F 584	responded to the work orders placed in the system by the Housekeeping Supervisor. Facility administrative employees will note condition of bathroom floors on room round form with negative findings documented on the form and reported during AM meeting to the Maintenance Director and Housekeeping Supervisor. Facility nursing, administrative, and housekeeping employees were educated on maintaining a clean resident environment, with a focus on bathrooms, on 7-6-18 by facility Administrator. Facility employees will receive training on maintaining a clean and safe resident environment upon hire and annually. 3. Housekeeping Supervisor and Administrator will randomly audit ten resident bathrooms weekly for four weeks and then monthly. Results of audits will be reported to facility QAPI Committee monthly by Housekeeping Supervisor or Administrator. 4. Housekeeping Supervisor and Administrator will be responsible for implementing this plan of correction. 5.7/19/2018	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		7/19/18

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F 609	Continued From page 6 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to file at 24-hour and 5-day report to the Health Care Personnel Investigations Division for an incident of resident (Resident #55 toward Resident #3) to resident abuse. Resident #55 hit Resident #3 on the back of the head with no negative outcome to Resident #3. This was for 1 of 1 incident reviewed for resident to resident abuse. The findings included: Review of the facility policy titled: "Reporting	F 609	1. Facility Administrator and Assistant Director of Clinical Services were re-educated by facility RN Senior Clinical Nurse regarding abuse reporting with emphasis on resident to resident altercations by 7-19-2018. Facility employees were re-educated on abuse prevention and reporting guidelines by the Director of Health Services on 6-29-2018. Resident #55 and Resident #3 have had no further documented altercations.	

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F 609	Continued From page 7 Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property" dated last revised 4/26/17 read as follows: The state survey agency and state agency for adult protective services should be notified in accordance with state law through established procedures of any allegation of abuse within 2 hours after the allegation is made if the events upon which the allegation is based involves abuse. If the events upon which the allegation is based do not involve abuse and do not result in serious injury, the allegation many be reported no later than 24 hours. a. Resident #55 was admitted on 10/3/16 with a diagnosis of unspecified Schizophrenia. Resident #55's quarterly Minimum Data Set (MDS) dated 12/8/17 indicated he had a Brief Inventory of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment and was not coded for any behaviors. b. Resident #3 was admitted 5/13/14 with cumulative diagnoses of seizures and dementia. Resident #3 quarterly MDS dated 12/14/17 indicated a BIMS score of 2 indicating severe cognitive impairment and he was coded for behaviors not directed toward other. Review of a nursing note dated 1/12/18 at 9:20 AM read Resident #55 and Resident #3 had a verbal altercation in the hall. The note indicated both residents were separated at that time. Resident #55 went into the dining room where Resident #3 was sitting and hit Resident #3 with an open hand on the back of the head. Both residents were again separated. The psychological services provider was called and Resident #55's medications were adjusted. The	F 609	2. The procedure for implementing the acceptable Plan of correction for the deficiency cited is as follows: Facility audit of current residents medical records by facility Administrator started 7-6-2018 and ending 7-10-2018 failed to reveal evidence of unreported resident to resident altercations. Facility nursing, dietary, housekeeping, and administrative employees were re-educated on 6-29-2018 by Director of Health Services regarding abuse reporting guidelines. Facility employees not attending the 6-29-18 education will be re-educated during their next working shift by the DHS, Administrator, or Immediate Supervisor. Facility employees are educated on abuse prevention and reporting upon hire and annually. 3. Facility Administrator and/or Department Heads will provide random scenarios to facility staff daily for fourteen days, then weekly for two weeks, then monthly where staff must decide if the scenario constitutes a reportable incident or not. Results of scenarios and subsequent education will be reported to the QAPI Committee meeting monthly to ensure compliance. 4. Facility Administrator will be responsible for implementing this plan of correction. 5.7/19/2018	

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F 609	Continued From page 8	F 609		

responsible party for both residents were notified as well as the physician.

Review of the facility incidents list from January 1, 2018 to 6/21/18 did not include any documentation of an incident involving Resident #55 and Resident #3.

Review of an Interdisciplinary Team note dated 1/12/18 indicated Resident #55's physical altercation with Resident #3 was discussed. An in-patient psychological consult was recommended.

Review of an Interdisciplinary Team note dated 1/15/18 indicated the facility request for a psychological inpatient setting was denied for Resident #55.

Review of a psychiatric evaluation note dated 1/24/18 indicated Resident #55 was seen because he recently hit another resident. The note indicated Resident #55 was alert and oriented to person and place and there were no changes made to his medical or medication regime.

Multiple attempts to discuss incident were refused by Resident #55.

In an interview on 6/20/18 at 7:40 AM, the Director of Nursing (DON) stated she was out on medical leave at the time of the incident and the Assistant DON (ADON) was left in charge of the nursing department. The DON stated the Administrator was the facility Abuse Coordinator.

In an interview on 6/20/18 at 10:57 AM, the ADON stated there was no evidence that an

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F 609	Continued From page 9 incident report was completed or that the incident on 1/12/18 involving Resident #55 toward Resident #3 was reported to the state. The ADON stated the incident was reported to the Administrator but she felt it was not a reportable incident. In an interview on 6/20/18 at 1:05 PM, the Administrator stated she did not feel the incident met the criteria for reporting to the state agency since both residents were cognitively impaired.	F 609		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		7/19/18

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before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

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F 623	Continued From page 11 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the Regional Ombudsman of residents ' transfers and/or discharges for 2 of 2 residents reviewed for hospitalization (Residents #37 and #332). The findings included: 1. Resident #37 was initially admitted to the facility on 1/8/10 and most recently readmitted on	F 623	1. On 6/20/2018 facility Administrator notified regional Ombudsman of facility discharges occurring in the month of May. Processes that lead to the deficiency cited were changes to the facility Social Worker position and the need for education regarding resident discharge notifications.	

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F 623	Continued From page 12 4/13/18 with diagnoses that included cerebrovascular accident and dementia. The annual Minimum Data Set (MDS) dated 3/29/18 indicated Resident #37 had severe cognitive impairment. A review of the Resident #37's medical record indicated she had been transferred to the hospital and discharged from the facility on 4/10/18. The record revealed no documentation that the Ombudsman was notified in writing the date and the reason for Resident #37 ' s transfer to the hospital. Resident #37 was readmitted to the facility on 4/13/18. An interview was conducted with the Administrator on 6/19/18 at 2:35 PM. She was asked who was responsible for notifying the Regional Ombudsman of any residents who had been transferred or discharged from the facility. She stated she thought it would have been the Social Worker (SW), but that the facility had not had a SW since February of 2018. She indicated the facility was still trying to fill the SW position. The Administrator stated she was going to speak to her staff and would follow up with additional information. A follow up interview was conducted with the Administrator on 6/20/18 at 4:30 PM. She revealed the facility had not been notifying the Regional Ombudsman of transfers and discharges since sometime in February of 2018 when their SW position became vacant. She stated she phoned the Regional Ombudsman to discuss her preferred method of communication regarding the facility ' s transfers and discharges. The Administrator reported the Regional Ombudsman requested that going forward, the	F 623	2. Facility Administrator compiled a list of residents discharged from the facility for the past 90 days and submitted the list to the regional Ombudsman via email on 7/5/2018. The list included resident name, discharge date, discharge location, and reason for discharge. On 6/20/2018 facility Administrator spoke with Regional Ombudsman and was instructed to send discharge list via email or facsimile to the Regional Ombudsman office each month. On 6/29/2018 facility Director of Health Services reviewed discharge notification and documentation with facility employees. Facility Administrator and/or Social Worker will compile monthly discharge list and submit to regional Ombudsman. 3. Facility Administrator will verify receipt of discharged residents monthly with Regional Ombudsman via email and save documentation of verification. Verification will be presented to facility QAPI Committee monthly to ensure compliance. 4. Facility Administrator will be responsible for implementing this plan of correction. 5.7/19/2018	

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F 623	Continued From page 13	F 623		

facility send a monthly list of all residents who were transferred and/or discharged.

2. Resident #332 was initially admitted to the facility on 8/14/14 and most recently readmitted on 3/16/18 with diagnoses that included dementia and sepsis due to urinary tract infection. The quarterly Minimum Data Set (MDS) dated 3/23/18 indicated Resident #332 had moderate cognitive impairment.

A review of the Resident #332 ' s medical record indicated she had been transferred to the hospital and discharged from the facility on 3/11/18. The record revealed no documentation that the Ombudsman was notified in writing the date and the reason for Resident #332 ' s transfer to the hospital. Resident #332 was readmitted to the facility on 3/16/18.

An interview was conducted with the Administrator on 6/19/18 at 2:35 PM. She was asked who was responsible for notifying the Regional Ombudsman of any residents who had been transferred or discharged from the facility. She stated she thought it would have been the Social Worker (SW), but that the facility had not had a SW since February of 2018. She indicated the facility was still trying to fill the SW position. The Administrator stated she was going to speak to her staff and would follow up with additional information.

A follow up interview was conducted with the Administrator on 6/20/18 at 4:30 PM. She revealed the facility had not been notifying the Regional Ombudsman of transfers and discharges since sometime in February of 2018

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F 623	Continued From page 14 when their SW position became vacant. She stated she phoned the Regional Ombudsman to discuss her preferred method of communication regarding the facility ' s transfers and discharges. The Administrator reported the Regional Ombudsman requested that going forward, the facility send a monthly list of all residents who were transferred and/or discharged.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS) for a resident with a change in mental status newly diagnosed with unspecified Schizophrenia and new medication regime. This was for 1 of 5 residents (Resident #55) reviewed for unnecessary medications. The findings included: Resident #55 was admitted on 10/3/16 with cumulative diagnoses of anxiety, unspecified convulsions and Cerebral Vascular Accident.	F 637	1.The plan of correction for the specific deficiency: Resident #55 will have a Significant Change Comprehensive Assessment completed on 7/5/18 by the Case Mix Coordinator. The Significant Change Assessment identified antipsychotic use, behaviors, and Diagnosis of Schizophrenia. Processes that lead to the deficiency cited identified as change in MDS personnel and unclear understanding of behaviors as a component constituting a Significant	7/17/18

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F 637	Continued From page 15 Review of Resident #55's Psychiatric Evaluation dated 7/3/17 read his diagnoses were anxiety and depression. He was prescribing medications for anxiety and depression. Review of Resident #55's Psychiatric Evaluation dated 8/14/17 read he was newly diagnosed with unspecified Schizophrenia and other psychotic disorder. He was newly prescribed Risperdal (an antipsychotic medication). Review of Resident #55's annual Minimum Data Set (MDS) dated 9/20/17 was coded for taking an antipsychotic for 7 of 7 days and he was coded for psychotic disorder (other than schizophrenia). Review of the Care Area Assessment (CAA) dated 9/20/17 for behavioral symptoms was unchecked for new medications, antipsychotics was checked but Schizophrenia was unchecked. The accompanying narrative note read Resident #55 had a diagnosis of Psychosis and taking multiple psychotropic medications. In an interview on 6/21/18 at 11:35 AM, the MDS Nurse stated she did not realize that a new mental diagnosis with new antipsychotic medications required a significant change MDS at the time the annual MDS was completed on 9/20/17. In an interview on 6/21/18 at 12:10 PM, the Director of Nursing stated it was her expectation that a significant change MDS would have been completed timely to reflect Resident #55's new diagnosis and antipsychotic medications.	F 637	Change. 2.The procedure for implementing the acceptable Plan of Correction for the cited deficiency: Medical record audit was conducted on 6/19/18 by Senior Nurse Consultant during annual survey. Identified residents receiving antipsychotic use and/or new psychiatric diagnosis requiring a Significant change were identified and new Assessment will be completed per MDS July schedule. All new admissions to facility and as well as newly diagnosed residents within the facility will be evaluated by the DHS/ADHS and/or Case Mix Coordinator. for new onset behaviors, antipsychotic use, and Diagnosis of Schizophrenia. A Significant Change Assessment will be conducted by the Case Mix Coordinator. Licensed Nurses received In-service training by the DHS on 6/25/18 related to component of Significant Change Assessment in relation to new diagnosis and initiation of antipsychotic medication. Additional in-servicing was provided for Non-licensed staff on 6/28/18 by DHS and CCC. New hires will receive education on F637 during orientation by the CCC. 3.The monitoring procedure to ensure effectiveness of the plan of correction constitutes monitoring medication orders related to psychotropic medication use daily x5, weeklyx5, then monthly until next Annual Survey. Findings will be discussed monthly in QAPI. 4.The person responsible for	

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F 637	Continued From page 16	F 637	implementing the acceptable plan of correction: DHS/CRC/CCC and ADHS. 5.Completion date: 7/19/18	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the Minimum Data Set (MDS) assessment accurately in the area of life expectancy (Resident #37) for 1 of 1 residents reviewed for hospice. The findings included: Resident #37 was most recently admitted to the facility on 4/13/18 with diagnoses that included cerebrovascular accident. A physician's order dated 4/13/18 indicated a hospice consultation for Resident #37. A physician's order dated 4/17/18 indicated Resident #37 was admitted to hospice care on 4/17/18. Hospice documentation dated 4/17/18 indicated Resident #37 was admitted to hospice on 4/17/18 with a terminal diagnosis of late effects of cerebrovascular accident. The significant change Minimum Data Set (MDS) assessment dated 4/26/18 indicated Resident #37's cognition was severely impaired. She was indicated to have received hospice services	F 641	Accuracy of Assessments 1.The plan of the correction for the specific deficiency: Resident #37 MDs was corrected on 6/26/18 with J1400 box checked indicating Life Expectancy of six months or less by the Case Mix Coordinator. Processes that lead to deficiency cited identified as change in MDS personnel and unclear understanding of checking Life Expectancy box without documentation by physician in progress notes. 2.The procedure for implementing the acceptable plan of correction for the cited deficiency: Residents receiving hospice services were audited on 6/26/18. Findings from the audit revealed one other resident affected. Corrections were conducted on the MDS in section J100 on 6/26/18 and submitted to the state by the Case Mix Coordinator. New residents admitted to facility that meet the criteria for hospice services will receive a Significant Change assessment	7/17/18

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F 641	Continued From page 17 during the last 14 days and while a resident at the facility. Section J, the Health Conditions section, had not indicated Resident #37 had a life expectancy of six months or less (Question J1400). An interview was conducted with the MDS Coordinator on 6/21/18 at 11:35 AM. She confirmed Resident #37 was admitted to hospice care on 4/17/18. A review of the significant change MDS assessment dated 4/26/18 that indicated Resident #37 was on hospice care, but did not have a life expectancy of six months or less (Question J1400) was reviewed with the MDS Coordinator. She revealed she was not aware that if a resident was on hospice that they also needed to be coded as having a life expectancy of less than 6 months. An interview was conducted with the Director of Nursing on 6/21/18 at 12:10 PM. She indicated she expected the MDS to be completed accurately.	F 641	conducted by the CMC at the time the assessment is due. The DHS will visually observe that J1400 is checked. Licensed Nurses and Case Mix Coordinator received in-service training by the DHS on 6/25/18 in relation to J1400. Additional in-servicing was provided for Non-licensed staff on 6/28/18 by the DHS. New hires will received education on F641 during orientation by the CCC. 3.The monitoring procedure to ensure the effectiveness of the plan of correction constitute monitoring new referrals for hospice services daily x5, weekly x5, then monthly until next Annual Survey. Findings will be discussed monthly in QAPI. 4.The person responsible for implementing the acceptable plan of correction: DHS,CRC,CCC, and/or ADHS. 5.Completion date: 7/17/18.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of	F 644		7/17/18

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F 644	Continued From page 18 care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to refer residents with newly evident diagnoses of serious mental illnesses for Pre-Admission Screening and Annual Resident Review (PASARR) Level II screen for 2 of 2 residents reviewed for PASARR (Residents #48 and #55). The findings included: 1. Resident #48 was admitted to the facility on 5/16/11 with a PASARR Level I screen effective 11/01/10 which indicated the screen did not go to Level II. Resident #48 had no mental health related diagnoses noted on admission to the facility. The quarterly Minimum Data Set (MDS) assessment dated 11/16/17 indicated Resident #48 ' s cognition was severely impaired. She had other behavioral symptoms daily. She was administered antipsychotic medication and antidepressant medication on 7 of 7 days. Her active diagnoses included psychotic disorder, mood disorder, anxiety disorder, and depression. A multidisciplinary care conference meeting note dated 12/12/17 included the diagnoses of psychosis, mood disorder, major depressive disorder, and anxiety disorder for Resident #48.	F 644	1.The plan of correction for the specific deficiency: Resident #48 and #55 received referral for PASARR Screening on 6/20/18 by the Admissions Director. On 6/22/18, PASARR Screening Representative conducted reviews on #48 and #55 for Level 2 PASARR. MDS corrections were conducted on 7/5/18 for #55 and 6/29/18 for #48 by CMC. Process that lead to the deficiency cited identified as open Social Worker position and remaining IDT unaware of process for referrals for Level 2 PASARR. 2.The procedure for implementing the acceptable plan of correction for the deficiency cited: On 6/19/18, Medical Record audit was conducted by SNC on 6/19/18 during Annual Survey. Residents identified with potential for PASARR Level 2 Screening were referred to PASARR representative on 6/20/18. On 6/22/18, PASARR Screening Representative conducted reviews on identified residents. MDS corrections will be conducted by CMC per MDS schedule. New admissions to facility as well as present residents that are identified for new diagnosis will be referred to PASARR representative for PASARR Screening by the Social Worker	

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F 644	Continued From page 19 She was noted with frequent socially inappropriate yelling. The quarterly Minimum Data Set (MDS) assessment dated 2/8/18 indicated Resident #48 ' s cognition was severely impaired. She had verbal behaviors and other behavioral symptoms on 1 to 3 days. She was administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days. Her active diagnoses included psychotic disorder, mood disorder, anxiety disorder, and depression. A multidisciplinary care conference meeting note dated 2/22/18 included the diagnoses of psychosis, mood disorder, major depressive disorder, and anxiety disorder for Resident #48. She was noted to be taking antipsychotic medications and was being followed by psychiatric services. Resident #48 was indicated to scream and yell constantly and deny any problem when asked. A psychiatric evaluation note dated 4/25/18 indicated Resident #48 was continuing to experience anxiety and mood lability (exaggerated changes in mood) per staff report. A gradual dose recommendation for her medication was declined due to the likelihood it would cause Resident #48 to decompensate. Resident #48 was noted with psychiatric medications that included an antipsychotic medication, antianxiety medication, antidepressant medication, and a mood stabilizer. She was noted with diagnoses of schizophrenia spectrum and other psychotic disorder, anxiety, and mood disorder. The annual Minimum Data Set (MDS)	F 644	and/or Admissions Director. Licensed Nurses and CRC received In-service training by the DHS on 6/25/18 in relation to identified components that require referral for PASARR Level Screening. Non-Licensed Staff received additional in-servicing on 6/28/18 by the DHS. New hires will receive education on F644 during orientation by the CCC. 3.The monitoring procedure to ensure effectiveness of the plan of correction constitutes monitoring orders related to new mental health diagnosis and psychotropic medication orders dailyx5, weeklyx5, then monthly until next Annual Survey. Findings will be discussed monthly in QAPI. The Admissions Cord. and DHS will monitor and take the information to QAPI. 4.The person responsible for implementing the acceptable plan of correction: Social Worker/Admissions Director/DHS/CMC. 5.Completion Date: 7/17/18	

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assessment dated 5/8/18 Section A 1500 indicated Resident #48 was not currently considered by the State Level II PASARR process to have a serious mental and/or intellectual disability or a related condition. Resident #48 ' s cognition was severely impaired. She had other behavioral symptoms on 4-6 days which interfered with social activities, intruded on the privacy of others, and disrupted the care environment. She was administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days. Her active diagnoses included psychotic disorder, mood disorder, anxiety disorder, and depression.

Resident #48 ' s plan of care, updated on 5/22/18, included the problem/need of the diagnoses of anxiety, psychosis, and depression in addition to taking psychotropic medications. This plan of care also included the problem/need of Resident #48 having outbursts of yelling, squealing, and singing loudly.

A psychiatric evaluation note dated 6/7/18 indicated Resident #48 was continuing to experience anxiety and yelling out per staff report. Resident #48 was noted with psychiatric medications that included an antipsychotic medication, antianxiety medication, antidepressant medication, and a mood stabilizer. She was noted with diagnoses of schizophrenia spectrum and other psychotic disorder, anxiety, and mood disorder.

Review of the June 2018 physician ' s order summary and Medication Administration Records indicated Resident #48 continued to receive antipsychotic medication, antianxiety medication, antidepressant medication, and a mood stabilizer.

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An interview was conducted with the Admissions Coordinator (AC) on 6/20/18 at 9:22 AM. She stated she was previously the Social Worker (SW) at the facility, but had switched to the AC in January of 2018. She indicated the facility ' s SW position was currently vacant. The AC stated when a resident was newly diagnosed with a mental illness the resident needed to be evaluated for a Level II PASARR. Resident #48 ' s medical record that indicated she was admitted to the facility with a Level I PASARR and no mental health diagnoses was reviewed with the AC. The medical record that indicated Resident #48 presently was receiving antipsychotic medication, antianxiety medication, antidepressant medication, and a mood stabilizer as well as being seen by psychiatry services related to the diagnoses of schizophrenia spectrum and other psychotic disorder, anxiety, and mood disorder was reviewed with the AC. She revealed she had not been made aware of the changes in Resident #48 ' s diagnoses when she was the SW. She indicated if she had been made aware she would have made a referral for a Level II PASARR evaluation. She confirmed no referral for a Level II PASARR evaluation had been made for Resident #48.

A follow up interview was conducted with the AC on 6/20/18 at 9:45 AM. She stated she was going to complete a referral for a Level II PASARR evaluation for Resident #48 today (6/20/18).

An interview was conducted with the Administrator on 6/20/18 at 1:20 PM. She stated she had not been aware that a referral for a Level II PASARR evaluation was required when a newly evident diagnosis of a serious mental illness was

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identified. She indicated her expectation was for the regulation to be followed.
2. Resident #55 was admitted on 10/3/16 with cumulative diagnoses of anxiety, unspecified convulsions and Cerebral Vascular Accident.

Review of Resident #55's Psychiatric Evaluation dated 8/14/17 read he was newly diagnosed with unspecified Schizophrenia and other psychotic disorder. He was newly prescribed Risperdal (an antipsychotic medication).

An interview was conducted with the Admissions Coordinator (AC) on 6/20/18 at 9:22 AM. She stated she was previously the Social Worker (SW) at the facility, but had switched to the AC in January of 2018. She indicated the facility's SW position was currently vacant. The AC stated when a resident was newly diagnosed with a mental illness the resident needed to be evaluated for a Level II PASARR. Resident #55's medical record that indicated he was admitted to the facility with a Level I PASARR and no mental health diagnoses was reviewed with the AC. The medical record indicated that Resident #55 presently was receiving antipsychotic medication, antianxiety medication and a mood stabilizer as well as being seen by psychiatry services related to the diagnoses of unspecified schizophrenia and psychosis. This was reviewed with the AC. She revealed she had not been made aware of the changes in Resident #55's diagnoses when she was the SW. She indicated if she had been made aware she would have made a referral for a Level II PASARR evaluation. She confirmed no referral for a Level II PASARR evaluation had been made for Resident #55.

A follow up interview was conducted with the AC

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F 644	Continued From page 23 on 6/20/18 at 9:45 AM. She stated she was going to complete a referral for a Level II PASARR evaluation for Resident #55 today (6/20/18). An interview was conducted with the Administrator on 6/20/18 at 1:20 PM. She stated she had not been aware that a referral for a Level II PASARR evaluation was required when a newly evident diagnosis of a serious mental illness was identified. She indicated her expectation was for the regulation to be followed.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights 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	F 656		7/17/18

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F 656	Continued From page 24 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. (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 record review, observation and interview the facility failed to develop a comprehensive care plan in the areas of psychotropic medication (Resident #37) and contracture management (Resident #27) for 2 of 23 residents reviewed for care plan. The findings included: 1. The resident was admitted on 5/17/17. Resident #27's quarterly minimum data set dated 4/10/18 revealed the resident had adequate hearing, clear speech, and was understood and understands. The resident had an intact cognition. Activities of daily living required extensive assistance of two staff members for all transfers and one staff members for all other assistance except meals were set up. The active diagnoses were hemiplegia and contracture of the bilateral knees and right hand.	F 656	1.The plan of correction for the specific deficiency: Resident #27 was evaluated by Physical Therapy and added to caseload on 6/25/18 for Orthotic Management and Training. Orders were obtained on 6/25/18 for adjusted knee extension splints of Bilateral Lower Extremities to accommodate contractures of bilateral knees. Application time and Nursing directives on monitoring were also obtained. The Care Plan and POS/MAR was updated on 6/25/18 by the DHS and Primary Nurse. Resident #37 received orders to discontinue prn Ativan and Begin Scheduled Ativan for terminal agitation on 6/20/18 by the Hospice Nurse during Annual Survey. The Care Plan of #27 was also updated on 6/26/18 by the CMC to reflect the use of Ativan as an Anti-anxiety medication. Processes that lead to the deficiency cited attributed to	

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F 656	Continued From page 25 Physician order date 9/26/17 revealed physical therapy 5 times a week for 6 weeks for treatment of positioning, orthotic evaluation and management. Review of the resident's care plan dated 4/23/18 revealed there were no goals or approaches for contractures of the bilateral knees and splint placement. Monthly physician orders dated 5/30/18 revealed prosthetic/orthotic consult for bilateral knee splints versus dynamic splints. On 6/18/19 at 3:30 PM, an observation of Resident #27 was done and the resident stated to the Treatment Nurse that the staff did not know how to place the splint and that he had been wearing the splint in the past. The resident had bilateral contracted knees. The knee splint device was not in place but was sitting on top of the cabinet. On 6/18/18 at 3:40 PM, an interview was conducted with Resident #27 who stated he had contracted knees and was wearing the knee splint in the past and it helped him. The resident stated that he did not know why "they don't put the pillow between my legs anymore." On 6/21/18 at 2:00 PM, the Director of Nursing was interviewed who stated she expected the staff to develop a care plan according to the resident s needs. 2. Resident #37 was admitted to the facility on 1/8/10 and most recently readmitted on 4/13/18 with multiple diagnoses that included dementia. The significant change Minimum Data Set (MDS)	F 656	change in MDS and Therapy personnel as well as discontinuation of residents from Restorative program without directives to floor staff for continuation of contracture management. 2.The procedure for implementing the acceptable Plan of correction for the deficiency cited: Audit conducted by DHS on 6/26/18, for residents with noted contractures and 6/28/18 for residents receiving prn psychotropic medications. Two residents were noted as affected related to contractures and 6 residents were affected in relation to prn use of psychotropic medications. Identified contractures received evaluation from Therapy Services and orders were obtained for contracture management. Identified residents receiving prn psychotropic medication received changes in orders in relation to timeframes for the use of these medications. Care Plans and POS/MARs received updates related to the identified changes on 6/27/18 by DHS and CRC. New admissions to facility will be assessed by the DHS/ADHS and/or primary nurse for contracture management and use of psychotropic medications with duration for any ordered prn usage. The DHS will ensure communication to Therapy Outcomes Coordinator via Daily Clinical Meetings. Licensed Nurses received in-service training by the DHS on 6/25/18 in relation to monitoring and documentation of contracture Management, use of prn psychotropic medications with the	

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F 656	Continued From page 26 assessment dated 4/26/18 indicated Resident #37 had severely impaired cognition. She was receiving hospice services and she had not received antianxiety medication during the 7-day MDS look back period. A physician's order dated 5/3/18 indicated Ativan (antianxiety medication) 0.5 milligrams (mg) every 4 hours as needed (PRN) for terminal anxiety for Resident #37. A review of the May 2018 and June 2018 Medication Administration Records (MARs) indicated Resident #37 received PRN Ativan multiple times each month. Resident #37's comprehensive plan of care was reviewed on 6/21/18. The care plan was noted to updated on 5/10/18 and included no problems/needs, goals, or interventions related to the use of psychotropic antianxiety medication (Ativan). An interview was conducted with the MDS Coordinator on 6/21/18 at 11:35 AM. The order dated 5/3/18 for PRN Ativan for Resident #37 was reviewed with the MDS Coordinator. The May 2018 and June 2018 MARs for Resident #37 that indicated she received PRN Ativan multiple times each month was reviewed with the MDS Coordinator. The comprehensive plan of care for Resident #37 that included no care plan related to the use of psychotropic antianxiety medication was reviewed with the MDS Coordinator. She revealed the care plan for Resident #37 should have been updated to include the use of the psychotropic antianxiety medication. An interview was conducted with the Director of	F 656	directive of no longer than 14 days duration, and Care Plan documentation/revision. Additional training was provided on 6/28/18 by the DHS. New hires will receive education on F656 during orientation by the CCC. 3.The monitoring procedure to ensure the effectiveness of the plan of correction constitutes monitoring orders related to psychotropic medications and identified contractures dailyx5, weekly x5, then monthly until next Annual Survey. The DHS/ADHS and CCC will be responsible for monitoring orders and identified contractures. The designated Charge Nurse will be responsible for assessing new residents for weekend admissions in regards to medications and contractures. The information will be kept in the acute charting book. Findings will be discussed monthly in QAPI by the DHS. 4.The person responsible for implementing the acceptable plan of correction: DHS/ADHS/TOC, and/or Primary Nurse. 5.Completion date: 7/17/18	

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F 656	Continued From page 27 Nursing on 6/21/18 at 12:10 PM. She indicated she expected the plans of care to be person centered and comprehensive. She additionally indicated that if a resident was receiving psychotropic medications she expected this to be included in their plan of care.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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 assessments. This REQUIREMENT is not met as evidenced by:	F 657		7/17/18

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F 657	Continued From page 28 Based on record review, observation, and interview the facility failed to revise the comprehensive care plan in the area of bed alarms for 2 of 5 residents reviewed for accidents (Residents #23 and 27). the findings included: 1. The resident was admitted on 5/17/17. Resident #27's quarterly minimum data set dated 4/10/18 revealed the resident had adequate hearing, clear speech, and was understood and understands. The resident had an intact cognition. Activities of daily living required extensive assistance of two staff members for all transfers and one staff members for all other assistance except meals were set up. The active diagnoses were hemiplegia and contracture of the bilateral knees and right hand. A review of Resident #27's care plan revealed there was a fall goal with an approach for a "bed alarm and to check the bed alarm placement and function during rounds and as needed" documented. A review of the physician order for the bed alarm revealed it was discontinued on January 31, 2018. On 6/18/18 at 2:45 PM, an observation was done of Resident #27 and a bed alarm was not in place. On 6/20/18 at 3:30 PM, an interview was conducted with the Assistant Director of Nursing who stated that her expectation was for the comprehensive care plan to be updated when there were resident care changes. 2. Resident #23 was admitted to the facility	F 657	1.The plan of correction for the specific deficiency: Resident #27 and #23 received clarification orders to discontinue alarms and Y connectors due to nonuse on 6/20/18 during Annual Survey by the DHS and Primary Nurse. Care Plans were revised on 6/22/18 by DHS and Primary Nurse to reflect the nonuse of alarms. Processes that lead to cited deficiency identified as changes in MDS personnel and Licensed Nurses lack of knowledge regarding care plan updates timely. 2.The procedure for implementing the acceptable plan of correction for the cited deficiency: Audit conducted by DHS and Primary Nurse on 6/27/18, for residents care planned at risk for falls. Audit findings revealed 11 residents were identified as affected. Interventions were audited and removal of nonuse devices were removed from the Care Plans on 6/27/18. Physicians Orders were audited by DHS/CCC and Primary Nurse and clarification orders were obtained for removal from POS/MARs. New admissions to facility will be assessed for fall risks with interventions refraining from alarms by DHS and Primary Nurse. Interventions will be applied to new admit care plan by DHS/CRC and Primary Nurse. Licensed Nurses received in-service training by the DHS on 6/25/18 in relation to Care Plan revisions to reflect accurate use of interventions. Focus education was provided on care plan revisions for interventions no longer in use. Additional training was provided on 6/28/18 by the DHS. New Hires will	

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F 657	Continued From page 29 4/30/14 and readmitted 3/4/15. Cumulative diagnoses included Alzheimer's dementia and osteoarthritis. A quarterly Minimum Data Set (MDS) dated 4/5/18 indicated Resident #23 had short-term and long-term memory impairment and was severely impaired in decision-making skills. No mood or behaviors were noted during the assessment period. Impairment of range of motion was noted to bilateral lower extremities. No restraints were utilized during the assessment period. A care plan last reviewed on 4/8/18 indicated Resident #23 was at risk for falls related to poor mobility, poor safety awareness, impaired cognitive status, fidgety movements, abnormal posture and contractures to bilateral lower extremities. Approaches included, in part, to check alarm each shift for function and placement. "Y" connector to alarm. On 6/18/18 at 2:30 PM, an interview was conducted with Nurse #2. She stated Resident #23 required total care by staff. Nurse #2 said staff used bolster cushions in both sides of the Geri-chair so positioning in the chair. She did not mention the use of any type of alarms used for Resident #23. On 6/18/18 at 2:50 PM, an observation of Resident #23 was conducted. She was lying in her Geri-chair. No alarms were seen on the chair or attached to the bed. On 6/19/18 at 2:45 PM, an interview was conducted with the Director of Nursing who stated they stopped using the alarms on residents and it should have been removed from physician orders	F 657	received training during orientation on F657 by the CCC. 3.The monitoring procedure to ensure the effectiveness of the plan of correction constitutes monitoring interventions and orders for fall risk residents dailyx5, weeklyx5 then monthly until Annual Survey. Findings will be discussed monthly in QAPI by the DHS. 4.The person responsible for implementing the acceptable plan of correction: DHS/ADHS/CCC and primary nurse. 5.Completion date: 7/17/18.	

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F 657	Continued From page 30 and care plans. On 6/21/18 at 11:42 AM, an interview was conducted with the MDS Coordinator. She stated she was responsible for the implementation, reviewing and revising of the care plans. She reviewed the care plan for Resident #23 and stated it must have been an oversight.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and Psychiatric Nurse Practitioner interview, the facility failed to administer antipsychotic medications as ordered by a physician (Resident #10) for 1 of 2 residents reviewed for behavioral and emotional status. The findings included: Resident #10 was initially admitted to the facility on 4/14/14 and most recently readmitted on 2/1/16 with multiple diagnoses that included major depressive disorder and psychosis. The annual Minimum Data Set (MDS) assessment dated 3/16/18 indicated Resident #10 ' s cognition was intact. She received no antipsychotic medication during the MDS review period. A physician ' s order for Resident #10 dated 5/22/18 indicated the initiation of Risperdal (antipsychotic medication) 0.25 milligrams (mg) twice daily for 6 days and then increase Risperdal	F 658	1.The plan of correction for the specific deficiency: Resident #10 received review of orders and MAR by DHS and Primary Physician on 6/25/18. No further orders received and Psychiatric Nurse Practitioner was also updated on 6/25/18. Process that lead to the cited deficiency attributed to lack of monitoring oversight of Licensed Nurses during monthly changeover. 2.The procedure to implementation of the acceptable plan of correction for deficiency cited: Audit performed on resident orders and MAR transcription on 6/26-6/30/18 by the DHS/CCC and Primary Nurse. Audit revealed 11 residents affected. Each order and POS/MAR received a 3 step process. The 3 step process consisted of checking the	7/17/18

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F 658	Continued From page 31 to 0.5 mg twice daily. An additional order dated 5/22/18 indicated a gradual dose reduction of Resident #10 ' s Seroquel (antipsychotic medication) to 75 mg twice daily for 3 days, then Seroquel 50 mg twice daily for 3 days, then Seroquel 50 mg once daily for 3 days, and then discontinue Seroquel. A review of Resident #10 ' s May 2018 Medication Administration Record (MAR) indicated Risperdal 0.25 mg twice daily for 6 days and Risperdal 0.5 mg twice daily were added to Resident #10 ' s MAR on 5/22/18, but no Risperdal was administered in May. This MAR additionally indicated Resident #10 ' s gradual dose reduction of Seroquel was added to Resident #10 ' s MAR on 5/22/18, was initiated on 5/23/18, and was administered as ordered until it was discontinued. A review of Resident #10 ' s June 2018 MAR indicated Risperdal 0.5 mg twice daily was initiated on 6/1/18. Resident #10 had not received Risperdal 0.25 mg twice daily for 6 days as ordered prior to the administration of Risperdal 0.5 mg twice daily. An interview was conducted with the Director of Nursing (DON) on 6/20/18 at 11:55 AM. She reported she had been out of the facility for the last couple of months and the Assistant Director of Nursing (ADON) was responsible for her duties during that time. An interview was conducted with the ADON on 6/21/18 at 10:15 AM. The May and June 2018 physician ' s orders and MARs for Resident #10 were reviewed with the ADON. She stated that the 5/22/18 physician ' s orders for Resident #10 ' s gradual dose reduction of Seroquel and the initiation of Risperdal were indicated to occur	F 658	POS/MAR with the medical record, Medication Administration Record, and any new orders from the previous day. Clarifications were obtained and added to July POS/MARs. New admissions to facility will receive orders written in medical record and POS/MAR by the DHS/ADHS and/or primary Nurse. MARs and reviewing of orders will be conducted by the DHS/ADHS/CCC and/or primary nurse. Licensed Nurses received in-service training by the DHS on 6/25/18 with additional training on 6/28/18 by the DHS and CCC regarding the 3 step process of checking the POS/MAR with the Medical Record. Return demonstration of the 3 step process was performed by the Licensed Nurses to the DHS and CCC. This process will be utilized for orders obtained and monthly changeover and Care Plan revisions. Each hall will be assigned to DHS, ADHS, and CCC for monitoring. New hires will receive education on F658 during orientation by the CCC. 3.The monitoring procedure to ensure the effectiveness of the plan of correction constitutes monitoring orders, care plan revisions, and POS/MAR revisions focused on psychotropic medications dailyx5, weeklyx5, then monthly until next Annual Survey by the DHS. Finding will be discussed in Monthly QAPI by the DHS. 4. The person responsible for implementing the acceptable plan of correction: DHS, ADHS, and CCC.	

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F 658	Continued From page 32 simultaneously. She confirmed Resident #10 ' s Risperdal had not been administered as ordered. She revealed Resident #10 had not received Risperdal 0.25 mg twice daily prior to receiving 0.5 mg twice daily. She was asked what the process was for reviewing orders and MARs to ensure they matched and that medications were administered as ordered. The ADON stated that several different nurses reviewed MARs and orders at the end of each month. She indicated there was not one person responsible for the review. She reported that ultimately herself and the DON were responsible for oversight of this task. The ADON revealed she was unaware of these errors previously. A phone interview was conducted with the Psychiatric Nurse Practitioner (PNP) on 6/21/18 at 10:40 AM. The 5/22/18 physician ' s orders for Resident #10 ' s gradual dose reduction of Seroquel and the initiation of Risperdal were reviewed with the PNP. She stated she had made these two orders (Seroquel and Risperdal) and she intended for both to occur simultaneously. She reported that Resident #10 had several medication adjustments in an effort to find the most effective dosage. She stated she expected medications to be administered as ordered, but she believed Resident #10 had no negative effects from the errors. A follow up interview was conducted with the DON on 6/21/18 at 12:10 PM. She stated she expected medications to be administered as ordered.	F 658	5.Completion date: 7/17/18.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		7/17/18

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F 688	Continued From page 33 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to place a knee splint for bilateral contracted knees as ordered for 1 of 1 residents reviewed for mobility (Resident #27). Physician order date 9/26/17 revealed physical therapy 5x week for 6 weeks for the treatment positioning, orthotic evaluation and management. Review of the resident's care plan dated 4/23/18 revealed there were no goals or approaches for contractures of the bilateral knees and splint placement. Monthly physician orders dated 5/30/18 revealed prosthetic/orthotic consult for bilateral knee splints versus dynamic splints. On 6/18/19 at 3:30 pm an observation of	F 688	1.The plan of correction for the specific deficiency: Resident #27 was evaluated by Physical Therapy and added to caseload on 6/25/18 for Orthotic Management and Training. Orders were obtained on 6/25/18 for adjusted knee extension splints of Bilateral Lower Extremities to accommodate contractures of bilateral knees. Application time and Nursing directives on monitoring were also obtained. The care plan and POS/MAR were revised by the DHS and Primary Nurse on 6/25/18. . Processes that lead to the deficiency cited attributed to change in MDS and Therapy personnel as well as discontinuation of residents from Restorative program without directives to floor staff for continuation of contracture management.	

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PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 688	Continued From page 34 Resident #27 was done and the resident stated to the Treatment Nurse that the staff did not know how to place the splint and that he had been wearing the splint in the past. The resident had bilateral contracted knees. The knee splint device was not in place but was on top of the cabinet. On 6/18/18 at 3:40 pm an interview was conducted with Resident #27 who stated he had contracted knees and was wearing the knee splint which helped him. The resident stated that he did not know why "they don't put the pillow between my legs anymore." On 6/19/18 at 4:00 pm an interview was conducted with Physical Therapist #1 (PT) who stated Resident #27 had a knee splint that was started 10/2017 and improved the contracture of his bilateral knees by 10%. Restorative nursing was educated on how to place and remove the knee splint used for 2-3 hours each day during the day on a continued basis to date. PT stated restorative nursing was currently in place and would provide their notes. On 6/19/18 at 4:30 pm an interview was conducted with the Assistant Director of Nursing (ADON) who provided the restorative nursing flow sheets for Resident #27 ' s knee splint placement and stated that when occupational therapy started service on 4/19/18 for the hand splint, restorative nursing was discontinued for splint placement of the knees. The last restorative nursing note was on 4/5/18. The ADON acknowledged that she was aware occupational therapy worked with the resident's contracted right hand and would not place a lower extremity splint. The ADON did not have any further comments as to why the	F 688	2.The procedure for implementing the acceptable plan of correction for the deficiency cited: Audit conducted by DHS on 6/26/18, for residents with noted contractures. Identified contractures received evaluation from Therapy Services and orders and/or directives were obtained for contracture management. Care Plans and POS/MARs received updates related to the identified changes on 6/27/18 by DHS and Primary Nurse. New admissions to facility will be assessed by the DHS/ADHS and/or primary nurse for contracture management. The DHS will ensure communication to Therapy Outcomes Coordinator via Daily Clinical Meetings. The DHS will ensure there is communication from therapy to Restorative for services needed for contracture management. Licensed Nurses received in-service training by the DHS on 6/25/18 in relation to monitoring and documentation of contracture Management and Care Plan documentation/revision. Additional training was provided on 6/28/18 by the DHS and CCC. New hires will receive education on F688 during orientation by the CCC. 3.The monitoring procedure to ensure the effectiveness of the plan of correction constitutes monitoring residents with contractures for splinting as continuation of care dailyx5, weeklyx5, then monthly until next Annual Survey by the DHS. Findings will be discussed monthly in QAPI by the DHS.	

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F 688	Continued From page 35 resident had no longer received knee splint placement treatment. A review of the weekly restorative nursing notes revealed that there was a weekly progress note that Resident #27 had received and tolerated passive range of motion and placement of the knee splint for 1-2 hours per day from 10/30/17 to 4/5/18. On 6/21/18 at 2:00 pm the Director of Nursing was interviewed who stated she expected the staff to follow the physician order.	F 688	4. The person responsible for implementation of the acceptable plan of correction: DHS/ADHS/TOC and/or primary nurse. 5. Completion date: 7/17/18	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to prevent an incident involving one resident (Resident #55) from hitting another resident (Resident #3) on the back of the head after an earlier verbal altercation involving both residents. The facility also failed to provide a safe walkway as evidenced by an electrical cord laying on the floor (Resident #75). This was for 2 of 5 residents reviewed for accidents. The findings included: 1a. Resident #55 was admitted on 10/3/16 with a	F 689	1. a-Resident #55 and resident #3 have had no further altercations after 1/12/2018. Processes that lead to the deficiency cited were changes in Administrative personnel. b-On 7/6/2018 Facility Maintenance Director placed tie around PTAC unit cord in resident #75□s room. The Maintenance Director secured the tied cord under the PTAC unit and out of the walkway. Processes that lead to the deficiency cited were changes in facility Maintenance	7/19/18

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F 689	Continued From page 36	F 689		

diagnosis of psychosis and later diagnosed with unspecified Schizophrenia on 8/14/17. Resident #55's quarterly Minimum Data Set (MDS) dated 12/8/17 indicated he had a Brief Inventory of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment and was not coded for any behaviors.

b. Resident #3 was admitted 5/13/14 with cumulative diagnoses of seizures and dementia. Resident #3 quarterly MDS dated 12/14/17 indicated a BIMS score of 2 indicating severe cognitive impairment and he was coded for behaviors not directed toward other.

Review of a nursing note dated 1/12/18 at 9:20 AM read Resident #55 and Resident #3 had a verbal altercation in the hall. The note indicated both residents were separated at that time. Resident #55 went into the dining room where Resident #3 was sitting and hit Resident #3 with an open hand on the back of the head. Both residents were again separated. The psychological services provider was called and Resident #55's medications were adjusted. The responsible party for both residents were notified as well as the physician. There was no psychological or physical injury to Resident #3.

Review of an Interdisciplinary Team note dated 1/12/18 indicated Resident #55's physical altercation with Resident #3 was discussed. Resident #55 was placed on 1:1 supervision for 24-hours and an in-patient psychological consult was recommended.

Review of an Interdisciplinary Team note dated 1/15/18 indicated the facility request for a

personnel and procedures for monitoring resident environment.

2. a-Facility audit of current residents medical records by Administrator started 7 -5-2018 and ending 7-10-2018 showed other resident to resident altercations were identified and effectively managed to prevent future altercations with other residents. On 6/29/2018 facility employees were educated by Director of Health Services regarding identification and management of resident to resident altercations. Facility employees will be trained on identification and management of resident to resident altercations upon hire and annually.

b-Facility Maintenance Director conducted audit starting 7/6/2018 and ending 7/13/2018 of facility PTAC units located in resident care areas. PTAC cords were tied and secured under units to prevent them from sticking out into walkway. On 6/29/2018 and again on 7/6/2018 facility employees were trained by Director of Health Services and Administrator respectively on identification of, reporting, and resolution of possible hazards with emphasis on cords in walkways. Facility administrative team members will monitor rooms for cords in walkways daily with negative findings documented on round sheets and reported Monday-Friday in morning administrative meeting. Negative findings will be corrected by Facility Maintenance Director.

3. a- Facility Administrator and/or

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F 689	Continued From page 37 psychological inpatient setting was denied for Resident #55. Review of a psychiatric evaluation note dated 1/24/18 indicated Resident #55 was seen because he recently hit another resident. The note indicated Resident #55 was alert and oriented to person and place and there were no changes made to his medical or medication regime. In an interview on 6/19/18 at 3:54 PM, Nursing Assistant (NA)#1 stated Resident #55 was s verbally and physically abusive to the staff and residents. She stated he was known to throw things when he was angry. In an interview on 6/19/18 at 4:00 PM, Nurse #2 stated Resident #55 was stated verbally and physically abusive to the staff and residents. She recalled an incident when Resident #55 and Resident #3 had a verbal altercation in the hall. She recalled the aide separated the two residents and she took Resident #3 into the dining room. It was at that time, Resident #55 entered the dining room and hit Resident #3 in the back of the head. Nurse #2 stated Resident #55 was then placed on 1:1 supervision for a while. Multiple attempts to discuss incident were refused by Resident #55. In an interview on 6/20/18 at 7:40 AM, the Director of Nursing (DON) stated she was out on medical leave at the time of the incident and the Assistant DON (ADON) was left in charge of the nursing department. In an interview on 6/20/18 at 10:57 AM, the	F 689	Department Heads will provide random scenarios to facility staff daily for fourteen days, then weekly for two weeks, then monthly where staff must decide if the scenario constitutes an altercation and tell the actions needed to prevent another occurrence. Results of scenarios and subsequent education will be reported to the QAPI Committee meeting monthly to ensure compliance. b- Facility Maintenance Director will randomly audit ten rooms weekly for four weeks then monthly starting 7/16/18 with reports of negative findings and subsequent corrections. Maintenance Director will report findings of audits facility QAPI Committee each month to ensure compliance. 4. The facility Maintenance Director and Facility Administrator will be responsible for implementing this plan of correction. 5. Completion Date: 7/19/18	

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F 689	Continued From page 38	F 689		

ADON stated there was no evidence that an incident report was completed on 1/12/18 but Resident #55 was placed on 1:1 supervision for 24 hours and an attempt was made to have Resident evaluated at an inpatient psychiatric facility that later denied taking him. She stated the physician and the Psychiatric Nurse Consultant were notified. There were new orders to increase Resident #55's antipsychotic medication.

In an interview on 6/21/18 at 12:10 PM, the DON stated it was her expectation that Resident #55 be monitored for verbal and physical behaviors involving residents and if any occurred, the involved residents be supervised to prevent re-occurrence.

2. The 5-day Minimum Data Set dated 6/1/18 revealed Resident #75 had adequate hearing, clear speech, understands and was understood. The resident had a moderately impaired cognition. There were no mood or behavior issues. The resident required extensive assistance of one person for all activities of daily living except meals were limited assistance. The active diagnoses were anemia, anxiety, chronic pain, muscle weakness, difficulty walking, and lack of coordination.

Resident #75's care plan dated 6/8/18 revealed goals and interventions for at risk for falls, full code, impaired cognition and vision, side effect of anti-anxiety med, chronic pain, and extensive assistance for activities of daily living.

On 6/18/18 at 3:08 pm the PTAC (air conditioning and heating unit) cord was lying on the floor in a coil for two observations on day one of the

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F 689	Continued From page 39 survey. The surveyor did not observe the cord and tripped but did not fall. On 6/19/18 at 8:30 am and 1:10 pm an observation was done of the PTAC cord which measured approximately 1/2 inch in diameter was lying on the floor next to the bed in the walk way and posed a potential trip hazard. Observation of 5 other resident rooms on Hall C for the PTAC cord revealed the cord was stored underneath the unit and not on the floor in the walkway. On 6/19/18 at 3:45 pm an interview was conducted with the Maintenance person who stated the PTAC wire for Resident #75 would be corrected and placed under the unit and off the floor/walkway as required. On 6/20/18 at 2:30 pm an interview was conducted with the Assistant Director of Nursing who stated she expected all electrical wires to be out of the way of a walking area.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		7/17/18

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F 692	Continued From page 40 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide a nutritional supplement as ordered for one (1) of one (1) residents reviewed for nutrition who had a significant weight loss (Resident #24). The findings included: Resident #24 was admitted to the facility 11/10/17 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 4/5/18 indicated that Resident #24 was severely impaired in cognition and she required limited assistance with eating. Her weight was documented as 152 pounds with no weight loss or gain. A care plan last reviewed on 4/19/18 stated Resident #24 had a potential for alteration in nutrition. Approaches included, in part, serve diet as ordered. Monitor intake of diet as ordered. An approach was added on 12/27/17 for a supplemental treat at dinner. Also, an approach was added on 6/17/18 to escort Resident #24 to assisted dining meals with nursing assistant, refer to Registered dietician and add to the weight monitoring program. A review of Resident #24 ' s weight revealed the following:	F 692	1.The plan of correction for the specific deficiency: Resident #24 received orders for Oral Supplements on 6/20/18. Resident also received additional orders related to oral supplements on 6/25/18. Resident remains on WMP. Care Plan was updated on 6/25/18 by the DHS. Process that lead to the cited deficiency identified as response in a timely manner on the part of designated Administrative Nurse. 2.The procedure for implementing the acceptable plan of correction for the deficiency cited: Audit conducted by DHS on 6/21/18 related to Recommendations related to currently identified weight status by RD/CDM. Orders were written with Care Plan revised to reflect current nutritional approaches by the DHS. New admissions weight will be monitored weekly x4 by the CDM, DHS/ADHS, or Restorative Aide. The restorative Aide and DHS/ADHS will visually monitor to ensure supplements are offered to identified residents. Licensed staff received in-service training on 6/25/18 by the DHS regarding transcription of RD recommendations. Additional education	

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F 692	Continued From page 41 1/3/18- 157.8 pounds (lbs.) 2/1/18- 153.4 lbs. 3/2/18- 151.6 lbs. 4/4/18- 150.8 lbs. 5/3/18- 151.6 lbs. 6/8/18- 130 lbs. A Registered Dietician note dated 12/26/17 recommended, in part, to provide a nutritional treat at dinner due to decreased intake at dinner. On 12/27/17, Resident #24 had a physician ' s order for a supplemental nutritional treat at dinner due to decreased food intake at dinner. A review of the physician ' s orders for January 2018, February 2018, March 2018, April 2018, May 2018 and June 2018 revealed there was no order for a supplemental nutritional treat to be provided at dinner. There also was not an order to discontinue the supplemental nutritional treat. A review of the Medication Administration Records (MAR) for January 2018, February 2018, Marc 2018, April 2018, May 2018 and June 2018 revealed no documentation for the supplemental nutritional treat to be provided at dinner. On 6/20/18 at 8:20AM, Resident #24 was observed eating breakfast in the dining room. She was feeding herself with staff encouragement. Nursing staff stated her appetite was fair to good when someone sat with her during the meal. On 6/20/18 at 11:15 AM, an interview was conducted with the Dietary Manager. She stated Resident #24 had a weight of 145 lbs. when she was first weighed on 6/5/18. A re-weight was	F 692	was provided on 6/28/18 by the DHS and CCC. regarding the 3 step process of checking the POS/MAR with the Medical Record. Return demonstration of the 3 step process was performed by the Licensed Nurses to the DHS and CCC. This process will be utilized for orders obtained and monthly changeover and Care Plan revisions. Each hall will be assigned to DHS, ADHS, and CCC for monitoring. New hires will receive education on F658 during orientation by the CCC. 3.The monitoring procedure to ensure the effectiveness of the plan of correction constitutes monitoring orders per Dietary Recommendations daily x5, weekly x5, then monthly until next Annual Survey by the DHS. Findings will be discussed in monthly QAPI by the DHS. 4.The person responsible for the implementation of the acceptable plan of correction: DHS, ADHS, CCC and/or primary nurse. 5.Completion date: 7/17/18	

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F 692	Continued From page 42 done on 6/8/18 and revealed a weight of 130 lbs. The Dietary Manager said she received the weights on 6/11/18. On 6/17/18, she wrote recommendations for Standard 2.0 nutritional supplement 60 milliliters (ml) twice a day in addition to the supplemental treat. The Dietary Manager stated the supplemental nutritional treat was being placed on Resident #24 ' s tray at the dinner meal by the dietary staff. On 6/20/18 at 1:59 PM, an interview was conducted with the Assistant Director of Nursing. She stated supplemental nutrition was written as a physician ' s order so they can be monitored. A review of the medical record revealed there was no physician ' s order for the Standard 2.0 60 ml. twice daily. There was no documentation on the June MAR for the Standard 2.0 supplement. On 6/20/18 at 2:45 PM, an interview was conducted with Nurse #2. She reviewed the June MAR and stated Resident #24 was not on any supplements. She stated that nutritional supplements were written on a physician ' s order and MAR. She said she was not aware that Resident #24 had a weight loss and said they would reweigh resident. Reweight was 131.8 pounds. On 6/21/18 at 12:17 PM, an interview was conducted with the Director of Nursing. She stated there should have been a physician ' s order for supplements (med pass and nutritional treat) so it could be monitored per the MAR	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		7/17/18

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F 695	Continued From page 43 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to administer oxygen as ordered for 1 of 2 residents reviewed for respiratory care (Resident #58). Resident #58 was admitted on 6/30/12 A review of the multi-disciplinary care conference meeting documentation dated 3/2/18 revealed the resident wore his oxygen in bed. A review of the annual Minimum Data Set dated 5/11/18 revealed the resident had adequate hearing, clear speech, and was understood and understands. His cognition was intact with no behaviors. The resident required one-person physical assistance for all activities of daily living. The active diagnoses were atrial fibrillation, heart failure, chronic obstructive pulmonary disease, bronchiectasis, and lung abscess. There was a hand-written physician order dated 5/7/18 for oxygen 3 liters per minute by nasal cannula as needed. Care plan dated 5/25/18 revealed the resident had goals and approaches for impaired mobility, full code, supervised smoker, fluid volume	F 695	1.The plan of correction for the specific deficiency: Resident #58 POS/MAR was updated on 6/18/18 by the primary nurse during Annual Survey. Process that lead to the cited deficiency attributed to lack of monitoring oversight of Licensed Nurses during monthly changeover. 2.The procedure for implementing the acceptable plan of correction for the cited deficiency: Medical Record audit was conducted on residents receiving oxygen by the DHS and primary nurse on 6/29/18. The ordered oxygen settings were verified in resident rooms with POS/MAR during the audit conducted on 6/29/18. The 3 step process was utilized for medical record, POS/MAR, and Care Plan revisions by the DHS, CCC, and Primary Nurse. Licensed staff received in-service training on documentation of oxygen administration utilizing the 3 step process on 6/25/18 by the DHS. Additional training was provided on 6/28/18 by the DHS and CCC. Return demonstration of the 3 step process was performed by the Licensed Nurses to the DHS and CCC. This process will be utilized for orders obtained	

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F 695	Continued From page 44 fluctuations, and at risk for respiratory distress. A review of the June 2018 monthly physician orders revealed the oxygen order was not carried over from the May 2018 order. On 6/18/18 at 10:30 am an observation of Resident #58 ' s oxygen concentrator revealed it was regulator dialed to 1.25 liters per minutes flow by nasal cannula. The tubing and humidification water was currently dated. The resident was observed to be independent with nasal cannula placement. The resident stated that his oxygen was supposed to be at 3 liters per minute and he cannot regulate the flow. Nurse #1 entered the resident ' s room and observed the oxygen concentrator regulator. Nurse #1 observed the oxygen concentrator regulator from a standing level and stated the flow was dialed to 2 liters. Nurse #1 bent over for eye level to the concentrator regulator and observed the oxygen was dialed to 1.25 liters. Nurse #1 informed the resident he was ordered to be on 2 liters of oxygen per minute by nasal cannula. Nurse #1 checked the medication administration record (MAR) and indicated that the oxygen order was not on the June 2018 MAR and there was no documentation. On 6/18/18 at 10:40 am an interview was conducted with Nurse #1 who stated that oxygen administration was required to be documented on the MAR and signed off by nursing each shift. Resident #58 ' s June 2018 MAR was missing the oxygen order. Nurse #1 stated that the oxygen order from May 2018 was not carried over onto the June 2018 monthly physician order and documented on the MAR. After Nurse #1 reviewed the oxygen order it was determined the	F 695	and monthly changeover and Care Plan revisions. Each hall will be assigned to DHS, ADHS, and CCC for monitoring to include visual observation in rotating shifts to include weekends. New hires will receive education on F695 during orientation by the CCC. 3.The monitoring procedure to ensure the effectiveness of the plan of correction constitutes monitoring oxygen orders and 3 step process daily x5, weekly x5, then monthly until next Annual Survey. Findings will be discussed monthly in QAPI by the DHS. 4.The person responsible for implementing the acceptable plan of correction: DHS, ADHS, and CCC. 5.Completion date: 7/17/18	

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F 695	Continued From page 45 it was for 3 liters. On 6/21/18 at 2:00 pm an interview was conducted with the Director of Nursing (DON) who stated that she expected staff to follow physician orders.	F 695		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(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. (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.	F 756		7/17/18

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F 756	Continued From page 46 §483.45(c)(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 review, staff interview, Psychiatric Nurse Practitioner interview, and Pharmacy Consultant interview, the facility failed to act upon recommendations made by Pharmacy Consultant for 2 of 7 residents reviewed (Residents #13 and #37). The findings included: 1. Resident #13 was admitted to the facility on 4/29/16 with diagnoses that included dementia with behavioral disturbance and major depressive disorder. A review of Resident #13 ' s medical record revealed an order dated 3/14/17 for Trazodone (antidepressant medication) 12.5 milligrams (mg) every 8 hours as needed (PRN) for anxiety or agitation. There was no stop date for this PRN order. The annual Minimum Data Set (MDS) assessment dated 3/16/18 indicated Resident #13 ' s cognition was severely impaired. She was assessed with verbal behaviors on 1 to 3 days and other behavioral symptoms on 4 to 6 days. Resident #13 was administered antipsychotic medication and antidepressant medication on 7 of 7 days during the MDS look back period.	F 756	1.The plan of correction for the specific deficiency: Resident #13 received orders to Discontinue Trazadone on 6/27/18 by the primary nurse. Resident #37 received orders to discontinue prn Ativan and Begin Scheduled Ativan for terminal agitation on 6/20/18 by the Hospice Nurse during Annual Survey. Process that lead to cited to deficiency failure of Licensed Nurses to identify importance of discontinuing psychotropic medications per order, lack of supervision from Administrative staff due to Medical Leave affecting DHS, ADHs, and CCC during calendar year. 2.The procedure for implementing the acceptable plan of correction for the cited deficiency: Audit conducted by DHS on 6/28/18, for residents receiving prn psychotropic medications. Audit revealed 6 residents affected. Identified residents receiving prn psychotropic medication received changes in orders in relation to timeframes for the use of these medications. Care Plans and POS/MARs received updates related to the identified changes on 6/29/18 by DHS and CRC. New admissions to facility will be assessed by the DHS/ADHS and/or	

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F 756	Continued From page 47 The Consultant Pharmacist Communication to Physician form dated 10/18/17 addressed Resident #13 ' s Trazodone PRN order that had been in place since 3/14/17 with no stop date. The Pharmacy Consultant recommended the physician indicate a duration for the PRN Trazodone that included documentation of their rationale if the order was to extend beyond 14 days. This recommendation was not acted upon. A review of Resident #13 ' s Drug Regimen Reviews (DRRs) dated 11/22/17, 12/18/17, 1/23/18, and 3/26/18 indicated the recommendations regarding the Trazodone PRN order for Resident #13 had been resent as they were not responded to by the physician. The Consultant Pharmacist Communication to Physician form dated 3/26/18 that addressed Resident #13 ' s PRN Trazodone order indicated the Psychiatric Nurse Practitioner (PNP) had signed and dated the form on 4/10/18 for a duration of 30 days for depression and anxiety. This form indicated instructions for a clarification order to be written for a specified duration of the PRN Trazodone. The medical record revealed no clarification order was written. A review of Resident #13 ' s June 2018 physician ' s order summary included the order dated 3/14/17 for Trazodone 12.5 mg every 8 hours PRN for anxiety or agitation. There continued to be no stop date for this PRN order. A review of Resident #13 ' s June 2018 MAR from 6/1/18 through 6/20/18 indicated the PRN order for Trazodone continued to be an active order with no stop date.	F 756	primary nurse for use of psychotropic medications with duration for any ordered prn usage. Licensed Nurses received in-service training by the DHS on 6/25/18 in relation to monitoring and use of prn psychotropic medications with the directive of no longer than 14 days duration, and Care Plan documentation/revision. Additional training was provided on 6/28/18 by the DHS and CCC. New hires will receive education on F756 during orientation by the CCC. 3.The monitoring procedure to ensure the effectiveness of the plan of correction constitutes monitoring orders focused on psychotropic medications daily x5, weekly x5, then monthly until next Annual Survey by the DHS. DHS will discuss monthly in QAPI. 4.The person responsible for implementing the acceptable plan of correction: DHS, ADHS, and CCC. 5.Completion Date: 7/17/18.	

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F 756	Continued From page 48	F 756		

An interview was conducted with the Director of Nursing (DON) on 6/20/18 at 11:55 AM. She reported she had been out of the facility for the last couple of months and the Assistant Director of Nursing (ADON) was responsible for her duties during that time.

An interview was conducted with the ADON on 6/21/18 at 8:35 AM. The Consultant Pharmacist Communication to Physician forms (dated 10/18/17 and 3/26/18) and the DRRs that addressed Resident #13 ' s Trazodone PRN order that had been in place since 3/14/17 with no stop date were reviewed with the ADON. She stated she reviewed the Pharmacy Recommendations that corresponded to the DRRs for Resident #13 and she had not found corresponding Consultant Pharmacist Communication to Physician forms for the 11/22/17, 12/18/17, and 1/23/18 reviews. She was asked if that meant they had not received recommendation forms for those dates related to Resident #13 ' s PRN Trazodone, or if she was just unable to locate them. She stated she was unable to say for certain if they had not been received. The ADON confirmed the 10/18/17 Consultant Pharmacist Communication to Physician form and the 3/26/18 Consultant Pharmacist Communication to Physician form were located in Resident #13 ' s medical record and had not been acted upon. The form dated 3/26/18 that had been signed by the PNP on 4/10/18 indicating a duration of 30 days was reviewed with the ADON. The medical record that included no clarification order was reviewed with the ADON. She stated the PNP or any of the nurses who had seen the form could have written a clarification order.

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F 756	Continued From page 49	F 756		

An interview was conducted with the Pharmacy Consultant on 6/21/18 at 9:15 AM. He stated he was aware of the regulation regarding PRN psychotropic medications being time limited in duration and that he had been making recommendations related to these orders since October 2017. The DRRs related to Resident #13 ' s PRN Trazodone order were reviewed with the Pharmacy Consultant. The Consultant Pharmacist Communication to Physician forms dated 10/18/17 and 3/26/18 related to Resident #13 ' s PRN Trazodone order were reviewed with the Pharmacy Consultant. He was informed the ADON stated the facility was unable to locate the corresponding Consultant Pharmacist Communication to Physician forms for the 11/22/17, 12/18/17, and 1/23/18 reviews. The Pharmacy Consultant provided hard copy print outs of these forms dated 11/22/17, 12/18/17, and 1/23/18. He stated he had provided all of these forms to the facility and the recommendations had not been acted upon.

This interview with the Pharmacy Consultant continued. He was asked if he spoke to the physicians or facility nursing staff regarding repeat recommendations that were not responded to. He indicated he informed the Director of Nursing (DON) or ADON of this issue, but he had not spoken directly to any of the physicians.

A phone interview was conducted with the PNP on 6/21/18 at 10:40 AM. She stated she was aware of the regulation regarding PRN psychotropic medications which was a time limited duration requiring a documented rationale if the order was to extend beyond 14 days. She

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F 756	Continued From page 50	F 756		

stated she had been working with the facility to identify and address any PRN psychotropic orders that had no stop dates. The PRN Trazodone order that had been in place since 3/14/17 for Resident #13 was reviewed with the PNP. She revealed this order was one of the PRN psychotropic orders that had been missed. The DRRs and Consultant Pharmacist Communication to Physician forms dated 10/18/17, 11/22/17, 12/18/17, 1/23/18, and 3/26/18 for Resident #13 were reviewed with the PNP. She stated that Consultant Pharmacist Communication to Physician forms related to psychotropic medications were normally given to her to address. She reported she responded to all of these forms that she received. The PNP indicated if a Consultant Pharmacist Communication to Physician form was not responded to that it was hard to pinpoint the exact reason why because there were many steps to the process. She explained that the Pharmacy Consultant completed the DRRs, he then completed Consultant Pharmacist Communication to Physician forms for recommendations, these forms were given to the facility, the facility gave the forms to her, she completed the forms, and then gave it back to the facility.

An interview was conducted with the DON on 6/21/18 at 12:10 PM. She stated she expected pharmacy recommendations to be acted upon.

2. Resident #37 was admitted to the facility on 1/8/10 and most recently readmitted on 4/13/18 with multiple diagnoses that included dementia.

The significant change Minimum Data Set (MDS) assessment dated 4/26/18 indicated Resident

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F 756	Continued From page 51	F 756		

#37 had severely impaired cognition. She was receiving hospice services and she had not received antianxiety medication during the 7-day MDS look back period.

A physician ' s order dated 5/3/18 indicated Ativan (antianxiety medication) 0.5 milligrams (mg) every 4 hours as needed (PRN) for terminal anxiety for Resident #37. There was no stop date for this PRN order.

A Consultant Pharmacist Communication to Physician form dated 5/9/18 requested a duration be specified for Resident #37 ' s PRN Ativan. The form additionally indicated the physician was to document a rationale if the duration was to extend beyond 14 days. This form was signed by Resident #37 ' s physician, dated 5/29/18, and "agitation" was documented on the form. There was no duration provided for the PRN Ativan.

A review of Resident #37 ' s June 2018 physician ' s order summary included the order dated 5/3/18 for Ativan 0.5 mg every 4 hours PRN. There continued to be no stop date for this PRN order.

A review of Resident #37 ' s June 2018 MAR from 6/1/18 through 6/19/18 indicated the PRN order for Ativan 0.5 mg continued to be an active order.

An interview was conducted with the Pharmacy Consultant on 6/20/18 at 11:05 AM. He stated he was aware of the regulation regarding PRN psychotropic medications being time limited in duration. He indicated he expected the physician to provide a specific duration for PRN psychotropic medications and to document a clinical rationale if the duration was to extend

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F 756	Continued From page 52 beyond 14 days. An interview was conducted with the Director of Nursing (DON) on 6/20/18 at 11:55 AM. The Consultant Pharmacist Communication form dated 5/9/18, signed by Resident #37 ' s physician on 5/29/18 with no documented duration for Resident #37 ' s PRN Ativan was reviewed with the DON. She indicated the facility has had difficulty working with this physician in the past and she was not surprised by the lack of a complete response to the Pharmacy Consultant ' s recommendation. The DON stated she expected pharmacy recommendations to be acted upon.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(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 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(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;	F 758		7/17/18

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F 758	Continued From page 53 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Psychiatric Nurse Practitioner interview, and Pharmacy Consultant interview, the facility failed to discontinue antipsychotic medications as ordered by the physician (Resident #10) and failed to ensure physician ' s orders for as needed (PRN) psychotropic medications were time limited in duration (Residents #13, #37, and #55) for 4 of 7 sampled residents. The findings included: 1. Resident #10 was readmitted on 2/1/16 with	F 758	1.The plan of correction for the specific deficiency cited: Resident #13 received orders to discontinue Trazadone on 6/27/18. Resident #10 received a review of orders and MAR by DHS and Primary Physician on 6/25/18. No further orders received and Psychiatric Nurse Practitioner was also updated on 6/25/18. Resident #37 received orders to discontinue prn Ativan and Begin Scheduled Ativan for terminal agitation on	

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F 758	Continued From page 54 diagnoses that included major depressive disorder and psychosis. The annual Minimum Data Set (MDS) assessment dated 3/16/18 indicated Resident #10 ' s cognition was intact. She received no antipsychotic medication during the MDS review period. A physician ' s order for Resident #10 dated 3/22/18 indicated Seroquel (antipsychotic medication) 25 milligrams (mg) twice daily (once in the morning and once in the evening) for seven days then Seroquel 50 mg once in the evening. The facility ' s Medication Administration Records (MARs) were maintained on hard copy forms. A review of the March 2018 MAR indicated Resident #10 received Seroquel 25 mg twice daily for 7 days from 3/23/18 through 3/29/18. A physician ' s order dated 3/29/18 indicated an increase in Resident #10 ' s Seroquel to 50 mg twice daily (once in the morning and once in the evening). Resident #10 ' s March 2018 MAR indicated the physician ' s order for Seroquel 25 mg twice daily was discontinued on the MAR after 3/29/18 and the order for Seroquel 50 mg once daily that was to be initiated at the completion of 25 mg twice daily for 7 days was discontinued on the MAR on 3/29/18. The physician ' s order dated 3/29/18 for Seroquel 50 mg twice daily was added to the MAR on 3/29/18 and was administered to Resident #10 beginning on 3/29/18. The MAR revealed this administration of 50 mg twice daily on 3/29/18 was in addition to the administration of 25 mg twice daily. Resident #10 ' s Seroquel 50 mg was administered twice a day as ordered on 3/30/18 and 3/31/18.	F 758	6/20/18 by the Hospice Nurse during Annual Survey. Resident #55 received clarified orders on 6/28/18 by DHS. Process that lead to cited to deficiency failure of Licensed Nurses to identify importance of discontinuing psychotropic medications per order, lack of supervision from Administrative staff due to Medical Leave affecting DHS, ADHs, and CCC during calendar year. 2.The procedure for implementing the acceptable plan of correction for the deficiency cited: Audit conducted by DHS on 6/28/18, for residents receiving prn psychotropic medications. Audit revealed 6 residents affected. Identified residents receiving prn psychotropic medication received changes in orders in relation to timeframes for the use of these medications. Care Plans and POS/MARs received updates related to the identified changes on 6/29/18 by DHS and CRC. New admissions to facility will be assessed by the DHS/ADHS and/or primary nurse for use of psychotropic medications with duration for any ordered prn usage. DHS will oversee response to Pharmacy Recommendations and designated Administrative Nurses will assist with implementation of recommendations for assigned hall. DHS, ADHS, and CCC will be assigned halls per DHS directives. Licensed Nurses received in-service training by the DHS on 6/25/18 in relation to monitoring and use of prn psychotropic medications with the directive of no longer than 14 days duration, and Care Plan	

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F 758	Continued From page 55 Resident #10 ' s April 2018 MAR included the physician ' s order dated 3/22/18 that had been discontinued on 3/29/18 for Seroquel 50 mg once daily for Resident #10. Handwritten on the April 2018 MAR was the active physician ' s order dated 3/29/18 for Seroquel 50 mg twice daily. This MAR revealed Resident #10 was administered the discontinued order dated 3/22/18 for Seroquel 50 mg once daily in the evening on 4/1/18 and 4/2/18 in addition to the active order for Seroquel 50 mg twice daily on 4/1/18 and 4/2/18. A physician ' s order dated 4/3/18 indicated an increase in Resident #10 ' s Seroquel to 75 mg in the morning and 100 mg in the evening. The April 2018 MAR was again reviewed. The order for Resident #10 ' s Seroquel 50 mg twice daily was discontinued on the MAR on 4/3/18. The order for Seroquel 50 mg once daily that was discontinued on 3/29/18 remained on Resident #10 ' s MAR. The 4/3/18 order for Seroquel 75 mg in the morning and 100 mg in the evening was added in handwriting to the MAR on 4/3/18 and was initiated on 4/4/18. This MAR revealed the discontinued order dated 3/22/18 for Seroquel 50 mg once daily was administered to Resident #10 from 4/4/18 through 4/10/18 in addition to the active order for Seroquel 75 mg in the morning and 100 mg in the evening. The discontinued order dated 3/22/18 for Seroquel 50 mg once daily was noted on the MAR in handwriting as discontinued on 4/10/18 and it was no longer administered to Resident #10. A review of the nursing notes during the timeframes that Resident #10 was administered	F 758	documentation/revision. Additional training was provided on 6/28/18 by the DHS and CCC. New hires will receive education on F756 during orientation by the CCC. 3.The monitoring procedure to ensure the effectiveness of the plan of correction constitutes monitoring medication orders with a focus on psychotropic daily x5, weekly x5, then monthly until next Annual Survey by the DHS. Findings will be discussed in QAPI monthly by the DHS. 4.The person responsible for implementing the acceptable plan of correction: DHS, ADHS, and CCC. 5.Completion Date: 7/17/18	

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additional doses of Seroquel revealed no noted issues with the resident experiencing side effects of antipsychotic medication or excessive sedation.

An interview was conducted with the Director of Nursing (DON) on 6/20/18 at 11:55 AM. She reported she had been out of the facility for the last couple of months and the Assistant Director of Nursing (ADON) was responsible for her duties during that time.

An interview was conducted with the ADON on 6/21/18 at 10:15 AM. The March and April 2018 physician ' s orders and MARs for Resident #10 were reviewed with the ADON. She confirmed Resident #10 ' s Seroquel had not been discontinued as ordered resulting in additional administrations of the antipsychotic medication. She was asked what the process was for reviewing orders and MARs from month to month to ensure they matched and that medications were administered as ordered and discontinued as ordered. The ADON stated that several different nurses were responsible for reconciling the orders and reviewing the MARS at the end of each month. She indicated there was not one person responsible for the monthly review. She reported that ultimately herself and the DON were responsible for oversight of this task. She revealed she was unaware of these errors previously.

A phone interview was conducted with the Psychiatric Nurse Practitioner (PNP) on 6/21/18 at 10:40 AM. The excess administrations of Resident #10 ' s Seroquel were reviewed with the PNP. She reported that Resident #10 had several medication adjustments in an effort to find

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the most effective dosage. She stated she expected medications to be administered as ordered and discontinued as ordered, but she believed Resident #10 had no negative effects from the errors.

A follow up interview was conducted with the DON on 6/21/18 at 12:10 PM. She stated she expected medications to be administered as ordered and discontinued as ordered.

2. Resident #13 was admitted to the facility on 4/29/16 with diagnoses that included dementia with behavioral disturbance and major depressive disorder.

A review of Resident #13 ' s medical record revealed an order dated 3/14/17 for Trazodone (antidepressant medication) 12.5 milligrams (mg) every 8 hours as needed (PRN) for anxiety or agitation. There was no stop date for this PRN order.

The annual Minimum Data Set (MDS) assessment dated 3/16/18 indicated Resident #13 ' s cognition was severely impaired. She was assessed with verbal behaviors on 1 to 3 days and other behavioral symptoms on 4 to 6 days. Resident #13 was administered antipsychotic medication and antidepressant medication on 7 of 7 days during the MDS look back period.

A review was conducted of Resident #13 ' s Pharmacy Consultant ' s Drug Regimen Reviews (DRRs). The DRR dated 10/18/17 addressed Resident #13 ' s Trazodone PRN order that had been in place since 3/14/17 with no stop date. The Pharmacy Consultant recommended the physician indicate a duration for the PRN

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Trazodone that included documentation of their rationale if the order was to extend beyond 14 days. The DRRs dated 11/22/17, 12/18/17, 1/23/18, and 3/26/18 indicated the recommendations regarding the Trazodone PRN order for Resident #13 had been resent as they were not responded to by the physician.

The Consultant Pharmacist Communication to Physician form dated 3/26/18 that addressed Resident #13 ' s PRN Trazodone order indicated the Psychiatric Nurse Practitioner (PNP) had signed and dated the form on 4/10/18 for a duration of 30 days for depression and anxiety. This form indicated instructions for a clarification order to be written for a specified duration of the PRN Trazodone. The medical record revealed no clarification order was written.

A review of Resident #13 ' s June 2018 physician ' s order summary included the order dated 3/14/17 for Trazodone 12.5 mg every 8 hours PRN for anxiety or agitation. There continued to be no stop date for this PRN order.

A review of Resident #13 ' s June 2018 MAR from 6/1/18 through 6/20/18 indicated the PRN order for Trazodone continued to be an active order with no stop date.

An interview was conducted with the Director of Nursing (DON) on 6/20/18 at 11:55 AM. She reported she had been out of the facility for the last couple of months and the Assistant Director of Nursing (ADON) was responsible for her duties during that time.

An interview was conducted with the ADON on 6/21/18 at 8:35 AM. She stated he was aware of

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the regulation regarding PRN psychotropic medications being time limited in duration. The DRRs that addressed Resident #13 ' s Trazodone PRN order that had been in place since 3/14/17 with no stop date were reviewed with the ADON. She stated she reviewed the Pharmacy Recommendations that corresponded to the DRRs for Resident #13 and she had not found corresponding Consultant Pharmacist Communication to Physician forms for the 11/22/17, 12/18/17, and 1/23/18 reviews. She was asked if that meant they had not received recommendation forms for those dates related to Resident #13 ' s PRN Trazodone, or if she was just unable to locate them. She stated she was unable to say for certain if they had not been received. The ADON confirmed the 10/18/17 Consultant Pharmacist Communication to Physician form and the 3/26/18 Consultant Pharmacist Communication to Physician form were located in Resident #13 ' s medical record. The form dated 3/26/18 that had been signed by the PNP on 4/10/18 indicating a duration of 30 days was reviewed with the ADON. The medical record that included no clarification order was reviewed with the ADON. She stated the PNP or any of the nurses who had seen the form could have written a clarification order.

An interview was conducted with the Pharmacy Consultant on 6/21/18 at 9:15 AM. He stated he was aware of the regulation regarding PRN psychotropic medications being time limited in duration. He indicated he had been making recommendations related to PRN psychotropic orders since October 2017. The DRRs related to Resident #13 ' s PRN Trazodone order were reviewed with the Pharmacy Consultant. The Consultant Pharmacist Communication to

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Physician forms dated 10/18/17 and 3/26/18 related to Resident #13 ' s PRN Trazodone order were reviewed with the Pharmacy Consultant. He was informed the ADON stated the facility was unable to locate the corresponding Consultant Pharmacist Communication to Physician forms for the 11/22/17, 12/18/17, and 1/23/18 reviews. The Pharmacy Consultant provided hard copy print outs of these forms dated 11/22/17, 12/18/17, and 1/23/18. He stated he had provided all of these forms to the facility.

This interview with the Pharmacy Consultant continued. He was asked if he spoke to the physicians or facility nursing staff regarding repeat recommendations that were not responded to. He indicated he informed the Director of Nursing (DON) or ADON of this issue, but he had not spoken directly to any of the physicians.

A phone interview was conducted with the PNP on 6/21/18 at 10:40 AM. She stated she was aware of the regulation regarding PRN psychotropic medications which was a time limited duration requiring a documented rationale if the order was to extend beyond 14 days. She stated she had been working with the facility to identify and address any PRN psychotropic orders that had no stop dates. The PRN Trazodone order that had been in place since 3/14/17 for Resident #13 was reviewed with the PNP. She revealed this order was one of the PRN psychotropic orders that had been missed. The DRRs and Consultant Pharmacist Communication to Physician forms dated 10/18/17, 11/22/17, 12/18/17, 1/23/18, and 3/26/18 for Resident #13 were reviewed with the PNP. She stated that Consultant Pharmacist

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Communication to Physician forms related to psychotropic medications were normally given to her to address. She reported she responded to all of these forms that she received. The PNP indicated if a Consultant Pharmacist Communication to Physician form was not responded to that it was hard to pinpoint the exact reason why because there were many steps to the process. She explained that the Pharmacy Consultant completed the DRRs, he then completed Consultant Pharmacist Communication to Physician forms for recommendations, these forms were given to the facility, the facility gave the forms to her, she completed the forms, and then gave it back to the facility.

An interview was conducted with the DON on 6/21/18 at 12:10 PM. She stated she expected all PRN psychotropic medications to be time limited in duration as per the regulations.

3. Resident #37 was admitted to the facility on 1/8/10 and most recently readmitted on 4/13/18 with multiple diagnoses that included dementia.

The significant change Minimum Data Set (MDS) assessment dated 4/26/18 indicated Resident #37 had severely impaired cognition. She was receiving hospice services and she had not received antianxiety medication during the 7-day MDS look back period.

A physician ' s order dated 5/3/18 indicated Ativan (antianxiety medication) 0.5 milligrams (mg) every 4 hours as needed (PRN) for terminal anxiety for Resident #37. There was no stop date for this PRN order.

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A Consultant Pharmacist Communication to Physician form dated 5/9/18 requested a duration be specified for Resident #37 ' s PRN Ativan. The form additionally indicated the physician was to document a rationale if the duration was to extend beyond 14 days. This form was signed by Resident #37 ' s physician, dated 5/29/18, and "agitation" was documented on the form. There was no duration provided for the PRN Ativan.

A review of Resident #37 ' s June 2018 physician ' s order summary included the order dated 5/3/18 for Ativan 0.5 mg every 4 hours PRN. There continued to be no stop date for this PRN order.

A review of Resident #37 ' s June 2018 MAR from 6/1/18 through 6/19/18 indicated the PRN order for Ativan 0.5 mg continued to be an active order.

An interview was conducted with the Pharmacy Consultant on 6/20/18 at 11:05 AM. He stated he was aware of the regulation regarding PRN psychotropic medications being time limited in duration. He indicated he expected the physician to provide a specific duration for PRN psychotropic medications and to document a clinical rationale if the duration was to extend beyond 14 days.

An interview was conducted with the Director of Nursing (DON) on 6/20/18 at 11:55 AM. The Consultant Pharmacist Communication form dated 5/9/18, signed by Resident #37 ' s physician on 5/29/18 with no documented duration for Resident #37 ' s PRN Ativan was reviewed with the DON. She indicated the facility has had difficulty working with this physician in

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the past and she was not surprised by the lack of a complete response to the Pharmacy Consultant ' s recommendation. The DON stated she expected all PRN psychotropic medications to be time limited in duration as per the regulations.
4. Resident #55 was admitted on 10/3/16 with a diagnosis of psychosis.

Review of a physician order dated 11/14/17 read: "Initiate Ativan 0.5 milligrams (mg) one tablet daily prn (as needed) for anxiety and agitation for fourteen days." This order was written by the Psychiatric Nurse Consultant.

Review of the monthly Pharmacy Consultant Drug Regimen Review dated 11/22/17 made no mention of the prn Ativan ordered for fourteen days on 11/14/17. There was no documented evidence of a pharmacy recommendation regarding the discontinuation of the prn Ativan.

Review of the monthly Pharmacy Consultant Drug Regimen Review dated 12/19/17 made no mention of the prn Ativan ordered for fourteen days on 11/14/17. There was no documented evidence of a pharmacy recommendation regarding the discontinuation of the prn Ativan.

Review of the January 2018 Physician Orders read as follows: Ativan 0.5mg one tablet by mouth daily prn for anxiety or agitation for 14 days dated 11/14/17. Review of the January 2018 Medication Admiration Record (MAR) indicated Resident #55 received a prn dose of Ativan on 1/5/18

Review of the monthly Pharmacy Consultant Drug Regimen Review dated 1/23/18 made no mention

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of the prn Ativan ordered for fourteen days on 11/14/17. Review of the pharmacy recommendation to the physician dated 1/23/18 did not include any recommendation to stop the prn Ativan.

Review of the February 2018 Physician Orders read as follows: Ativan 0.5mg one tablet by mouth daily prn for anxiety or agitation for 14 days dated 11/14/17. Review of the February 2018 MAR indicated Resident #55 did not receive any prn doses of Ativan.

Review of the monthly Pharmacy Consultant Drug Regimen Review dated 2/22/18 made no mention of the prn Ativan order dated 11/14/17. There was no documented evidence regarding a pharmacy recommendation to discontinue the prn Ativan.

Review of the March 2018 Physician Orders read as follows: Ativan 0.5mg one tablet by mouth daily prn for anxiety dated 2/6/18. The March 2018 MAR read Ativan 0.5mg one by mouth prn for anxiety dated 2/6/18 and indicated Resident #55 did not receive any doses of the prn Ativan.

There was no documented evidence of a new physician order dated 2/6/18 regarding Resident #55's prn Ativan.

Review of the monthly Pharmacy Consultant Drug Regimen Review dated 3/26/18 made no mention of the prn Ativan with a reorder date of 2/6/18. There was no documented evidence regarding a pharmacy recommendation to discontinue the prn Ativan.

Review of the April 2018 Physician Orders read as follows: Ativan 0.5mg one tablet by mouth

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daily prn for anxiety dated 2/6/18. The April 2018 MAR read Ativan 0.5mg one by mouth daily prn for anxiety effective 2/6/18 and indicated Resident #55 did not receive any doses of the prn Ativan.

Review of the monthly Pharmacy Consultant Drug Regimen Review dated 4/18/18 read to discontinue the prn Ativan per pharmacy automatic stop. Review of the pharmacy recommendation to the physician dated 4/18/18 did not include any recommendation to stop the prn Ativan.

Review of the May 2018 Physician Orders read as follows: Ativan 0.5mg one tablet by mouth daily prn for anxiety dated 4/5/18. The May 2018 MAR read Ativan 0.5mg one by mouth daily prn for anxiety effective 4/5/18 and indicated Resident #55 received a dose of the prn Ativan on 5/8/18.

There was no documented evidence of a new physician order dated 4/5/18 regarding Resident #55's prn Ativan.

Review of the monthly Pharmacy Consultant Drug Regimen Review dated 5/9/18 made no mention of the prn Ativan with a reorder date of 4/5/18. There was no documented evidence regarding a pharmacy recommendation to discontinue the prn Ativan.

Resident #55's quarterly Minimum Data Set dated 5/11/18 indicated moderate cognitive impairment, physical and verbal behaviors and rejection of care. He was coded as taking antianxiety medication.

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Resident #55's last revised psychotropic medication care plan dated 5/25/18 indicated he was to have gradual dose reductions as instructed by the pharmacy or the physician as indicated.

Review of the June 2018 Physician Orders read as follows: Ativan 0.5mg one tablet by mouth daily needed for anxiety dated 4/5/18. The June 2018 MAR read Ativan 0.5mg one by mouth as needed for anxiety effective 4/5/18 and indicated Resident #55 did not receive any as needed doses of Ativan.

In an interview on 6/20/18 at 4:30 PM, the Consultant Pharmacist stated he was unable to explain why the time limited in duration Ativan was continued past the original 14 days in November 2017. He stated he "missed it." He confirmed there was no documented recommendation to the facility or the physician regarding the need to discontinue the prn Ativan after the original order for 14 days dated 11/14/17. He unable to state the reason for the new order dates of 2/6/18 and 4/5/18 on the pharmacy generated monthly orders and monthly MAR. The Consultant Pharmacist stated he was aware that any prn medication for anxiety must be time limited in duration or reassessed for the continued use with a new physician order written specifying the duration.

In a telephone interview on 6/21/18 at 10:40 AM, the Psychiatric Nurse Practitioner stated it was her expectation that the Ativan order dated 11/14/17 would have been discontinued after the 14 days as ordered. She stated if continued use was indicated, she would re-evaluate Resident #55 before re-ordering the Ativan.

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F 758	Continued From page 67 In an interview on 6/21/18 at 12:10 PM, the Director of Nursing stated it was her expectation that all prn antianxiety medications should be time limited in duration and no long than 14 days without a reassessment for the continued need for the medication with a new written physician order.	F 758		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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. §483.75(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 staff interview, the facility ' s Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and to monitor the interventions that the committee put into place in May 2017. This was for three (3) recited deficiencies (safe, clean, comfortable, homelike	F 865	1. The plan of correction for the specific deficiency cited: a- The bathroom floors in rooms 140, 144, 145, and 148 were deep cleaned by the housekeeping supervisor on 6/20/2018 with the caulking around the base of the commode in each room	7/19/18

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	345378	A. BUILDING _____ B. WING _____	C 06/21/2018

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F 865	Continued From page 68	F 865		

environment, life expectancy, free of accident hazards) which were originally cited on 5/11/17 during the recertification/ complaint investigation survey and the current recertification/ complaint investigation of 6/21/18. The continued failure of the facility during the two federal surveys of record show a pattern of the facility ' s inability to sustain an effective QAPI program. The finding included:

This tag is cross referred to:

1. F584-safe, clean, comfortable, homelike environment: Based on observation and interview the facility failed to provide a clean bathroom as evidenced by a brown ring, soil stain at the base of the toilet in 4 of 8 bathrooms observed for environment (Room #s 140, 144, 145, and 148).

During the recertification survey of 5/11/17, the facility was cited F253 for failure to remove a broken chair from Resident #86 ' s room on 1 of 4 halls.

2.F641-Accuracy of assessments: Based on record review and staff interview, the facility failed to complete the Minimum Data Set (MDS) assessment accurately in the area of life expectancy (Resident #37) for 1 of 1 residents reviewed for hospice.

During the recertification survey of 5/11/17, the facility was cited F278 for failure to conde the Minimum Data Set (MDS) accurately in the areas of restraints, diagnosis and cognition.

3. F689-Free of Accident Hazards/ Supervision/ Devices: Based on observation, staff interview

replaced by the facility Maintenance Director on 6/20/2018. On 7/6/2018 chairs in resident□s room were checked by the Maintenance Director to ensure they were in good working condition. Processes that lead to the deficiency cited were changes to administrative personnel as well as changes to environmental monitoring procedures.

b- Resident #37 MDs was corrected on 6/26/18 with J1400 box checked indicating Life Expectancy of six months or less by the Case Mix Coordinator.

c- Resident #55 and resident #3 have had no further altercations after 1/12/2018. On 7/6/2018 Facility Maintenance Director placed tie around PTAC unit cord in resident #75□s room. The Maintenance Director secured the tied cord under the PTAC unit and out of the walkway. Sigma shields are monitored for function and placement daily by facility personnel. Processes that lead to the deficiency cited were changes to the reporting guidelines, facility Maintenance personnel, and environmental monitoring procedures.

2. The procedure for implementing the acceptable plan of correction for the deficiency cited:

a- Facility bathrooms in residents□ rooms were inspected by the housekeeping supervisor starting 6/21/2018 and ending 7/6/2018. Floors in need of deep cleaning and subsequent caulking were cleaned on the day of the inspection and caulked by facility Maintenance Director. Resident

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F 865	Continued From page 69 and record review, the facility failed to prevent an incident involving one resident (Resident #55) from hitting another resident (Resident #3) on the back of the head after an earlier verbal altercation involving both residents. The facility also failed to provide a safe walkway as evidenced by an electrical cord laying on the floor (Resident #75). This was for 2 of 5 residents reviewed for accidents. During the recertification survey of 5/11/17, the facility was cited for F323 for failure to monitor the function and placement of a Sigma Shield for a period of 16 days following the date of implementation for a resident who was identified as a significant risk of wandering to a dangerous place. On 6/21/18 at 12:29 PM, an interview was conducted with the Director of Nursing and the Administrator. The Director of Nursing stated, with the deficiencies cited in May 2017, corporate staff came in and assisted with the Plan of Correction (POC). The limited amount of time for monitoring after the last POC was possibly a factor. She stated accidents had been a part of monitoring anyway and there had been an increase in the monitoring of potential safety hazards. The facility had Administrative changes, changes in MDS Coordinator which could be a factor with the repeat citations.	F 865	bathrooms are cleaned daily by facility housekeeping staff. Bathrooms noted to need deep cleaning or caulking will be placed in facility maintenance log for housekeeping supervisor and Maintenance Director to address. Facility administrative employees will note condition of bathroom floors on room round form with negative findings documented on the form and reported during AM meeting to the Maintenance Director and Housekeeping Supervisor. Facility employees will be educated on maintaining a clean resident environment, with a focus on bathrooms, on 7-6-18 by facility Administrator. Facility employees will receive training on maintaining a clean and safe resident environment upon hire and annually. b- Residents receiving hospice services were audited on 6/26/18 and corrections were conducted on the MDS in section J100 on 6/26/18 by the Case Mix Coordinator. New residents admitted to facility that meet the criteria for hospice services will receive a Significant Change assessment conducted by the CMC at the time the assessment is due. The DHS will visually observe that J1400 is checked. Licensed Nurses and Case Mix Coordinator received in-service training by the DHS on 6/25/18 in relation to J1400. Additional in-servicing was provided for Non-licensed staff on 6/28/18 by the DHS. New hires will received education on F641 during orientation by the CCC. c- Facility audit of current residents medical records by Administrator started 7 -5-2018 and ending 7-10-2018 showed	

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F 865	Continued From page 70	F 865	other resident to resident altercations were identified and effectively managed to prevent future altercations with other residents. Facility Maintenance Director conducted audit starting 7/6/2018 and ending 7/13/2018 of facility PTAC units located in resident care areas. PTAC cords were tied and secured under units to prevent them from sticking out into walkway. On 6/29/2018 facility employees were educated by Director of Health Services regarding identification and management of resident to resident altercations. Facility employees will be trained on identification and management of resident to resident altercations upon hire and annually. On 6/29/2018 and again on 7/6/2018 facility employees were trained by Director of Health Services and Administrator respectively on identification of, reporting, and resolution of possible hazards with emphasis on cords in walkways. Facility administrative team members will monitor rooms for cords in walkways daily with negative findings documented on round sheets and reported Monday-Friday in morning administrative meeting. Negative findings will be corrected by Facility Maintenance Director. 3. The monitoring procedure to ensure the effectiveness of the plan of correction: a- Housekeeping Supervisor and Administrator will randomly audit ten resident bathrooms weekly for four weeks and then monthly. Results of audits will be reported to facility QAPI Committee monthly by Housekeeping Supervisor or	

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F 865	Continued From page 71	F 865	Administrator. b- The facility will monitor daily x5, weekly x5, then monthly until next Annual Survey. Findings will be discussed monthly in QAPI. Monitoring will be conducted by the DHS,CRC,CCC, and/or ADHS. c- Facility Administrator and/or Department Heads will provide random scenarios to facility staff daily for fourteen days, then weekly for two weeks, then monthly where staff must decide if the scenario constitutes an altercation and tell the actions needed to prevent another occurrence. Results of scenarios and subsequent education will be reported to the QAPI Committee meeting monthly to ensure compliance. Facility Maintenance Director will randomly audit ten rooms weekly for four weeks then monthly starting 7/16/18 with reports of negative findings and subsequent corrections. Maintenance Director will report findings of audits facility QAPI Committee each month to ensure compliance. 4. a- The facility Housekeeping Supervisor and Administrator will be responsible for implementing this plan of correction. b- The facility DHS,CRC,CCC, and ADHS will be responsible for implementing this plan of correction. c- The facility Administrator will be responsible for implementing this plan of correction. 5. Completion date: 7/19/18.	