

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345143	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/19/2019
NAME OF PROVIDER OR SUPPLIER SILER CITY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	
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E 000	Initial Comments	E 000		
F 000	INITIAL COMMENTS	F 000		
F 641 SS=D	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§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 code the Minimum Data Set (MDS) assessment in the areas of diagnoses (Resident #35), Nutrition (Resident #34) and medications (Resident #55) for 3 of 26 sampled residents reviewed.</p> <p>Findings included:</p> <p>1. Resident #35 was admitted to the facility on 9/24/19 with multiple diagnoses including anxiety. The quarterly MDS assessment dated 10/2/19 indicated that Resident #35 did not have a diagnosis of anxiety.</p> <p>Resident #35 was admitted to the facility on</p>	F 641	<p>F641</p> <p>1. Modifications were made to the Minimum Data Set (MDS) for residents where data was miscoded. For Resident #35, the MDS Nurse modified the MDS to correct it on 12/18/19. For Resident #34, the Registered Dietician modified the MDS to correct it on 1/14/20. Modifications were made to the MDS of resident #55 by the MDS Nurse on 12/17/19. The modification for Resident #35 included adding diagnosis of Anxiety to Section I, Resident #34 included changing diet to nothing by mouth (NPO) in section K, and resident #55 the</p>	1/17/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/15/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641	<p>Continued From page 1</p> <p>9/24/19 with orders for Buspar (antianxiety medication) 10 milligrams (mgs) 1 tablet by mouth 3 times a day for anxiety and Ativan (antianxiety medication) 0.5 mgs by mouth every 8 hours as needed for 14 days for anxiety.</p> <p>The Care Area Assessment (CAA) dated 9/30/19 revealed that Resident #35 was on psychotropic medications and had diagnoses of depressive disorder and anxiety state.</p> <p>The September 2019 Medication Administration Records (MARs) revealed that Resident #35 had received Buspar and Ativan during the assessment period.</p> <p>On 12/18/19 at 1:25 PM, the MDS Nurse was interviewed. The MDS Nurse had verified that Resident #35 had received Buspar and Ativan during the assessment period. She also stated that she was responsible for the completion of the CAA dated 9/30/19 for Resident #35 which indicated that the resident had a diagnosis of anxiety. The MDS Nurse reported that it was a mistake on her part, she should have coded anxiety under the active diagnoses on the quarterly MDS assessment dated 10/2/19.</p> <p>On 12/19/19 at 10:01 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.</p> <p>2. Resident #34 was admitted to the facility on 12/27/18 with multiple diagnoses including dysphagia. The quarterly Minimum Data Set (MDS) assessment dated 10/2/19 indicated that Resident #34 had received mechanically altered</p>	F 641	<p>modification included adding resident had been administered anticoagulation 7 days instead of Hypnotic to section N. Modifications made to the MDS corrected previous information in the MDS for each of the residents. No apparent impact for the three residents were noted.</p> <p>2. The MDS Nurse completed an audit of the Minimum Data Set (most current MDS) for those residents with diagnosis of Anxiety to ensure coding was correct on 1/16/20. Nine discrepancies were noted in the audit and were modified in the MDS. Registered Dietician completed an audit of residents who are on an NPO diet to ensure accurate coding on 1/14/20. No additional issues were discovered. MDS Nurse completed an audit on residents receiving anticoagulation to ensure accurate coding on 1/14/20. No additional issues were discovered. Deviations were corrected with a modification assessment.</p> <p>3. Regional Clinical Reimbursement Coordinator provided re-education to MDS Nurse & Registered Dietician (RD) on MDS accuracy on 1/15/19. Re-education focused on eliminating coding errors.</p> <p>4. Assistant Director of Nurses (ADON), MDS Nurse, RD, and Nursing Supervisor will audit sections I, K and N prior to transmission of MDS assessment. Audit will be completed five times a week for three months. The center's MDS Nurse will present the results of the audit for accuracy for Sections I, K, and N of the MDS that was completed prior to</p>		

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F 641	<p>Continued From page 2 diet.</p> <p>The dietary progress note dated 9/25/19 revealed that Resident #34 was nothing by mouth (NPO). The care plan dated 10/2/19 indicated that Resident #34 had a gastrostomy (G) tube and was receiving an enteral feeding formula.</p> <p>On 12/18/19 at 12:50 PM, the Registered Dietician (RD) was interviewed. The RD stated that she was responsible for completing the section K on the MDS assessment. She verified that she had completed the quarterly MDS assessment dated 10/2/19 for Resident #34. The RD reported that Resident #34 was NPO during the assessment period and she should have not coded the quarterly MDS dated 10/2/19 for the mechanically altered diet.</p> <p>On 12/19/19 at 10:01 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.</p> <p>3. Resident #55 was admitted to the facility on 12/24/18 with diagnoses that included a personal history of pulmonary embolism.</p> <p>A physician' s order for Resident #55 dated 12/24/18 indicated Eliquis (anticoagulant medication) 5 milligrams (mg) twice daily.</p> <p>A review of the October 2019 Medication Administration Record (MAR) indicated Resident #55 was administered Eliquis twice daily each day. This MAR also showed Resident #55 was administered no hypnotic medication.</p>	F 641	<p>submission monthly to the Quality Assurance and Performance Improvement Committee monthly. The QAPI committee is responsible for the ongoing compliance.</p> <p>5. Date of compliance 1/17/2020.</p>		

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F 641	Continued From page 3 The significant change Minimum Data Set (MDS) assessment dated 10/17/19 indicated Resident #55 ' s cognition was severely impaired. The Medications section, Section N, of this MDS indicated Resident #55 had received hypnotic medication on 7 of 7 days and no anticoagulant medication during the 7-day MDS look back period (10/11/19 through 10/17/19). Section N of the 10/17/19 MDS for Resident #55 was coded by the Corporate MDS Consultant. An interview was conducted with the Corporate MDS Consultant on 12/17/19 at 10:45 AM. She stated that this facility had only one 1 MDS Nurse so she came to assist her with MDS completion whenever she could. The 10/17/19 MDS for Resident #55 that indicated he had received hypnotic medication on 7 of 7 days and no anticoagulant medication during the MDS look back period was reviewed with the Corporate MDS Consultant. The MAR that indicated Resident #55 had received anticoagulant medication on 7 of 7 days and no hypnotic medication during the 10/17/19 look back period was reviewed with the Corporate MDS Consultant. She revealed this MDS was inaccurate. She stated that this was a simple transposition error and the MDS should have indicated 7 of 7 days for anticoagulant medication and no hypnotic medication. During an interview with the Director of Nursing on 12/18/19 at 4:07 PM she stated that the MDS assessments were expected to be coded accurately by both the MDS Nurse and the Corporate MDS Consultant.	F 641			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		1/17/20	

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F 656	Continued From page 4 §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 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	F 656			

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F 656	<p>Continued From page 5</p> <p>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, the facility failed to implement the care plan interventions related to antipsychotic medication (Resident #103) for 1 of 5 residents reviewed for unnecessary medications.</p> <p>The findings included:</p> <p>Resident #103 was admitted to the facility on 11/4/19 with diagnoses that included dementia with behavioral disturbance and anxiety.</p> <p>A physician's order dated 11/4/19 for Resident #103 indicated Seroquel (antipsychotic medication) 50 milligrams (mg) in the morning and 75 mg with dinner.</p> <p>The admission Minimum Data Set (MDS) assessment dated 11/11/19 indicated Resident #103's cognition was severely impaired, and he received antipsychotic medication on 7 of 7 days.</p> <p>Resident #103's care plan, last reviewed on 11/25/19, included a focus area related to the use of antipsychotic medication. The interventions included, in part, an Abnormal Involuntary Movement Scale (AIMS) assessment per facility protocol.</p> <p>The December 2019 active physician's orders for Resident #103 were reviewed on 12/17/19 and revealed the 11/4/19 orders for Seroquel remained active.</p>	F 656	<p>F656</p> <ol style="list-style-type: none"> 1. Abnormal Involuntary Movement Score (AIMS) assessment was completed by staff nurse for resident # 103 on 12/17/19. 2. The Director of Nursing completed an audit of residents receiving medications requiring AIMS assessments on 1/8/2020. All Residents requiring AIMS assessments had current assessments. Residents receiving medications requiring AIMS assessments have current assessments as indicated and care planned interventions followed accordingly. 3. Director of Nursing, Assistant Director of Nursing (ADON), and Nursing Supervisors educated license nurses by 1/16/20 (including weekend, agency, and as needed (prn) licensed nurses), regarding requirements for completion of AIMS assessment and ensuring that care planned interventions are implemented accordingly. Staff on leave of absence/vacation will not be permitted to work until completing education. 4. Nursing Supervisors will audit residents receiving medications that require AIMS assessments five days a week for three months. New residents/new orders will be reviewed by the Nursing Supervisors five 		

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F 656	<p>Continued From page 6</p> <p>The hard copy and electronic medical record were reviewed from 11/4/19 through 12/17/19 and revealed an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #103 related to the use of Seroquel.</p> <p>An interview was conducted with Nurse Supervisor #1 on 12/17/19 at 5:01 PM. She reported that the facility ' s normal protocol was for AIMS assessments to be completed on admission for residents on antipsychotic medication, on initiation of an antipsychotic medication, and then every 6 months. She revealed that the electronic medical record (EMR) system had an update a month or two ago and that there had been some issues with assessments "triggering" for completion. She explained that assessments, such as the AIMS, were supposed to automatically come up for the nurse to complete. She further explained that since the EMR update they had noticed some assessments were not triggering causing the assessment to be missed by the nurse. Nurse Supervisor #1 revealed that AIMS assessments were one of the assessments that they identified the EMR system update had affected. She stated that the Director of Nursing (DON) was aware of the issue.</p> <p>The DON was interviewed on 12/17/19 at 5:07 PM. She confirmed Nurse Supervisor #1 ' s report of the facility ' s protocol for AIMS assessments to be completed. She additionally confirmed Nurse Supervisor #1 ' s report of issues with AIMS assessments triggering for completion since the EMR system was updated. She stated that they had been completing any missed assessments as they came across them.</p>	F 656	<p>days a week on-going. The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement Meeting monthly with The QAPI committee responsible for the ongoing compliance.</p> <p>5. Date of compliance 1/17/2020.</p>		

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F 656	Continued From page 7 Resident #103 ' s medical record was reviewed with the DON and she confirmed there was no AIMS assessment completed for this resident. Resident #103 ' s care plan related to antipsychotic medication that indicated the intervention of an AIMS assessment per facility protocol was reviewed with the DON. She revealed that this care plan intervention was not implemented for Resident #103. The DON stated that care plan interventions were expected to be implemented and that an AIMS assessment would be completed today (12/17/19) for Resident #103.	F 656			
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 observations, facility and hospital record reviews, dispensing pharmacy, consulting pharmacist, physician, and staff interviews, the facility failed to follow a physician ' s order to administer the correct dose of a controlled substance pain medication for 1 of 6 residents reviewed (Resident #121) who received the medication on an "as needed" basis. The findings included: Resident #121 was admitted to the facility on 4/16/19. A review of the resident ' s cumulative diagnoses included Type 2 diabetes with diabetic neuropathy and osteoarthritis. A review of her	F 658	F658 1. Physician was notified of medication dosage error for resident #121 on 12/18/19. Physician in facility to visit resident #121 on 12/18/19. Physician assessment on 12/18/19 revealed pain has been managed with medications resident has been receiving. Physician discontinued the Oxycodone 10mg every four hours as needed for pain and previous dose of Oxycodone 5mg every four hours as needed for pain was prescribed on 12/18/19.	1/17/20	

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F 658	<p>Continued From page 8</p> <p>medications included 5 milligrams (mg) oxycodone to be given as 1 tablet by mouth every 4 hours as needed (PRN) for moderate to severe pain (initiated on 9/3/19). Oxycodone is an opioid pain medication and a controlled substance.</p> <p>The resident ' s medical record revealed she had an unplanned transfer out to a hospital on 11/15/19. A review of her hospital records included a History and Physical dated 11/15/19. This assessment indicated Resident #121 had a 2 - 3 week history of right great toe gangrene with associated pain. The resident was sent to the hospital for further evaluation. On 11/16/19, a wound evaluation was done and she was diagnosed with dry, stable gangrene to the right hallux (great toe). The stated goal was to allow this digit to auto amputate and prevent conversion from dry to wet gangrene.</p> <p>Resident #121 ' s hospital records included a Physician Discharge Summary which read, in part: Gangrene: "...Pain was controlled with increase in oral pain meds..." The Hospital Discharge Orders dated 11/22/19 included 10 mg oxycodone to be given as one tablet by mouth every 4 hours PRN for pain. A notation indicated this 10 mg dose was intended to replace the previously prescribed 5 mg dose of oxycodone.</p> <p>Resident #121 ' s medical record indicated she was discharged from the hospital and re-entered the facility on 11/22/19. Her physician orders (dated 11/22/19) included 10 mg oxycodone to be given as one tablet by mouth every 4 hours PRN for moderate to severe pain (with a start date of 11/22/19). The previous order for 5 mg oxycodone to be given as one tablet by mouth every 4 hours PRN for moderate to severe pain</p>	F 658	<p>2. Director of Nursing, Assistant Director of Nursing (ADON), and Nursing Supervisor completed audit of residents receiving Narcotic pain medications on 1/11/20. One discrepancy was found during audit, dose on hand did not match dose ordered. Medication was returned to the pharmacy. Audit included review of each residents narcotic pain medication order, each residents current narcotic medication stock, and each residents declining inventory record for accurate dosing.</p> <p>3. Director of Nursing, ADON, and Nursing Supervisors educated license nurses by 1/16/20 (including weekend, agency, and as needed (prn) licensed nurses) on five rights of medication administration to include: Right patient, Right drug, Right dose, Right route, and Right time. Staff on leave of absence/vacation will not be permitted to work until completing education.</p> <p>4. Nursing Supervisors will audit 5 random residents receiving narcotic medications three times weekly for four weeks, then twice weekly for four weeks, and weekly for four weeks. Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.</p> <p>5. Date of compliance 1/17/2020.</p>		

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F 658	<p>Continued From page 9 was discontinued on 11/22/19.</p> <p>Resident #121 ' s most recent Minimum Data Set (MDS) assessment was a quarterly assessment dated 11/27/19. The MDS indicated Resident #121 had moderately impaired cognitive skills for daily decision making. She had no behaviors nor rejection of care. The resident was totally dependent on staff for all of her Activities of Daily Living (ADLs) with the exception of requiring extensive assistance for eating. Section J of the MDS assessment revealed the resident received medication for frequent pain rated as a 7 on a scale of 0 to 10 (with 0 indicative of no pain and 10 indicative of the most severe pain). Section N of the MDS revealed Resident #121 received an opioid pain medication on 5 out of 7 days during the look back period.</p> <p>A review of the resident ' s Care Plan included the following area of focus, in part: --Resident exhibits or is at risk for alterations in comfort related to chronic pain, osteoarthritis and circulatory concerns in her lower extremity (Created 4/17/19; Revised 11/22/19). Interventions for this area of focus included, "Medicate resident as ordered for pain and monitor for effectiveness and monitor for side effects, report to physician as indicated" (Created 4/17/19; Revised 11/22/19).</p> <p>Review of Resident #121 ' s November 2019 and December 2019 Medication Administration Records (MARs) indicated 10 mg oxycodone was to be given to the resident as one tablet by mouth every 4 hours PRN for moderate to severe pain (start date 11/22/19). The MARs also documented the PRN oxycodone was effective each time it was administered.</p>	F 658			

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F 658	Continued From page 10 Resident #121 ' s controlled substance declining inventory logs revealed only one - 5 mg oxycodone tablet was pulled for administration to Resident #121 from 11/22/19 to the date of the review with one exception. Two - 5 mg oxycodone tablets (for a total dose of 10 mg) were provided on only one occasion (12/16/19) since the prescribed dose was changed from 5 mg to 10 mg oxycodone on 11/22/19. An interview was conducted on 12/18/19 at 9:30 AM with the Nurse #12. Nurse #12 was the 1st shift hall nurse assigned to care for Resident #121. Nurse #12 was identified by her signature on the controlled substance declining inventory log and December 2019 MAR as administering the correct dose of oxycodone (10 mg) to the resident on 12/16/19. During the interview, the resident's medication card for the oxycodone was pulled from the med cart for review. The medication card (dated 11/7/19) contained 14 - 5 mg tablets of oxycodone. A sticker applied to the top of the card indicated in red that the directions/dosage for this medication had been changed. Upon inquiry, Nurse #12 reported the dose of the oxycodone had been recently changed so she put this sticker on the card to call attention to the new dose (10 mg oxycodone). However, the nurse could not recall when she noticed the dose change and applied the sticker to the medication card. An interview was conducted on 12/18/19 at 9:40 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she was not aware an order had been received to increase Resident #121's dose of oxycodone. Upon review of the resident ' s electronic chart, the	F 658			

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F 658	<p>Continued From page 11</p> <p>DON identified Nurse Supervisor #2 as the nurse who had input the new order for 10 mg oxycodone on 11/22/19. She indicated the new order appeared to be input correctly and the correct dosage (10 mg) was reflected on the resident ' s November 2019 and December 2019 Medication Administration Records (MARs).</p> <p>An interview was conducted on 12/18/19 at 10:26 AM with Nurse Supervisor #2. When asked, the nurse confirmed she had correctly entered Resident #121 ' s new order for 10 mg oxycodone into the computer system when the resident returned from the hospital. The nurse stated if there was a new script for the increased dose, it should have been faxed to the pharmacy. She could not recall for certain if a new script was available at that time. Nurse Supervisor #2 also reported medication orders were typically rechecked the next day and verification done to ensure the meds had come in from the pharmacy.</p> <p>A telephone interview was conducted on 12/18/19 at 10:50 AM with a pharmacist from the facility ' s dispensing pharmacy. During the interview, the pharmacist reviewed the medication dispensing records for Resident #121. She reported the pharmacy last dispensed 30 - 5 mg tablets of oxycodone for Resident #121 on 11/7/19. Upon further inquiry, the pharmacist reported 10 mg tablets of oxycodone had not been dispensed for this resident.</p> <p>An interview was conducted on 12/18/19 at 12:28 PM with the facility ' s consultant pharmacist. During the interview, concerns regarding the discrepancy between the dose of oxycodone prescribed (10 mg) and the dose administered (5</p>	F 658			

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F 658	<p>Continued From page 12</p> <p>mg) to Resident #121 were discussed. The pharmacist reported a check of the facility ' s controlled substances declining inventory records would typically have been done at the end of his monthly visit (either later on 12/18/19 or 12/19/19). The pharmacist reported he would have expected nursing staff to administer two - 5 mg tablets of oxycodone (total dose of 10 mg) in accordance with the 11/22/19 physician ' s order until 10 mg tablets were obtained from the pharmacy.</p> <p>A telephone interview was conducted on 12/18/19 at 11:27 AM with Nurse #13. Nurse #13 was identified by her signature on the oxycodone declining inventory log and November 2019/December 2019 MARs as having administered 5 mg oxycodone (versus 10 mg) to Resident #121 on 6 occasions since 11/22/19. During the interview, Resident #121 ' s increased oxycodone dose on 11/22/19 was discussed. When informed of the increased dose, the nurse responded by saying, "Oh Oh ...I should have given her two tablets, right? I must not have realized it." Upon further inquiry, Nurse #13 reported she would typically check the resident ' s MAR for information on the medication and dose to administer to a resident. She reported she must not have done so in this case and instead "gone off what was given before" (5 mg) to this resident. The nurse stated she would always try to go back in about an hour to check on the effectiveness of the medication given for pain. With the possible exception of one occasion (date unknown), she thought the medication had been effective for the resident.</p> <p>A telephone interview was conducted on 12/18/19 at 2:49 PM with Nurse #8. Nurse #8 was</p>	F 658			

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F 658	<p>Continued From page 13</p> <p>identified by her signature on the oxycodone declining inventory log and November 2019/December 2019 MARs as having administered 5 mg oxycodone (versus 10 mg) to Resident #121 on 5 occasions since 11/22/19. During the interview, Resident #121 ' s increased oxycodone dose on 11/22/19 was discussed. Nurse #8 reported it was only recently that she was told the resident ' s pain medication was increased. Upon further inquiry, the nurse reported she utilized a resident ' s MAR to determine the dosage of medication administered.</p> <p>An unsuccessful attempt was made to contact Nurse #14 for a telephone interview. Nurse #14 was identified by her signature on the oxycodone declining inventory log and November 2019/December 2019 MARs as having administered 5 mg oxycodone (versus 10 mg) to Resident #121 on 12 occasions since 11/22/19.</p> <p>An observation and interview were conducted with Resident #121 on 12/18/19 at 10:05 AM. The resident was observed to have her right lower leg elevated with a pillow and was rubbing her right leg with her right hand. Upon inquiry, the resident reported she had pain every day, but stated sometimes it was worse than other times. Resident #121 stated she knew she could ask for pain medication to help manage the pain. When asked if the pain medication helped, she stated, "some."</p> <p>An interview was conducted on 12/18/19 at 11:39 AM with the resident ' s physician, who also served as the facility ' s Medical Director. During the interview, concerns regarding the discrepancy between the dose of oxycodone prescribed (10</p>	F 658			

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F 658	Continued From page 14 mg) and the dose typically administered (5 mg) to Resident #121 since her readmission to the facility were discussed. The physician reported he assessed Resident #121 earlier on this date (12/18/19) and the resident relayed to him that the pain medication she was receiving did help to relieve the pain. He stated since her pain was controlled on the 5 mg oxycodone, he intended to write a new physician ' s order for 5 mg (versus 10 mg) oxycodone to given every 4 hours as needed for pain. An interview was conducted on 12/18/19 at 3:21 PM with the DON. During the interview, the DON reported she expected the nurses to medicate a resident in accordance with the physician ' s orders.	F 658			
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and consulting pharmacist, physician, and staff interviews, the facility failed to assess residents ' level of pain prior to the administration of a controlled substance pain medication for 2 of 6 residents reviewed (Residents #12 and #38) who received the medication on an "as needed" basis. The findings included:	F 697	F697 1. Pain assessment was completed on resident #12 on 1/13/20 by his physician. As needed pain medication (PRN) orders for resident # 12 were evaluated by his physician on 1/13/20. Ibuprofen order was discontinued on 1/13/20. Oxycodone order was revised to include numeric pain rating scale to assist with accurate pain	1/17/20	

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F 697	<p>Continued From page 15</p> <p>1. Resident #12 was admitted to the facility on 7/31/19 with a cumulative diagnoses which included a recent above knee amputation (AKA) of his left leg.</p> <p>A review of Resident #12 ' s medication orders revealed physician orders were received for the following medications, in part: --600 milligrams (mg) ibuprofen (an over the counter pain medication) to be given as one tablet by mouth every 8 hours as needed (PRN) for mild pain/fever (Start Date 7/31/19); --5 milligrams (mg) oxycodone (an opioid pain medication) to be given as one tablet by mouth every 4 hours PRN for moderate to severe pain (Start Date 7/31/19). Oxycodone is an opioid pain medication and a controlled substance; --100 mg gabapentin (a medication which may be indicated to manage neuropathic or nerve pain) to be given as one capsule by mouth three times a day for pain (Start Date 8/30/19).</p> <p>Resident #12 ' s most recent Minimum Data Set (MDS) assessment was a quarterly assessment dated 9/12/19. The MDS indicated Resident #12 had intact cognitive skills for daily decision making. He had no behaviors nor rejection of care. The resident was independent for all of his Activities of Daily Living (ADLs); he utilized a wheelchair for locomotion. Section J of the MDS assessment revealed the resident received medication for frequent pain rated as an 8 on a scale of 0 to 10 (with 0 indicative of no pain and 10 indicative of the most severe pain). Section N of the MDS revealed Resident #12 received an opioid pain medication on 6 out of 7 days during the look back period.</p> <p>The resident ' s current Care Plan included an</p>	F 697	<p>assessment on 1/15/20. Pain assessment was completed on resident # 38 on 1/13/20. PRN pain medication for resident #38 was evaluated by his physician on 1/13/20. Oxycodone order was revised to include numeric pain rating scale to assist with accurate pain assessment on 1/14/20.</p> <p>2. Director of Nursing, Assistant Director of Nursing (ADON), and Nursing Supervisor completed an audit of residents receiving PRN pain medications on 1/16/20. Residents audited showed inconsistent pain rating scale. Residents receiving PRN pain medications orders were reviewed and revised to include numeric pain rating scale to assist with accurate pain assessment.</p> <p>3. Director of Nursing, ADON, and Nursing Supervisors educated license nurses by 1/16/20 (including weekend, agency, and as needed (prn) licensed nurses) on adequate pain assessment using the numeric pain rating scale and/or nonverbal pain assessment tool. Staff on leave of absence/vacation will not be permitted to work until completing education. Licensed nurses to administer as needed medication based on the physician's order and level of pain documented. All Residents receiving PRN pain medication have had the numeric scale guidelines added to their orders.</p> <p>4. Nursing Supervisors to audit residents receiving PRN pain medications. Audits</p>		

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F 697	<p>Continued From page 16</p> <p>area of focus which read, "Resident exhibits or is at risk for alterations in comfort related to surgical post-op" (Created 7/31/19; Revised 8/22/19). Interventions for this area of focus included the following interventions:</p> <ul style="list-style-type: none"> --Evaluate pain characteristics: quality, severity, location, precipitating/relieving factors; --Utilize pain scale; --Advise resident to request pain medication before pain becomes severe; --Medicate resident as ordered for pain and monitor for effectiveness and monitor for side effects, report to physician as indicated; --Monitor for non-verbal signs/symptoms of pain and medicate as ordered; --Complete pain assessment per protocol. <p>Resident #12 ' s November 2019 Medication Administration Record (MAR) indicated the resident ' s gabapentin was given on a scheduled basis as ordered by the physician. There was no documentation on the MAR to indicate PRN ibuprofen was administered at any time during the month of November. Further review of Resident #12 ' s November 2019 MAR revealed the resident ' s level of pain was documented as a "0" on a scale of 0 - 10 (0 being indicative of no pain and 10 indicative of the most severe pain) on four occasions immediately prior to administering PRN oxycodone on 11/16/19, 11/24/19, 11/25/19 and 11/30/19.</p> <p>Resident #12 ' s December 2019 Medication Administration Record (MAR) indicated the resident ' s gabapentin was given on a scheduled basis as ordered by the physician. There was no documentation on the MAR to indicate PRN ibuprofen was administered at any time during the month of December (to date). Further review</p>	F 697	<p>will be completed weekly on 10 random residents to ensure that pain is being assessed accordingly for three months. The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.</p> <p>5. Date of compliance 1/17/2020.</p>		

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F 697	<p>Continued From page 17</p> <p>of Resident #12 ' s December 2019 MAR revealed the resident ' s level of pain was documented as a "0" on a scale of 0 - 10 on three occasions immediately prior to administering PRN oxycodone on 12/1/19, 12/9/19, and 12/15/19.</p> <p>A telephone interview was conducted on 12/18/19 at 2:49 PM with Nurse #8. Nurse #8 was identified as the nurse who documented Resident #12 had a pain level of "0" prior to administering a PRN dose of oxycodone to the resident on 11/16/19, 11/24/19, 11/25/19, 11/30/19, 12/1/19, and 12/9/19. Upon request, the nurse described the process used for administering PRN pain medication to a resident who complained of pain. The nurse reported when a resident requested a pain medication, she would go and check to see when the medication was last given. She stated if enough time had elapsed since the last dose of pain medication, she would give the medication to the resident. If not, she would tell the resident when he could get the next dose. When asked if she assessed the resident for his level of pain prior to administering a PRN pain medication, the nurse reported she was told by someone that when a medication was ordered and a resident asked for it, she was supposed to give it to him. Nurse #8 could not identify who had provided these instructions to her. When asked how she would decide whether to give 600 mg ibuprofen ordered for mild to moderate pain or the 5 mg oxycodone ordered for moderate to severe pain, she stated Resident #12 would ask for the medication he wanted by name. At the conclusion of the interview, Nurse #8 was asked if the administration of a prescribed PRN controlled substance pain medication was based on resident request rather than an assessment of the resident's level of pain. The nurse stated this</p>	F 697			

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F 697	<p>Continued From page 18 was correct.</p> <p>An interview was conducted on 12/17/19 at 2:45 PM with Nurse #2. Nurse #2 was identified as the nurse who documented Resident #12 had a pain level of "0" prior to administering a PRN dose of oxycodone to the resident on 12/15/19. During the interview, Resident #12 ' s MAR was reviewed with the nurse. Upon his review, Nurse #2 stated the pain level of "0" recorded on the MAR was, "my mistake." He reported the resident typically stated his level of pain was a "10". A follow-up interview was conducted with Nurse #2 on 12/17/19 at 4:39 PM. At that time, the nurse reported the resident would sometimes refuse to tell him anything about his level of pain. In this case, Nurse #2 stated he would sometimes put a "0" down as the pain rating noted on the resident ' s MAR.</p> <p>An interview was conducted on 12/18/19 at 11:39 AM with the resident ' s physician, who also served as the facility ' s Medical Director. During the interview, concerns were discussed in regards to a pain level of "0" being documented immediately prior to the administration of a PRN controlled substance pain medication. While the physician reported he had a problem of assessing levels of pain with a number, he also felt there was a need to figure out how to document results of a pain assessment appropriately.</p> <p>An interview was conducted on 12/18/19 at 12:28 PM with the facility ' s consultant pharmacist. During the interview, the pharmacist reported if nursing staff was using a scale of 0 to 10 for pain, he would consider a "5" to be a moderate level of pain. The pharmacist stated this issue may be an educational opportunity for the nursing staff.</p>	F 697			

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F 697	<p>Continued From page 19</p> <p>An interview was conducted on 12/17/19 at 4:54 PM with the facility ' s Director of Nursing (DON). During the interview, the DON described the process nursing staff was expected to follow for the administration of a controlled substance pain medication. The DON stated the nurse was expected to assess the resident ' s level of pain and check the orders on the resident ' s MAR to see what medication was ordered and appropriate at that time to manage pain. A follow-up interview was conducted with the DON on 12/18/19 at 3:21 PM. During the follow-up interview, the DON stated she expected nurses to assess a resident ' s pain and medicate the resident in accordance with the physician ' s orders.</p> <p>2. Resident #38 was admitted to the facility on 2/22/2019 with diagnoses that included chronic pain due to abnormalities of the spine in the head and neck region.</p> <p>The resident's most recent quarterly Minimum Data Set (MDS), dated 10/3/2019, indicated the resident was cognitively intact. The MDS also indicated Resident #38 had received scheduled pain medications and "as needed" pain medication during the assessment period. Additionally, the MDS revealed the resident reported he experienced pain almost constantly in the assessment period, rated his pain an 8 out of 10, and received opioids 7 out of 7 days.</p> <p>Review of Resident #38's medication orders revealed the resident was ordered Oxycodone10 milligram (mg) tablets orally every 4 hours as needed for moderate to severe pain.</p>	F 697			

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F 697	<p>Continued From page 20</p> <p>A review of the resident's medication administration record (MAR) revealed the order for 10 mg oxycodone by mouth every 4 hours as needed for moderate to severe pain. It also revealed the resident received oxycodone after documented pain levels of 0, 1, and 2, (with 0 being no pain and 10 being the worst pain) during the months of September, October, November, and December.</p> <p>On 12/17/19 at 11:05 AM and interview was conducted with Nurse # 2 regarding administration of pain medications on the morning of 12/17/19 at 7:23 AM after documenting resident #38's pain as 0. Nurse #2 stated he did assess the resident's pain and stated the resident's level was a 10, so he gave medication. Upon reviewing his documentation, he acknowledged he documented 0 and not 10. Similar documentation was found on 11/29/19 at 7:43 AM where the documented pain level was 0 and the oxycodone was administered by Nurse #2. Nurse #2 stated he may have put 0 because the resident refused to give a pain level when asked. Nurse #2 reported the resident often became angry when asked to give a pain level and sometimes refused. He further stated he considers moderate pain to be a 4 or higher.</p> <p>In an interview with Nurse #16 on 12/18/19 at 12:56 PM she stated she occasionally worked on the medication cart and passes medications to resident #38. She further stated if a resident had an order for oxycodone for moderate to severe pain she would give the medication for a self-reported pain level of 5 or higher. Nurse #16 acknowledged she documented a pain scale of 2 or 3 and administered oxycodone anyway, on</p>	F 697			

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F 697	<p>Continued From page 21</p> <p>12/14/2019 at 8:00 PM and 12/15/19 at 8:00 AM. Nurse #16 stated they give resident #38 his oxycodone every 4 hours at the resident's request.</p> <p>On 12/18/19 at 2:49 PM and interview was conducted with Nurse #8. She stated she has administered oxycodone to Resident #38 while working the medication cart. She stated she is aware the resident's order is written as needed every hours for moderate to severe pain, and the resident requests his oxycodone every four hours. Nurse #8 documented a pain level of 2 on 9/7/2019 at 8:33pm, a pain level of 0 on 9/8/2019 at 12:44 AM, and a pain level of 0 on 9/30/2019 at 8:37 PM each time the MAR reflects administration of oxycodone by Nurse #8.</p> <p>Attempts were made to contact Nurse #15 who administered oxycodone to Resident #38 on 10/15/2019 at 7:28 AM for a pain level of 1, on 11/10/2019 at 7:53 PM for a pain level of 1, and on 11/13/2019 at 7:37 AM for a pain level of 1. Attempts to reach this nurse were unsuccessful.</p> <p>Attempts were made to contact Nurse #4 who administered oxycodone to Resident #38 on 12/13/2019 at 12:15 AM for a pain level of 0. Attempts to reach this nurse were unsuccessful.</p> <p>In an interview with the Director of Nursing on 12/18/19 at 12:06 PM she stated she expected the medication to be given as written on the MAR. She further stated she expected the nurses to assess the resident's pain level, administer the medication according to the order, then reassess the effectiveness of the medication.</p> <p>In an interview with facility's medical director on</p>	F 697			

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F 697	Continued From page 22 12/18/19 at 12:39 PM he stated he has been working with the resident for a while to get him to a point where he is both comfortable and functional. He further stated, complicating the situation was the resident's prior history of drug dependency. The medical director stated he did not write the oxycodone as a scheduled medication because he did not want the nurses to wake the resident to give him his scheduled pain medication if he did not need it.	F 697			
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		1/17/20	

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F 755	<p>Continued From page 23</p> <p>sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, pharmacist, physician, and staff interviews, the facility failed to have a system in place for reconciling controlled medication, oxycodone, administered to residents (Resident #38, #12, #101) in 3 of 6 residents reviewed for pain.</p> <p>Findings included:</p> <p>1. Resident #38 was admitted to the facility on 2/22/2019 with diagnoses that included chronic pain, due to abnormalities of the spine in the head and neck region.</p> <p>The resident's most recent quarterly Minimum Data Set (MDS), dated 10/3/2019, indicated the resident was cognitively intact. The MDS also indicated Resident #38 had received scheduled pain medications and "as needed" pain medication during the assessment period. Additionally, the MDS revealed the resident reported he experienced pain almost constantly in the assessment period, rated his pain an 8 out of 10, and received opioids 7 out of 7 days.</p> <p>Review of Resident #38's medication orders, from September 2019 thru November 2019, revealed the resident was ordered Oxycodone 10 milligram (mg) tablets orally every 4 hours as needed for moderate to severe pain.</p>	F 755	<p>F755</p> <p>1. Residents # 38, #12 and # 102 current Medication Administration Record (MAR) was compared with the current narcotic declining inventory sheet to assess for discrepancies.</p> <p>2. Director of Nursing, Assistant Director of Nursing (ADON), and Nursing Supervisors completed an audit of residents with narcotic pain medication orders. Orders were compared by current MAR against current narcotic declining inventory record for discrepancies on 1/11/20. Discrepancies were noted in some resident records. Residents have demonstrated no adverse effect.</p> <p>3. Director of Nursing, ADON, and Nursing Supervisors educated license nurses by 1/16/20 (including weekend, agency, and as needed (prn) licensed nurses). Education included proper documentation of PRN pain medication on the MAR and the narcotic declining inventory sheet. Staff on leave of absence/vacation will not be permitted to work until completing education. to work prior to receiving education.</p>		

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F 755	<p>Continued From page 24</p> <p>On 12/16/2019 a record review of declining count narcotic log for oxycodone 10mg tablets from 11/1/2019 through 11/29/2019 indicated 108 tablets were pulled for Resident #38. The Medication Administration Record (MAR) for this resident indicated administration of oxycodone 10 mg only 99 times during this same period. Discrepancies were found with documentation by Nurses #4, #5, and #6.</p> <p>On 12/16/2019 record review of the decline narcotics count sheet to Resident #38's 10 milligram oxycodone indicated on 11/19/2019, the resident received a tablet at 1:15 AM, 7:30 AM, 12:30 PM, and 7:00 PM. The MAR revealed the resident only received a 7:35 AM dose and a 7:00 PM dose of oxycodone.</p> <p>An interview was conducted with Nurse #5 on 12/18/19 at 11:15 AM where she stated she did work the medication cart on 11/19/2019 and the initials on the declining count narcotics log at 7:30 AM and 12:30 PM were her initials. Nurse #5 acknowledged the medication administration record for Resident #38 did not reflect a 12:30 PM administration of oxycodone. She stated she did not know why the administration documentation was not showing up, she further stated she always documents in the MAR after she administers the oxycodone. Nurse #5 was made aware of similar discrepancy between the declining narcotic count log on 11/1/2019 at 1:00 PM, 11/10/2019 at 1:00 PM, and 11/18/2019 at 12:30 PM where there was no documentation in the MAR that indicated the oxycodone was administered. Nurse #5 stated again that she was not sure why the documentation was not showing up.</p>	F 755	<p>4. Director of Nursing to audit 10 random residents weekly to monitor for irregularities in the reconciliation of narcotic administration on declining inventory sheets and medication administration records. The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.</p> <p>5. Date of compliance 1/17/2020.</p>		

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F 755	<p>Continued From page 25</p> <p>On 12/18/19 at 3:43 PM an interview was conducted with Nurse #6. She stated she has worked in the facility for 26 years and is very familiar with Resident #38. She stated she did not know why the MAR did not reflect the oxycodone was given when the declining narcotics log indicated she pulled the medication. She further stated she was working the dates of 11/10/19 and 11/17/19 but did not recall a reason she would not have documented the administration of the oxycodone on those dates.</p> <p>Multiple attempts were made to contact Nurse #4 regarding discrepancy between the declining narcotic count log and the MAR on 11/8/2019 and 11/19/2019 for Resident #38 but the nurse did not return calls.</p> <p>On 12/18/19 in an interview with the facility's consultant pharmacist, he stated they did provide periodic auditing of medication carts. He stated they primarily check for expired medications, proper packaging, and labeling. He further stated it is up to the facility to reconcile and account for controlled drugs.</p> <p>In an interview with the Director of Nursing (DON) on 12/19/19 at 9:55 AM, she stated she was not aware of the discrepancies between the declining count narcotics log and the MARs. She stated she believes the nurses are failing to document the administration of the oxycodone after they pull the medication and document it on the declining count sheet. She further stated the facility does not have a practice in place to reconcile control drugs periodically and she did not believe the consultant pharmacists provided the service for the facility. She also stated she would consider it a professional standard to periodically reconcile</p>	F 755			

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F 755	<p>Continued From page 26</p> <p>the control drug count with the medication administration record.</p> <p>2. Resident #12 was admitted to the facility on 7/31/19. A review of Resident #12 ' s medication orders revealed a physician ' s order was written on 7/31/19 for 5 milligrams (mg) oxycodone (an opioid pain medication) to be given as one tablet by mouth every 4 hours as needed for moderate to severe pain. Oxycodone is a controlled medication.</p> <p>Resident #12 ' s controlled substance declining inventory sheet indicated 17 doses of 5 mg oxycodone were pulled from the medication cart from 11/13/19 to 11/30/19 on the following dates:</p> <ul style="list-style-type: none"> --On 11/13/19, 1 dose of oxycodone was documented as removed from the med cart; --On 11/14/19, 1 dose of oxycodone was documented as removed from the med cart; --On 11/15/19, 1 dose of oxycodone was documented as removed from the med cart; --On 11/16/19, 1 dose of oxycodone was documented as removed from the med cart; --On 11/18/19, 1 dose of oxycodone was documented as removed from the med cart; --On 11/19/19, 1 dose of oxycodone was documented as removed from the med cart; --On 11/20/19, 1 dose of oxycodone was documented as removed from the med cart; --On 11/21/19, 1 dose of oxycodone was documented as removed from the med cart; --On 11/24/19, 1 dose of oxycodone was documented as removed from the med cart; --On 11/25/19, 1 dose of oxycodone was documented as removed from the med cart; --On 11/26/19, 1 dose of oxycodone was documented as removed from the med cart; --On 11/27/19, 2 doses of oxycodone were documented as removed from the med cart; 	F 755			

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F 755	<p>Continued From page 27</p> <p>--On 11/28/19, 2 doses of oxycodone were documented as removed from the med cart;</p> <p>--On 11/29/19, 1 dose of oxycodone was documented as removed from the med cart;</p> <p>--On 11/30/19, 1 dose of oxycodone was documented as removed from the med cart.</p> <p>Resident #12 ' s November 2019 Medication Administration Record (MAR) documented only 11 doses of 5 mg oxycodone were administered to the resident from 11/13/19 to 11/30/19. Based on information from the MAR, a dose of oxycodone was not documented as administered to the resident on the following dates: 11/13/19, 11/18/19, 11/21/19, 11/28/19 (only one dose was documented as administered), 11/29/19, and 11/30/19.</p> <p>Resident #12 ' s controlled substance declining inventory sheet indicated 18 doses of 5 mg oxycodone were pulled from the medication cart from 12/1/19 to 12/13/19 on the following dates:</p> <p>--On 12/1/19, 1 dose of oxycodone was documented as removed from the med cart;</p> <p>--On 12/2/19, 1 dose of oxycodone was documented as removed from the med cart;</p> <p>--On 12/3/19, 1 dose of oxycodone was documented as removed from the med cart;</p> <p>--On 12/4/19, 2 doses of oxycodone were documented as removed from the med cart;</p> <p>--On 12/5/19, 1 dose of oxycodone was documented as removed from the med cart;</p> <p>--On 12/6/19, 1 dose of oxycodone was documented as removed from the med cart;</p> <p>--On 12/7/19, 1 dose of oxycodone was documented as removed from the med cart;</p> <p>--On 12/9/19, 1 dose of oxycodone was documented as removed from the med cart;</p> <p>--On 12/10/19, 1 dose of oxycodone was documented as removed from the med cart;</p>	F 755			

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F 755	<p>Continued From page 28</p> <p>--On 12/11/19, 1 dose of oxycodone was documented as removed from the med cart;</p> <p>--On 12/12/19, 1 dose of oxycodone was documented as removed from the med cart;</p> <p>--On 12/13/19, 1 dose of oxycodone were documented as removed from the med cart.</p> <p>Resident #12 ' s December 2019 MAR documented only 13 doses of 5 mg oxycodone were administered to the resident from 12/1/19 to 12/13/19. Based on information from the MAR, a dose of oxycodone was not documented as administered to the resident on the following dates: 12/1/19, 12/2/19, 12/4/19 (only one dose was documented as administered), 12/5/19, 12/7/19, and 12/12/19.</p> <p>An interview was conducted on 12/17/19 at 4:54 PM with the facility ' s Director of Nursing (DON). During the interview, the DON described the process nursing staff was expected to follow for the administration of a controlled substance pain medication. The DON stated the nurse should assess the resident ' s level of pain and check the orders on the resident ' s MAR to see what medication was ordered and appropriate at that time to manage pain. She expected the nurse to pull the controlled substance medication from the medication cart and administer the medication. When the nurse returned to the med cart, the nurse would be expected to document the use of the medication on both the narcotic sheet (a declining inventory record) and the resident ' s MAR.</p> <p>An interview was conducted on 12/18/19 at 11:39 AM with the resident ' s physician, who also served as the facility ' s Medical Director. During the interview, concerns regarding the discrepancies noted between the residents '</p>	F 755			

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F 755	<p>Continued From page 29</p> <p>controlled substance declining inventory sheets and MARs were discussed. Upon inquiry, the physician expressed concern as to whether the discrepancy was a documentation issue or possibly indicative of another concern.</p> <p>An interview was conducted on 12/18/19 at 12:06 PM with the DON. During the interview, the DON reported she would expect use of a controlled substance medication to be documented on both the declining inventory sheet and the MAR. She also indicated the information on these records should be consistent with one another.</p> <p>An interview was conducted on 12/18/19 at 12:28 PM with the facility ' s consultant pharmacist. During the interview, the pharmacist was asked what role he assumed in the reconciliation of controlled substance medications. The pharmacist reported he typically did a 10 percent (%) cart audit each month but mainly looked for expired medications. The pharmacist also stated he did a check of the controlled substance declining inventory records at the end of his monthly visits. When asked about the discrepancy noted between the residents ' MARs and declining inventory sheets, the pharmacist stated this was, "not what you would expect." He did not recall identifying this issue in the past.</p> <p>A telephone interview was conducted on 12/18/19 at 2:49 PM with Nurse #8. Nurse #8 was identified by her initials on the controlled substance declining inventory sheet as having pulled a dose of oxycodone for Resident #12 without documenting the medication administration on his MAR for 11/18/19, 11/30/19, 12/1/19 and 12/7/19. Upon request, the nurse</p>	F 755			

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F 755	<p>Continued From page 30</p> <p>described the process used for administering as needed controlled substance medication to a resident who complained of pain. The nurse reported when a resident requested a pain medication, she would go and check to see when the medication was last given. If she determined the resident could have it, she would get the medication from the med cart and immediately write this on the declining inventory sheet as well as the resident ' s MAR. When asked about the discrepancies noted between the controlled substance declining inventory sheets and the MARs, Nurse #8 reported she probably just missed signing it off on the MAR.</p> <p>An interview was conducted on 12/18/19 at 4:00 PM with Nurse #9. Nurse #9 was identified by her initials on the controlled substance declining inventory sheet as having pulled a dose of oxycodone for Resident #12 without documenting the medication administration on his MAR on 11/21/19, 11/29/19, 12/2/19, 12/4/19 (for one of two doses), 12/5/19 and 12/12/19. Upon request, the nurse described the process used for administering as needed controlled substance medication to a resident who complained of pain. The nurse stated if a resident requested a pain medication, she would ask where the pain was and assess the pain as needed. If a controlled substance medication such as oxycodone was determined to be appropriate (based on the resident ' s level of pain and time frame), she would obtain the pain medication from the med cart and document its withdrawal from the cart on the declining inventory sheet. When asked, the nurse reported she would also document the administration on the resident ' s MAR at the same time. When asked about the discrepancies noted between the declining inventory sheet and</p>	F 755			

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F 755	<p>Continued From page 31</p> <p>the MAR, Nurse #9 reported the documentation on the two records should correspond with one another. She also stated, "The only thing I can think of....if give the med and something comes up that needs to be addressed it might get missed."</p> <p>An unsuccessful attempt was made to contact Nurse #11 for a telephone interview. Nurse #11 was identified by her initials on Resident #12 ' s controlled substance declining inventory sheet as the nurse who withdrew a dose of oxycodone from the med cart on 11/13/19 without documenting its administration to the resident on the MAR.</p> <p>Further review of Resident #12 ' s controlled substance declining inventory sheet revealed the nurse ' s initials which indicated a dose of oxycodone was withdrawn from the med cart on 11/28/19 were illegible. This nurse was not interviewed.</p> <p>A follow-up interview was conducted on 12/19/19 at 10:33 AM with the facility ' s DON. During the interview, the DON reported nursing staff did a narcotic count at the change of each shift. Upon further inquiry, the DON reported the facility did not have a system in place for the reconciliation of controlled substance medications.</p> <p>3. Resident #102 was originally admitted to the facility on 8/2/19 and was readmitted on 11/7/19 and 12/11/19.</p> <p>Resident #102 had doctor's orders for oxycodone 5 milligrams (mgs) 1 tablet by mouth every 4 hours as needed for pain on 11/7/19 and 12/11/19.</p>	F 755			

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F 755	<p>Continued From page 32</p> <p>Resident #102's declining narcotic inventory sheets for November and December 2019 were reviewed. The sheets revealed that oxycodone 5 mgs 1 tablet was signed out on 11/7/19 by Nurse #8 and on 12/11/19 by Nurse #2.</p> <p>The November 2019 Medication Administration Records (MARs) were reviewed and did not indicate that Resident #102 had received oxycodone on 11/7/19.</p> <p>The December 2019 MARs were reviewed and did not indicate that Resident #102 had received oxycodone on 12/11/19.</p> <p>On 12/17/19 at 4:37 PM, Nurse # 2 was interviewed. Nurse #2 verified his initial on the declining narcotic inventory sheet on 12/11/19. He reported that he signed out 1 tablet of oxycodone on 12/11/19 and administered it to Resident #102 but forgot to sign the Medication Administration Record (MAR).</p> <p>An interview was conducted on 12/18/19 at 11:39 AM with the resident's physician, who also served as the facility's Medical Director. During the interview, concerns regarding the discrepancies noted between the resident's controlled substance declining inventory sheets and MARs were discussed. Upon inquiry, the physician expressed concern as to whether the discrepancy was a documentation issue or possibly indicative of another concern.</p> <p>An interview was conducted on 12/18/19 at 12:06 PM with the DON. During the interview, the DON reported she would expect use of a controlled substance medication to be documented on both the declining inventory sheet and the MAR. She</p>	F 755			

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F 755	Continued From page 33 also indicated the information on these records should be consistent with one another. An interview was conducted on 12/18/19 at 12:28 PM with the facility's consultant pharmacist. During the interview, the pharmacist was asked what role he assumed in the reconciliation of controlled substance medications. The pharmacist reported he typically did a 10 percent (%) cart audit each month but mainly looked for expired medications. The pharmacist also stated he did a check of the controlled substance declining inventory records at the end of his monthly visits. When asked about the discrepancy noted between the residents' MARs and declining inventory sheets, the pharmacist stated this was, "not what you would expect." He did not recall identifying this issue in the past. On 12/18/19 at 2:30 PM, Nurse #8 was interviewed. She stated that if she had signed out 1 tablet of oxycodone on 11/7/19, she had administered it to Resident #102 but failed to sign the MAR. On 12/19/19 at 10:35 AM, the Director of Nursing (DON) was interviewed. The DON stated that the facility had no system in place in reconciling the controlled medications. The DON reported that she had not done a narcotic reconciliation at the facility at all.	F 755			
F 756 SS=D	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.	F 756		1/17/20	

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F 756	Continued From page 34 §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. §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 reviews, staff and pharmacist interviews, the consultant pharmacist failed to identify incorrect medication administration route (Resident # 52) for 1 of 2 residents sampled for	F 756	F756 1. Medication order for resident # 52 was changed by staff nurse (LPN) to be		

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F 756	<p>Continued From page 35 gastric feeding tubes.</p> <p>Findings included:</p> <p>Resident # 52 was admitted on 7/11/2019 with diagnoses including aphasia, gastrostomy, and cerebral vascular accident (CVA).</p> <p>The resident's September 2019, October 2019, November 2019, and December 2019 Medication Administration Record (MAR) revealed the resident had an active order for glycopyrrolate, 1miligram tablet, given by mouth three times a day for increased secretions. The order had a start date of 9/5/2019.</p> <p>The resident's quarterly Minimum Data Set (MDS) dated 10/17/2019 indicated the resident was severely cognitively impaired. The MDS also indicated Resident #52 was total care for all activities of daily living and received nutrition via feeding tube.</p> <p>Review of Resident #52's comprehensive care plan, dated 10/17/2019, revealed the resident was at risk for malnutrition and received nothing by mouth.</p> <p>On 12/15/2019 at 5:15 PM a record review of the resident's medication administration record revealed the resident had an active order for glycopyrrolate, 1mg tablet, given by mouth three times a day for increased secretions. The order had a start date of 9/5/2019.</p> <p>An interview was conducted on 12/16/19 at 4:29 PM with Nurse #1 who was working on the medication cart for Resident #52's hall. She stated she was familiar with the resident and had</p>	F 756	<p>administered via gastric feeding tube on 12/16/19. Pharmacy notified of change in orders on 12/16/19.</p> <p>2. Director of Nursing, Assistant Director of Nursing (ADON), and Nursing Supervisor completed audit of residents receiving medications by route of gastric feeding tube for accuracy of medication route on 1/11/20. No additional discrepancies noted.</p> <p>3. Director of Nursing, ADON, and Nursing Supervisors educated license nurses by 1/16/20 (including weekend, agency, and as needed (prn) licensed nurses). Education included the five rights of medication administration: Right patient, Right drug, Right dose, Right route, and Right time. Licensed nurses will ensure physician order for medication administration route is accurate. Staff on leave of absence/vacation will not be permitted to work until completing education.</p> <p>4. Nursing Supervisors will audit 100% of residents' receiving medications administration via gastric tube weekly for four weeks, 50% of residents medications via gastric tube weekly for four weeks, 25% of residents receiving medication administration via gastric tube weekly for four weeks and then 10% of residents receiving medication administration via gastric tube weekly for four weeks. New orders will be reviewed in the clinical morning meeting to ensure that the correct route is ordered. The Director of</p>		

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F 756	<p>Continued From page 36</p> <p>administered the resident's medications many times. Nurse #1 stated the resident did not receive any medications by mouth. The nurse reviewed Resident #52's MAR and acknowledged the order on the MAR for the resident to receive glycopyrrolate by mouth, was inaccurate. She further stated the resident does not take any medications by mouth and she had not given the medication, glycopyrrolate, by mouth.</p> <p>On 12/17/19 at 10:02 AM an interview was conducted with Nurse #2 who was working the medication cart on the resident's hall. Nurse #2 stated he worked the resident's hall regularly and was familiar with Resident #52. He further stated the resident had an order for nothing by mouth and confirmed he did not give Resident #52 her 8:00 AM dose of glycopyrrolate by mouth. Nurse #2 acknowledged the order for glycopyrrolate on the MAR read the medication was ordered by mouth. Nurse #2 stated the order on the MAR was inaccurate due to the resident being unable to tolerate any medication administration by mouth.</p> <p>Record review indicated the resident had monthly medication reviews completed by the consultant pharmacist on 9/18/19, 10/21/2019, and 11/15/2019. All reviews indicated no irregularities for Resident #52.</p> <p>On 12/17/19 at 12:09 PM an interview was conducted with the facility's consultant pharmacist where he stated the glycopyrrolate order on the MAR indicated the medication was to be given by mouth. He further stated, all of the resident's other medications were ordered to be given by feeding tube. The pharmacist stated the error in administration route should have been caught on</p>	F 756	<p>Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.</p> <p>5. Date of compliance 1/17/2020.</p>		

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F 756	Continued From page 37 the monthly medication review and was likely an oversight. In an interview with the Director of Nursing (DON) on 12/19/2019 at , she stated on 9/5/2019 the Resident #52's physician orders to receive glycopyrrolate by mouth was sent to pharmacy where the pharmacist should have caught the error during the resident's medication review which was done on admission, readmission, and monthly.	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; §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	F 758		1/17/20	

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F 758	Continued From page 38 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 observation, record review, and interviews with staff, Pharmacy Consultant, and physician, the facility failed to identify targeted behavioral symptoms and monitor those behaviors to support a clinical rationale for the use of antipsychotic and antianxiety medications (Resident #86), failed to assess a resident on antipsychotic medication for extrapyramidal symptoms (EPS), a drug induced movement disorder (Resident #103), and failed to obtain documentation of the rationale to extend as needed (PRN) psychotropic medication beyond 14 days (Resident #111) for 3 of 7 residents reviewed for psychotropic medications.	F 758	F758 1. Resident #86 was assessed for appropriate target behavioral symptoms by the Director of Nurses to support clinical rationale for use of psychotropic medications. Behaviors (hallucinations, wandering, and hitting) were identified and added to the medical records on 1/15/20. Resident #103 was assessed by Staff Nurse (LPN) for extrapyramidal symptoms by AIMS assessment on 12/17/19. Resident #111 received physician order to discontinue use of as needed Trazadone on 12/16/19.		

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F 758	<p>Continued From page 39</p> <p>The findings included:</p> <p>1. Resident #86 was admitted to the facility on 7/30/19 with diagnoses that included dementia without behavioral disturbance, anxiety, and depression.</p> <p>A physician ' s order dated 7/30/19 for Resident #86 indicated Seroquel (antipsychotic medication) 25 milligrams (mg) at bedtime for psychosis.</p> <p>A physician ' s order dated 7/30/19 indicated Buspar (antianxiety medication) 30 mg twice daily for anxiety.</p> <p>A physician ' s order dated 7/30/19 indicated Xanax (antianxiety medication) 0.25 mg every 12 hours (PRN) as needed.</p> <p>A physician ' s order dated 7/30/19 indicated Resident #86 ' s behaviors were to be monitored and documented on the Medication Administration Record (MAR). There were no targeted behaviors identified.</p> <p>A physician ' s order dated 7/31/19 indicated Wellbutrin (antidepressant medication) extended release 150 mg once daily for depression.</p> <p>A psychotropic medication review assessment dated 7/31/19 indicated Resident #86 had no behavioral symptoms and no non-pharmacological interventions. Newly initiated psychotherapeutic medications were started with the targeted behaviors identified as "major depression, anxiety, psychosis". The medications were noted to be Seroquel, Xanax, Buspar, and Wellbutrin.</p>	F 758	<p>2. Director of Nursing, Assistant Director of Nursing (ADON), and Nursing Supervisors completed audit of residents receiving psychotropic medications to ensure appropriate target behaviors are identified and documented to support clinical rationale for the use of the medication ordered on 1/15/20. The Director of Nursing completed an audit of residents receiving medications requiring AIMS assessment on 1/8/20. The Director of Nursing completed an audit of residents receiving PRN psychotropic medications on 1/8/20 to ensure the orders reflected the 14 day increments. Audit indicated that some target behaviors required revision or discontinuation of certain medications. Medications that had not been used, and those not meeting the time limit requirements were discontinued by the physician. Orders for behavior monitoring to include target behaviors, are added to the Medication Administration Record (MAR) for residents receiving psychotropic medication.</p> <p>3. Director of Nursing, Assistant Director of Nursing (ADON), and Nursing Supervisors educated license nurses by 1/16/20 (including weekend, agency, and as needed (prn) licensed nurses) on identifying and documenting target behavioral symptoms to support use of psychotropic medications and completion of AIMS assessments. Director of Nursing, ADON, and Nursing Supervisors educated licensed nurses by 1/16/20 (including weekend, agency, and prn</p>		

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F 758	Continued From page 40 The admission Minimum Data Set (MDS) assessment dated 8/6/19 indicated Resident #86 ' s cognition was severely impaired. She had no behaviors and no rejection of care. Resident #86 received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days. A physician ' s order dated 8/8/19 indicated a discontinuation of Buspar 30 mg twice daily and an initiation of a routine order for Xanax 0.25 mg twice daily for increased anxiety. On 8/13/19 Resident #86 ' s PRN Xanax order was discontinued. A review of the MAR for Resident #86 showed no PRN Xanax was utilized for Resident #86. A Nurse Practitioner (NP) note dated 9/11/19 indicated that Resident #86 had dementia without behavioral disturbance and major depression with anxiety but no psychotic features. She was noted to isolate herself in her room at times. Staff reported no acute issues with the resident. On 10/8/19, the 7/30/19 physician ' s order for behavior monitoring was revised to add the identified targeted behavior "withdrawn" for Resident #86. This was the only identified targeted behavior for Resident #86. A psychotropic medication review assessment dated 10/31/19 indicated Resident #86 had no change in behavioral symptoms since the 7/31/19 assessment. Resident #86 was noted to occasionally wander and the non-pharmacological intervention that was attempted was redirection. Medications in use	F 758	licensed nurses), Optum Nurse Practitioner, OnSite Care Nurse Practitioner and centers Medical Director, concerning as needed order (PRN) psychotropic medications to include that this class of medications are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the medication. Staff on leave of absence/vacation will not be permitted to work until completing education. 4. Director of Nursing, ADON, and Nursing Supervisors will review residents receiving psychotropic medications to ensure appropriate target behaviors have been identified and documented in the medical record weekly. New orders for psychotropic medications will be reviewed during the clinical morning meeting to ensure any new orders for psychotropic medications have appropriate behavior monitoring in place. Nursing Supervisors will audit residents receiving medications that require AIMS assessments weekly for one month, then every two weeks for one month, and monthly for two months to ensure AIMS assessment completed per protocol. PRN or as needed psychotropic medications, will be reviewed during standup by the Director of Nursing, ADON, and Nursing supervisors each week five times weekly for three months. The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure		

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F 758	<p>Continued From page 41</p> <p>were noted to be Seroquel, Xanax, and Wellbutrin.</p> <p>A review of Resident #86 ' s active physician ' s orders was conducted on 12/16/19. Resident #86 continued to receive the psychotropic medications Seroquel 25 mg once daily, Xanax 0.25 mg twice daily, and Wellbutrin 150 mg once daily.</p> <p>An observation was conducted of Resident #86 on 12/15/19 at 4:00 PM seated in her wheelchair in the hall outside of her room on the locked unit of the facility. Resident #86 was alert and oriented to self, but she was unable to answer open ended questions with logical responses. She had a bright affect and there were no behavioral issues observed.</p> <p>An observation was conducted of Resident #86 on 12/17/19 at 2:48 PM on the locked unit of the facility. The resident was self-propelling her wheelchair in the hall of the facility.</p> <p>An interview was conducted with Nursing Assistant (NA) #1 on 12/17/19 at 2:50 PM. NA #1 reported that Resident #86 ' s only behavior was wandering and occasional exit seeking. She stated that Resident #86 often wanted and/or believed she was going home.</p> <p>During an interview with NA #2 on 12/17/19 at 2:51 PM she stated that she was familiar with Resident #86 and that she had no behavioral issues other than thinking that she was going home which resulted in wandering and exit seeking.</p> <p>Nurse #10 was interviewed on 12/17/19 at 2:53</p>	F 758	<p>compliance. The QAPI committee is responsible for the ongoing compliance.</p> <p>5. Date of compliance 1/17/2020.</p>		

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F 758	<p>Continued From page 42</p> <p>PM. She reported that she has regularly worked with Resident #86 since she moved to the locked unit in October. She stated that the resident was moved to this unit due to exit seeking behaviors. Nurse #10 indicated that exit seeking, and wandering were Resident #86 ' s only behaviors and that these were baseline behaviors for Resident #86. She explained that due to Resident #86 ' s dementia, she frequently had behaviors that revolved around going home, such as, looking for her car keys and going to the exit doors. Nurse #10 was asked what the facility ' s protocol was for behavior monitoring documentation. She stated that behavior monitoring documentation was on the MAR and targeted behaviors were selected by administrative nursing staff. Resident #86 ' s only targeted behavior, "withdrawn", was reviewed with Nurse #10. She stated that there were some days when Resident #86 wanted to stay in her room most of the day and she believed this was why "withdrawn" was chosen as the targeted behavior for Resident #86. She indicated this behavior was not a frequent occurrence for the resident since she has been on the locked unit. Resident #86 ' s physician ' s orders for Seroquel for psychosis and Xanax for increased anxiety were reviewed with Nurse #10. Nurse #10 was unable to explain what behaviors Resident #86 had that related to the use of Seroquel and Xanax for Resident #86.</p> <p>Social Worker (SW) #2 was interviewed on 12/17/19 at 3:30 PM. SW #2 stated that Resident #86 ' s only behavioral issue was exit seeking/wandering. She reported that this was why the resident was moved to the locked unit. She indicated that Resident #86 had not been seen by a psychiatric provider since her</p>	F 758			

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F 758	<p>Continued From page 43</p> <p>admission to the facility. She explained that not all residents were referred to psychiatric services on admission. SW #2 stated that the facility normally waited to see if behavioral issues/changes required a referral to psychiatric services.</p> <p>An interview was conducted with Nurse Supervisor #1 on 12/17/19 at 3:15 PM. She reported that targeted behaviors were selected by a group discussion of administrative nursing staff and the SWs. She stated that the facility normally waited a few weeks after admission in order to get to know the resident before selecting specific targeted behaviors. She indicated that the targeted behaviors selected should encompass behaviors related to each psychotropic medication. Resident #86 ' s only targeted behavior, "withdrawn", was reviewed Nurse Supervisor#1. She stated that she needed to look into this further to discuss why this targeted behavior was selected.</p> <p>During a follow up interview with Nurse Supervisor #1 on 12/17/19 at 5:07 PM she reported that the targeted behavior "withdrawn" was selected for Resident #86 as she sometimes wanted to stay in her room all day causing isolation for the resident. Resident #86 ' s orders for Seroquel for psychosis and Xanax for increased anxiety were reviewed with Nurse Supervisor #1. Nurse Supervisor #1 was unable to explain why there were no behaviors identified for Resident #86 that related to the use Seroquel and Xanax.</p> <p>During a phone interview with the Pharmacy Consultant on 12/18/19 at 3:30 PM he stated that targeted behaviors were expected to be identified</p>	F 758			

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F 758	<p>Continued From page 44</p> <p>for psychotropic medications, so the facility was able to track what the medication was being used for, if behaviors were ongoing or were stable, and if the medication was needed or was able to be decreased and/or discontinued. He explained that identification of targeted behaviors provided a rationale for what the medication was being used to control.</p> <p>An interview was conducted with Resident #86 ' s physician on 12/18/19 at 12:10 PM. The physician was asked what the clinical indication for use was for Resident #86 ' s Seroquel and Xanax. He stated that he believed Resident #86 was on these medications when she was admitted to the facility. He explained that the resident had multiple medical issues that required stabilization through medication adjustments and that this was his focus for Resident #86 since her admission to the facility. He further explained that this caused the Seroquel and Xanax use to be a lower priority and they were placed on the "back burner" as he had not wanted to change all of her medications at one time. The physician reported that recently these medical conditions stabilized, and that Resident #86 was now on the list to be seen for psychotropic medication management when the psychiatric provider next came to the facility. He added that he expected staff to identify targeted behaviors to support the use of psychotropic medications and to document these behaviors in the medical record.</p> <p>The Director of Nursing (DON) was interviewed on 12/18/19 at 4:07 PM. The DON restated the Pharmacy Consultant ' s report that indicated targeted behaviors were expected to be identified for psychotropic medications, so the facility was able to track what the medication was being used</p>	F 758			

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F 758	<p>Continued From page 45</p> <p>for, if behaviors were ongoing or were stable, and if the medication was needed or was able to be decreased and/or discontinued. She explained that targeted behaviors were not normally selected upon as admission as they needed to wait a few weeks to get to the know the resident and to identify the targeted behaviors that related to their medications. She further explained that when the targeted behaviors were identified they were placed on the MAR for behavior monitoring documentation. Resident #86 ' s only targeted behavior, "withdrawn", was reviewed the DON. The DON revealed that this targeted behavior was not sufficient as a rationale for the use of Resident #86 ' s Seroquel prescribed for psychosis and Xanax prescribed for increased anxiety. She stated that over the past year the facility has been focusing on psychotropic medication use in an effort to decrease overall usage. She indicated that this focus included ensuring targeted behaviors were identified to justify the use of psychotropic medications and to ensure behavior monitoring documentation was completed. She indicated that a lot of their admissions came from the hospital and the residents were on multiple psychotropic medications. The DON stated that it was a process to ensure these medications were monitored closely so that gradual dose reductions and/or discontinuations of the medications could be done if appropriate for medications that had no clinical indication for use. She indicated that despite all of their efforts they still had room for improvement.</p> <p>2. Resident #103 was admitted to the facility on 11/4/19 with diagnoses that included dementia</p>	F 758			

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F 758	<p>Continued From page 46 with behavioral disturbance and anxiety.</p> <p>A physician ' s order dated 11/4/19 for Resident #103 indicated Seroquel (antipsychotic medication) 50 milligrams (mg) in the morning and 75 mg with dinner.</p> <p>The admission Minimum Data Set (MDS) assessment dated 11/11/19 indicated Resident #103 ' s cognition was severely impaired. He was noted with hallucinations and delusions. He was assessed with physical behaviors and rejection of care on 1 to 3 days. Resident #103 received antipsychotic medication on 7 of 7 days.</p> <p>A Pharmacy Consultation Report dated 11/15/19 indicated Resident #103 received antipsychotic medication and that an Abnormal Involuntary Movement Scale (AIMS) assessment (used to assess for extrapyramidal symptoms) was due for this resident.</p> <p>Resident #103 ' s care plan, last reviewed on 11/25/19, included a focus area related to the use of antipsychotic medication. The interventions included, in part, an AIMS assessment per facility protocol.</p> <p>The December 2019 active physician ' s orders for Resident #103 were reviewed on 12/17/19 and revealed the 11/4/19 orders for Seroquel remained active.</p> <p>The hard copy and electronic medical record were reviewed from 11/4/19 through 12/17/19 and revealed an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #103 related to the use of Seroquel.</p>	F 758			

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F 758	Continued From page 47 An observation was conducted of Resident #103 on 12/17/19 at 12:15 PM. The resident was observed with no abnormal involuntary movements. During a phone interview with the Pharmacy Consultant on 12/18/19 at 3:30 PM he reported that he expected an AIMS assessment to be completed on admission for residents admitted on antipsychotic medication, on initiation of antipsychotic medication if the resident was started on the antipsychotic while at the facility, and then every 6 months thereafter as long as the antipsychotic medication was in use. He explained that routine AIMS assessments for antipsychotic medication were necessary due to the potential side effects of antipsychotic medications. An interview was conducted with Nurse Supervisor #1 on 12/17/19 at 5:01 PM. She reported that the facility 's normal protocol was for AIMS assessments to be completed on admission for residents on antipsychotic medication, on initiation of an antipsychotic medication, and then every 6 months. She revealed that the electronic medical record (EMR) system had an update a month or two ago and that there had been some issues with assessments "triggering" for completion. She explained that assessments, such as the AIMS, were supposed to automatically come up for the nurse to complete. She further explained that since the EMR update they had noticed some assessments were not triggering causing the assessment to be missed by the nurse. Nurse Supervisor #1 revealed that AIMS assessments were one of the assessments that they identified	F 758			

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F 758	<p>Continued From page 48</p> <p>the EMR system update had affected. She stated that the Director of Nursing (DON) was aware of the issue.</p> <p>The DON was interviewed on 12/17/19 at 5:07 PM. She confirmed Nurse Supervisor #1 ' s report of the facility ' s protocol for AIMS assessments. She additionally confirmed Nurse Supervisor #1 ' s report of issues with AIMS assessments triggering for completion since the EMR system was updated. She stated that they had been completing any missed assessments as they came across them. Resident #103 ' s medical record was reviewed with the DON and she confirmed there was no AIMS assessment completed for this resident. The Pharmacy Consultation Report dated 11/15/19 that identified an AIMS assessment was needed for Resident #103 was reviewed with the DON. She stated that this recommendation came to her through email and that it was overlooked.</p> <p>3. Resident #111 was admitted to the facility on 11/20/19 with diagnoses that included dementia.</p> <p>A physician ' s order dated 11/21/19 for Resident #111 indicated Trazodone (antidepressant medication) 50 milligrams (mg) every 24 hours as needed (PRN) at bedtime for agitation. There was no stop date for this PRN Trazodone order. This order was entered into the electronic medical record (EMR) by Nurse Supervisor #1.</p> <p>The admission Minimum Data Set (MDS) assessment dated 11/27/19 indicated Resident #111 ' s cognition was severely impaired, and she received antidepressant medication on 1 of 7 days.</p>	F 758			

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F 758	<p>Continued From page 49</p> <p>A review of November 2019 Medication Administration Record (MAR) for Resident #111 indicated PRN Trazodone was administered one time on 11/27/19.</p> <p>A review of Resident #111 ' s December 2019 ' s active physician ' s orders on 12/16/19 indicated the 11/21/19 physician ' s order for PRN Trazodone remained active and had no stop date. The December 2019 MAR from 12/1/19 through 12/16/19 showed no administrations of PRN Trazodone for Resident #111.</p> <p>An interview was conducted with Nurse Supervisor #1 on 12/16/19 at 3:25 PM. Resident #111 ' s active PRN Trazodone order, initiated on 11/21/19, with no stop date was reviewed with Nurse Supervisor #1. She confirmed she entered this order into the EMR. Nurse Supervisor #1 stated she was aware of the regulation that indicated physician documentation of a rationale was required to extend a PRN psychotropic medication ' s duration beyond 14 days. She revealed she was unaware that antidepressant medications, such as Trazodone, fell under this regulation. She explained that she knew the regulations for PRN psychotropic medications applied to antianxiety medications and antipsychotic medications.</p> <p>During an interview with Resident #111 ' s physician on 12/18/19 at 12:10 PM he stated he was aware of the regulation that indicated physician documentation of a rationale was required to extend a PRN psychotropic medication ' s duration beyond 14 days. The physician revealed he was unaware that antidepressant medications, such as Trazodone,</p>	F 758			

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F 758	Continued From page 50 fell under this regulation. The Director of Nursing (DON) was interviewed on 12/19/19 at 10:36 AM. The DON restated Nurse Supervisor #1 ' s interview and the physician ' s interview that indicated they were unaware the regulations related to PRN psychotropic medications included antidepressants. She reported that over the past year the facility was working hard to monitor PRN antianxiety medication orders in an effort to either discontinue the PRN orders or to ensure 14 day stop dates were in place. The DON stated that they would include antidepressant medications in their PRN monitoring moving forward. During a phone interview with the Pharmacy Consultant on 12/18/19 at 3:30 PM he reported that he was aware that the regulations related to PRN psychotropic medications included antidepressant medications. He indicated he previously made recommendations to the facility related to the need for the prescriber to document the indication for use, the intended duration of therapy, and the rationale for the extended time period if a PRN psychotropic was ordered for greater than 14 days.	F 758			
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:	F 867		1/17/20	

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F 867	<p>Continued From page 51</p> <p>Based on record reviews, observations, staff interviews and physician interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee had put into place following the annual recertification survey dated 11/1/18. This was for two recited deficiencies in the areas of Accuracy of Assessments at F641- not coding the Minimum Data Set (MDS) accurately and Free from Unnecessary Psychotropic Medications use at F758- not placing time duration on as needed psychotropic medications, previously cited on 11/1/18. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.</p> <p>The findings included:</p> <p>This citation is cross referenced to:</p> <p>F641- Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment in the areas of diagnoses (Resident #35), Nutrition (Resident #34) and medications (Resident #55) for 3 of 26 sampled residents reviewed.</p> <p>During the facility's recertification survey of 11/01/18 the facility was cited for failure to code the Minimum Data Set (MDS) assessment accurately in the areas of dialysis (Resident #321) for 1 of 2 sampled residents on dialysis, in the area of diagnoses (Resident #55) for 1 of 5 sampled residents reviewed for unnecessary medications and in the area of discharge (Resident #121) for 1 of 3 discharged sample residents.</p>	F 867	<p>F867</p> <p>1.The center Quality Assurance and Performance Improvement Committee has developed revised plans to correct the repeat deficient practices.</p> <p>Accuracy of Assessments (F641) Modifications were made to the Minimum Data Set (MDS) for residents where data was miscoded. For Resident #35, the MDS Nurse modified the MDS to correct it on 12/18/19. For Resident #34, the Registered Dietician modified the MDS to correct it on 1/14/20. Modifications were made to the MDS of resident #55 by the MDS Nurse on 12/17/19. The modification for Resident #35 included adding diagnosis of Anxiety to Section I, Resident #34 included changing diet to nothing by mouth (NPO) in section K, and resident #55 the modification included adding resident had been administered anticoagulation 7 days instead of Hypnotic to section N. Modifications made to the MDS corrected previous information in the MDS for each of the residents. No apparent impact for the three residents were noted.</p> <p>The MDS Nurse completed an audit of the Minimum Data Set (most current MDS) for those residents with diagnosis of Anxiety to ensure coding was correct on 1/14/20. No additional issues were discovered. Registered Dietician completed an audit of residents who are on an NPO diet to ensure accurate coding on 1/14/20. No additional issues were discovered. MDS</p>		

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F 867	<p>Continued From page 52</p> <p>F758- Based on observation, record review, and interviews with staff, Pharmacy Consultant, and physician, the facility failed to identify targeted behavioral symptoms and monitor those behaviors to support a clinical rationale for the use of antipsychotic and antianxiety medications (Resident #86), failed to assess a resident on antipsychotic medication for extrapyramidal symptoms (EPS), a drug induced movement disorder (Resident #103), and failed to obtain documentation of the rationale to extend as needed (PRN) psychotropic medication beyond 14 days (Resident #111) for 3 of 7 residents reviewed for psychotropic medications.</p> <p>During the facility's recertification survey of 11/01/18 the facility was cited for failure to ensure as needed psychotropic medications were time limited in duration (Residents #15, #33, #57, and #86) for 4 of 5 residents reviewed for as needed psychotropic medication.</p> <p>An interview was completed on 12/19/19 at 10:30am with the Administrator and the Director of Nursing (DON). The DON stated the repeat citation in MDS accuracy was felt to be related to human error and she was not aware antidepressants fell under the same category for time limited duration, which in turn caused the repeat citation for the PRN psychotropic medications.</p>	F 867	<p>Nurse completed an audit on residents receiving anticoagulation to ensure accurate coding on 1/14/20. No additional issues were discovered. Deviations were corrected with a modification assessment.</p> <p>Regional Clinical Reimbursement Coordinator provided re-education to MDS Nurse & Registered Dietician (RD) on MDS accuracy on 1/15/19. Re-education focused on eliminating coding errors.</p> <p>Assistant Director of Nurses (ADON), MDS Nurse, RD, and Nursing Supervisor will audit sections I, K and N prior to transmission of MDS assessment. Audit will be completed five times a week for three months. The center's MDS Nurse will present the results of the audit for accuracy for Sections I, K, and N of the MDS that was completed prior to submission monthly to the Quality Assurance and Performance Improvement Committee monthly. The QAPI committee is responsible for the ongoing compliance.</p> <p>Free from Unnecessary Psychotropic Meds/PRN Use (F758) Resident #86 was assessed for appropriate target behavioral symptoms by the Director of Nurses to support clinical rationale for use of psychotropic medications. Behaviors (hallucinations, wandering, and hitting) were identified and added to the medical records on 1/15/20. Resident #103 was assessed by Staff Nurse (LPN) for extrapyramidal symptoms</p>		

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F 867	Continued From page 53	F 867	<p>by AIMS assessment on 12/17/19. Resident #111 received physician order to discontinue use of as needed Trazadone on 12/16/19.</p> <p>Director of Nursing, Assistant Director of Nursing (ADON), and Nursing Supervisors completed audit of residents receiving psychotropic medications to ensure appropriate target behaviors are identified and documented to support clinical rationale for the use of the medication ordered on 1/15/20. The Director of Nursing completed an audit of residents receiving medications requiring AIMS assessment on 1/8/20. The Director of Nursing completed an audit of residents receiving PRN psychotropic medications on 1/8/20 to ensure the orders reflected the 14 day increments. Audit indicated that some target behaviors required revision or discontinuation of certain medications. Medications that had not been used, and those not meeting the time limit requirements were discontinued by the physician. Orders for behavior monitoring to include target behaviors, are added to the Medication Administration Record (MAR) for residents receiving psychotropic medication.</p> <p>Director of Nursing, Assistant Director of Nursing (ADON), and Nursing Supervisors educated license nurses by 1/16/20 (including weekend, agency, and as needed (prn) licensed nurses) on identifying and documenting target behavioral symptoms to support use of psychotropic medications and completion</p>		

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F 867	Continued From page 54	F 867	<p>of AIMS assessments. Director of Nursing, ADON, and Nursing Supervisors educated licensed nurses by 1/16/20 (including weekend, agency, and prn licensed nurses), Optum Nurse Practitioner, OnSite Care Nurse Practitioner and centers Medical Director, concerning as needed order (PRN) psychotropic medications to include that this class of medications are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the medication. Staff on leave of absence/vacation will not be permitted to work until completing education.</p> <p>Director of Nursing, ADON, and Nursing Supervisors will review residents receiving psychotropic medications to ensure appropriate target behaviors have been identified and documented in the medical record weekly. New orders for psychotropic medications will be reviewed during the clinical morning meeting to ensure any new orders for psychotropic medications have appropriate behavior monitoring in place. Nursing Supervisors will audit residents receiving medications that require AIMS assessments weekly for one month, then every two weeks for one month, and monthly for two months to ensure AIMS assessment completed per protocol. PRN or as needed psychotropic medications, will be reviewed during standup by the Director of Nursing, ADON, and Nursing supervisors each week five times weekly for three months.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345143	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2019
NAME OF PROVIDER OR SUPPLIER SILER CITY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344		
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F 867	Continued From page 55	F 867	<p>The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.</p> <p>2. The Regional Nurse along with the Center Quality Assurance and Performance Improvement Committee met on 1/14/20 and reviewed the plans that were implemented as a result of the previous year s annual survey in response to identified deficient practice to ensure that the remainder of the plans had sustained effective compliance. This was accomplished by completing audits as outlined in the original plans and staff interviews.</p> <p>3. Education was provided by the Regional Nurse with the Quality Assurance and Performance Improvement Committee in regards to the QAPI Process. This education included ongoing review of prior plans to ensure that compliance is maintained. This education was completed on 1/14/20.</p> <p>4. The Quality Assurance and Performance Improvement Committee will meet monthly and review the plans that have been developed to address the identified deficient practice to ensure that the center has maintained compliance. As part of the QAPI Meeting ongoing reviews of systems will be completed to identify other potential deficient practice. The Administrator is responsible for the QAPI</p>		

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F 867	Continued From page 56	F 867	Process and sustaining an effective program. The Regional Nurse will review the QAPI Minutes monthly x 3 months to ensure the process is followed to implement and correct identified deficiencies.		
F 880 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify</p>	F 880	5. Date of compliance 1/17/2020.	1/17/20	

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F 880	<p>Continued From page 57</p> <p>possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the</p>	F 880			
			F880		

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F 880	<p>Continued From page 58</p> <p>facility failed to disinfect a shared glucometer (device used to measure a resident ' s blood glucose or blood sugar level) after the glucometer was used on one resident and prior to staff intending to use it on another for 1 of 4 residents (Resident #121) observed to have blood glucose monitoring.</p> <p>The findings included:</p> <p>A review of the facility ' s policy entitled, "NSG217 Glucose Meter" (Effective 6/1/96; Revised on 5/15/17) was conducted. The policy read, in part: "To ensure the accuracy and validity of blood glucose monitoring, blood glucose meters will be disinfected before and after patient use ..." The stated purpose of the policy included, "To ...maintain infection control standards."</p> <p>On 12/15/19 at 4:18 PM, Nurse #7 was observed as she used a glucometer to obtain a blood glucose reading for Resident #70. After checking the resident ' s blood glucose, the nurse set the glucometer used for Resident #70 on top of the medication cart. The glucometer was not disinfected.</p> <p>On 12/15/19 at 4:23 PM, Nurse #7 was observed as she obtained the necessary supplies and a second glucometer from a drawer of the med cart to do a blood glucose check for Resident #121. A continuous observation was made as the glucometer used for Resident #70 remained on top of the medication cart. Nurse #7 left the med cart and immediately returned to the cart, stating the second glucometer she attempted to use for Resident #121 was not working properly. The nurse picked up the first glucometer (which was used for Resident #70 but had not been</p>	F 880	<ol style="list-style-type: none"> 1. Blood Glucometer was properly disinfected prior to obtaining blood specimen of resident #121. Staff nurse cleaned glucometer by policy prior to additional resident use on 12/15/19. 2. Diabetic residents who have a physician order to monitor blood sugar by accu-check are at risk. Director of Nursing (DON), Assistant Director of Nursing (ADON), and Nursing Supervisors completed audit of residents with orders to check blood sugar on 1/15/19 no evidence of infection noted. Director of Nursing, Nurse Supervisor, and Nurse Practice Educator (NPE) conducted observation of staff nurses completing accu-check beginning 12/16/19 through 1/16/20 with no issues noted. 3. Director of Nursing provided education to nurse #7 on 12/15/19. Director of Nursing, Assistant Director of Nursing (ADON) and Nursing Supervisors educated licensed nurses by 1/16/20 (including weekend, agency, and as needed (prn) licensed nurses,) education included policy and procedure for disinfection of the glucometer between patients with return demonstration provided. Staff on leave of absence/vacation will not be permitted to work until completing education. 4. NPE will audit 5 residents per day five times a week for four weeks, then 5 residents per day three times a week for four weeks, then 5 residents weekly for 		

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F 880	<p>Continued From page 59</p> <p>disinfected after being used) and supplies to again try to check Resident #121 ' s blood glucose. Nurse #7 then proceeded to Resident 121 ' s room. As she began to enter Resident #121's room, the nurse was asked to stop. At that time, the nurse was asked if the glucometer she was holding was the same one used to check Resident #70 ' s blood glucose. Nurse #7 confirmed it was the same meter. When asked if she should have done anything with the shared glucometer before using it for another resident, she paused then stated, "I need to wash it." The nurse expressed gratitude for being stopped before proceeding with the blood glucose check for Resident #121. Nurse #7 returned to the cart and disinfected the glucometer with germicidal bleach wipes in accordance with the manufacturer ' s recommendations.</p> <p>An interview was conducted with Nurse #7 on 12/15/19 at 4:25 PM. During the interview, the nurse reported she did not know why she had forgotten to disinfect the meter. Nurse #7 stated she usually disinfected a shared glucometer with the germicidal bleach wipes stored on the med cart. The nurse stated, "I'm glad you stopped me."</p> <p>An interview was conducted with the facility's Director of Nursing (DON) on 12/17/19 at 10:30 AM. During the interview, the DON reported Nurse #7 had made her aware of the observed failure to disinfect a shared glucometer. The DON stated the facility had been working quite hard to ensure shared glucometers were appropriately disinfected. She reported each hall med cart had two shared glucometers to allow time for one glucometer to be appropriately disinfected while the nurse used the second</p>	F 880	<p>four weeks, to ensure that the appropriate disinfecting procedure is followed for glucometer use. NPE will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance.</p> <p>5. Date of compliance 1/17/20.</p>		

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F 880	Continued From page 60 glucometer. The DON stated Nurse #7 acknowledged she simply didn't think about disinfecting the glucometer prior to using the glucometer and that, "She just grabbed it."	F 880		