STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 10/01/2020

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FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 000	INITIAL COMMENTS A complaint investigation was completed on site 9/29/20 and continued remotely until 10/1/20. Event ID #EIER11 1 of 7 complaint allegations was substantiated with a deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the 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)-	F 656		10/21/20

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

Electronically Signed | 10/16/2020

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F 656	Continued From page 1 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop an accurate and individualized care plan in the area of psychotropic medications for 1 of 3 residents (Resident #3) reviewed for unnecessary medications. The findings included: Resident #3 was initially admitted to the facility on 9/22/19 and most recently readmitted on 8/10/20 with diagnoses that included psychosis. A physician ' s order dated 7/16/20 for Resident #3 indicated Quetiapine Fumarate (antipsychotic medication) 25 milligrams (mg) twice daily for delusions. A physician ' s order dated 8/10/20 discontinued Resident #3 ' s Quetiapine Fumarate and initiated Olanzapine (antipsychotic medication) 7.5 mg in the evening for delirium. A psychiatry progress note dated 8/24/20 indicated Resident #3 was prescribed olanzapine	F 656	Resident #3 is currently residing in facility. Resident #3□s care plan was immediately reviewed and updated by MDS nurse on 10/01/2020. All residents have the potential to be affected by this deficient practice. All current residents□ care plans were reviewed by Regional MDS Coordinator on 10/15/2020 to ensure an accurate and individualized care plan in the area of psychotropic medications and to confirm that all psychotropic medications were necessary and appropriate according to their diagnosis. Residents□ care plans identified as needing corrections were addressed at the time of the review, accordingly. There were nine care plans that required updating. MDS care plans will be updated during clinical stand up meeting to reflect changes in resident condition. Care plans will be reviewed weekly at clinical Risk Meeting to ensure all changes are documented on the care plan. Education of Licensed Nurses completed by RN	

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F 656	Continued From page 2 for the diagnosis of psychosis related to symptom management of hallucinations and delusions. The quarterly Minimum Data Set (MDS) assessment dated 9/3/20 indicated Resident #3 ' s cognition was intact, and she received antipsychotic medication on 7 of 7 days. Resident #3 ' s active care plan, last reviewed on 9/18/20, included the focus area, "The resident is on antipsychotic therapy for depression". This focus area was created by the MDS Nurse. Resident #3 ' s active physician ' s orders were reviewed on 9/30/20 and revealed the 8/10/20 order for Olanzapine was an active order. An interview was conducted with the MDS Nurse on 10/1/20 at 8:08 AM. Resident #3 ' s care plan that indicated she was on antipsychotic medication for depression was reviewed with the MDS Nurse. The MDS Nurse revealed this care plan was inaccurate. She acknowledged that Resident #3 ' s antipsychotic medication was prescribed for management of hallucinations and delusions. She stated that she had not recalled entering this care plan for Resident #3. The MDS Nurse indicated she must have hit the wrong drop down box which incorrectly put depression as the diagnosis for Resident #3 ' s antipsychotic medication. During a phone interview with the Director of Nursing (DON) on 10/1/20 at 9:55 AM she indicated that her expectation was for care plans to be accurate and individualized.	F 656	Divisional Director of Clinical Services, 10/12/2020, regarding care plan development, implementation, accuracy and individualization to include, but not limited, to psychotropic medications and appropriate diagnoses. For staff who are not available for in servicing, they will be in serviced prior to their next scheduled shift to work. Education will also be given to new hires at orientation. The Regional MDS Coordinator will conduct quality improvement monitoring using a sample of 8 current residents□ care plans weekly x2 months and then monthly x4 months to ensure the care plans are individualized in the area of psychotropic medications. This is to confirm that all psychotropic medications are necessary and appropriate according to their diagnosis and updated on the care plan accordingly. Findings from the quality improvement monitoring will be reported to the Quality Assurance and Performance Improvement Committee monthly for 6 months to ensure continued compliance and to determine the need for further audits and/or corrective actions.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		10/21/20

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F 657	Continued From page 3 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and revise a care plan in the area of medication for 1 of 3 residents reviewed for unnecessary medications. (Resident #1) The findings included: Resident #1 was initially admitted to the facility	F 657	Resident #1 is no longer residing at the facility. Resident #1 care plan was immediately reviewed and updated by MDS Nurse on 10/01/2020 to reflect the discontinuation of antipsychotic medication per physicians order. All residents have the potential to be affected. All current residents□ care plans were reviewed to ensure they are	

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F 657	Continued From page 4 5/15/17 and most recently readmitted 8/13/20 with diagnoses that included chronic pain syndrome, depressive disorder and anxiety disorder. An admission Minimum Data Set (MDS) assessment dated 8/20/20 indicated Resident #1's cognition was fully intact. She was not coded for receiving an antipsychotic medication during the MDS review period. A review of the August 2019 Medication Administration Record (MAR) revealed Resident #1's Seroquel 25 milligrams (mg) 1 tab by mouth every night was discontinued on 8/4/20. Resident #1's care plan revealed a focus area of antipsychotic therapy related to delusions. This focus area was initiated on 10/15/19 and most recently reviewed on 9/3/20. On 10/1/20 at 11:08 AM an interview occurred with the MDS Coordinator. After reviewing Resident #1's medical record, she confirmed the resident received an antipsychotic medication in the form of Seroquel until 8/4/20. The MDS Coordinator added the care plan for antipsychotic therapy should have been resolved when the review was completed on 9/3/20. An interview occurred with the Executive Director and Director of Nursing on 10/1/20 at 2:30 PM. The both indicated it was their expectation for the care plan to be an accurate representation of the resident.	F 657	completed timely and revised accordingly with a change in condition and as needed to meet their individual needs. Audit results showed additional resident care plans requiring updates. There were nine care plans that required updating. These were addressed at the time of the review by Regional MDS Coordinator on 10/15/2020. Education of Licensed Nurses completed by RN DDCS, regarding when to revise/update care plans (with quarterly and comprehensive assessments, significant changes in condition, and changes in medications; new or discontinued) on 10/12/2020. For staff who are not available for in servicing, they will be in serviced prior to their next scheduled shift to work.¿ Education will also be given to new hires at orientation. The Regional MDS Coordinator will conduct quality improvement monitoring using a sample of 8 current residents□ care plans weekly x2 months and then monthly x4 months to ensure they are accurate, individualized, and appropriately address changes to care plan in the area of psychotropic medications. This is to confirm that all psychotropic medications are necessary and appropriate according to their diagnosis. Findings from the quality improvement monitoring will be reported to the Quality Assurance and Performance Improvement Committee monthly for 6 months to ensure continued compliance and to determine the need for further audits and/or corrective actions.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices	F 689		10/21/20

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F 689	Continued From page 5 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to prevent a dependent resident from rolling out of bed onto the floor, hitting her head on a nightstand, and becoming wedged between the bed and the nightstand during a bed bath. Resident #1 sustained a laceration to her head requiring staples as well as multiple skin tears to her left lower extremity. This was for 1 of 3 residents reviewed for accidents (Resident #1). The findings included: Resident #1 was initially admitted to the facility on 5/15/17 and most recently readmitted to the facility on 8/13/20 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), COVID-19, and muscle weakness. Resident #1 ' s care plan with a review of date of 7/21/20 included the following focus areas: - The risk for falls related to decreased physical function (initiated on 7/15/19). The interventions included, in part, ensuring Resident #1 ' s call light was within reach and encouraging her to use it for assistance as needed (initiated on 7/15/19). A Transfer/Mobility Status Criteria assessment	F 689	Resident #1 identified during the survey no longer resides in the facility Nurse Aide #1 identified during the during the survey was in-serviced by the Director of Nursing on adequate supervision and assistance during bed mobility with a resident requiring +2 assistance Completion on 10/2/20 All residents have the potential to be affected. Bed Mobility assessments were completed by Regional Nurse Consultant on current residents to determine assistance required by staff while in bed to include during bathing. The results of this audit showed all current residents were accurately coded for their current level of assistance on their care plan and Kardex (Completion date 10/14/20) Bed Mobility assessments will be completed on residents per change of condition, quarterly assessments, annually and admission/readmission by the admitting nurse. Director of Nursing/RN Nurse Manager will in-service nurses regarding these practices. Careplan and Kardex updated to reflect bed mobility status by Regional Nurse	

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F 689	Continued From page 6 form dated 8/13/20 indicated Resident #1 required extensive assistance to total dependence. The admission Minimum Data Set (MDS) assessment dated 8/20/20 indicated Resident #1 was cognitively intact. She required extensive assistance of 1 for bed mobility, she was dependent of 1 for dressing and toileting, and dependent of 2 or more for transfers. Resident #1 had impaired range of motion on one side of her lower extremities. She had no falls noted. A hard copy form, "Report of Resident Fall", dated 9/2/20 completed by Nurse #2 indicated Resident #1 had a fall with injury that was witnessed by Nursing Assistant (NA) #1 at 11:45 AM. Resident #1 rolled out of bed while "staff [was] cleaning resident". The resident was on the floor on her left side wedged between her bed and nightstand. Resident #1 ' s side of her head was pressed against the nightstand with blood drainage noted. Her left lower leg was observed with skin tears. Nurse #2 indicated Resident #1 was alert and oriented and complained of back and head pain. Under the possible causative factors section of the form, Nurse #2 indicated "bed remote in way". An SBAR (Situation Background Assessment Recommendation) change in condition electronic note dated 9/2/20 (was there a time) indicated Resident #1 had a witnessed fall from bed resulting in a laceration to left side of head and skin tears to left lower extremity. Resident #1 ' s left side of head was leaning on nightstand and blood was noted under the head on a blanket between the resident ' s head and the nightstand. During a pain assessment Resident #1 indicated	F 689	Consultant on 10/14/20 An in-service will be completed by the Director of Nursing/RN Nurse Manager for staff not limited to licensed nurses, certified nursing assistants, Personal Care Attendants for correct bed mobility. The education will include reporting change of condition for residents including but not limited to bathing, dressing, bathing, grooming, bed mobility and transferring, etc., reviewing and utilizing the Kardex information for resident care, transfer/bed mobility evaluation prior to care given by staff, reporting resident requiring more assistance to the Director of Nursing, Nurse, MDS, Therapy Director, utilizing the STOP AND WATCH form for change of condition, Fall Management, Fall Risk residents, Fall Risk Assessment form. Education will be given in orientation for new hires. Bed mobility assessment changes will be reported by the Director of Nursing/RN Nurse Manager during daily clinical meeting. Issues identified will be corrected immediately. Completion date (10/21/20) Director of Nursing/RN Nurse Manager will complete quality improvement monitoring on using a sample size of 5 resident□s bed mobility assessment (5) 2x weekly for 4 weeks, then 1x weekly for 2 months and then 1x monthly for 3 months. The Director of Nursing/RN Nurse Manager will report the results of the quality monitoring (audits) to the Quality Assurance Improvement Committee. The findings will be reviewed	

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F 689	Continued From page 7 an "aching back and throbbing head pain" at a rating of 8 on a scale of 1 to 10. The Nurse Practitioner (NP) was notified, and the resident was sent to the Emergency Department (ED) for evaluation and treatment. ED documentation dated 9/2/20 indicated Resident #1 rolled off bed while being cleaned up by staff, she hit her head on a dresser, and sustained wounds to her left leg. The physical exam showed a 2 centimeter (cm) linear scalp laceration to the head with minimal gaping as well as superficial scattered skin tears to lower extremity, and a large skin tear to the left lateral leg adjacent to the left knee approximately 8 cm x 8 cm. 2 staples were placed to Resident #1 ' s scalp laceration and her skin tears were cleansed, treated with antibiotic ointment, and dressed. The ED physician indicated that given the multiple scattered skin tears, Keflex (antibiotic medication) was ordered for outpatient therapy to prevent the development of bacterial infections. A nursing note dated 9/2/20 at 7:42 PM written by Nurse #1 indicated Resident #1 arrived back from hospital via Emergency Medical Services (EMS). She had 2 staples to the left upper forehead with some bleeding and skin tears to upper and lower outer leg. A review of the facility Nurse Aide Activity of Daily Living assistance documentation for Resident #1 from her most recent readmission on 8/13/20 to 9/2/20 revealed the following: - Bed Mobility: 3 total documented, 1 documented as dependent with 2+ assist (8/15/20 1st shift, 9/1/20 2nd shift), and 1 documented as dependent with 1 assist (9/2/20 2nd shift)	F 689	monthly by the Quality Assurance Improvement Committee and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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F 689	Continued From page 8	F 689		

The NA Care Guide, a guide that describes the resident ' s care needs, undated, indicated Resident #1 was incontinent of bowel and required 2 person assist with incontinence care, required total assistance of 2 staff members with mechanical lift for transfers, and required hands on assistance of one staff member to turn and reposition in bed.

An interview was conducted with NA #1 on 9/29/20 at 1:00 PM. NA #1 reported she was familiar with Resident #1 and was working with her at the time of her 9/2/20 fall from bed that occurred during care. She indicated that Resident #1 required assistance with ADLs and that when she became "sick" from COVID (confirmed positive 7/30/20) she needed additional assistance as she was weaker. She stated that once on the COVID unit Resident #1 required the assistance of 2 staff for a bed bath due to the increased weakness as well as her physical size, and it was too much for 1 person to do on their own safely. NA #1 indicated that Resident #1 was on the COVID unit on 9/2/20 and she and Nurse #2 were the only staff members working on the COVID unit as there were about 10 residents total on the unit. She stated that on 9/2/20 she needed to give Resident #1 a bed bath which required 2 staff members for assistance. NA #1 revealed that at the time of the bed bath, Nurse #2 was completing her medication pass and she had not wanted to interrupt her, so she gave the bed bath to Resident #1 without anyone else ' s assistance. She explained that once staff entered the COVID unit, they were not able to re-enter any other areas of the facility. She further explained that this was why she was unable to ask a staff member who was not assigned to the COVID unit

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for help. NA #1 indicated that when she was finishing up Resident #1 ' s bed bath on 9/2/20, she rolled Resident #1 onto her side, away from the center of the bed, in order to change her linens. She reported that she was then positioned on the opposite side of the bed as the resident. She stated that Resident #1 must have accidentally hit the bed remote which tilted the head of the bed up and subsequently caused her to roll off the bed and onto the floor. NA #1 stated that she was unable to stop Resident #1 from rolling as she was on the opposite side of the bed. She indicated that Resident #1 hit her head on her nightstand and had several cuts on her leg. She stated that she immediately called for help and Nurse #1 came to assist her. NA #1 revealed that she should have waited for assistance from Nurse #2 to provide the bed bath. She explained that if Nurse #2 was with her, that she would have been positioned on the side of the bed the resident had rolled off of and could have prevented the fall. NA #1 was asked how she knew how much assistance Resident #1 required. She stated that she was familiar with the resident and that she talked to the other NAs who worked with her.

An interview was conducted with NA #2 on 9/29/20 at 3:35 PM. She indicated that she was familiar with Resident #1 and that she required a 2 person assist for bed baths. She explained that this level of assistance was needed because of physical limitations and physical size.

An interview was conducted with Nurse #1 on 9/29/20 at 3:40 PM. Nurse #1 indicated she was familiar with Resident #1. She reported that once Resident #1 was diagnosed with COVID that she required the assistance of 2 for all ADL care with

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the exception of eating. Nurse #1 explained this was because of physical limitations and physical size.

A phone interview was conducted with Nurse #2 on 9/30/20 at 3:20 PM. She reported that she was familiar with Resident #1 and that she was working on the COVID unit at the time of her 9/2/20 fall from bed that occurred during care. She stated that on 9/2/20 she was in another resident ' s room when she heard NA #1 calling for help. She indicated that she stopped what she was doing and went into Resident #1 ' s room to assist NA #1. She stated she observed Resident #1 lying on the floor on the left side between the bed and the nightstand with her head against the nightstand. She reported that when she assessed the resident she had a laceration to the head, skin tears to her left leg, and the resident self-reported pain in her neck, back, and head. She stated that she wanted to transfer the resident from the floor to the bed, but was unable to secure a mechanical lift pad under the resident without additional staff assisting. She explained that she and NA #1 were not able to complete this task without help due to Resident #1 ' s bodyweight and her physical inability to bear weight at that time so the resident remained on the floor and EMS was called. Nurse #2 reiterated NA #1 ' s interview that once a staff member entered the COVID unit that they were unable to return to their previous assignment off of the COVID unit. She stated that she asked NA #1 what happened, and she said that she rolled Resident #1 onto her side and the resident must have either pressed the head tilt button on the remote or rolled on top of it, causing the head of the bed to raise up, and subsequently caused the resident to start rolling and she rolled right off the

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F 689	Continued From page 11 bed. Nurse #2 indicated that she was not sure what level of assistance Resident #1 normally required for bed baths, but that if NA #1 had asked her for help that she would have assisted when she was able. An interview was conducted with the DON on 9/29/20 at 1:40 PM. She stated that she began working at the facility in the beginning of August 2020. She indicated that she was familiar with Resident #1 and she completed an investigation into the 9/2/20 fall that occurred during care. The DON stated that she interviewed NA #1 and Nurse #2 in detail about the fall. During these interviews she determined that most often Resident #1 required 2+ assistance with ADL tasks of bed mobility, incontinent care, and bed baths. She stated that her investigation identified a twofold root cause for Resident #1 ' s 9/2/20 fall. The DON explained that 2 staff should have been used for Resident #1 ' s bed bath due to her care needs and that staff needed to ensure the bed control was positioned off of the bed to avoid any accidental pressing of the control. She reported that she began a PIP (Performance Improvement Plan) related to the 9/2/20 fall for Resident #1, but the plan had not been fully implemented as of 9/29/20. On 9/29/20 at 3:10 PM the DON provided a copy of the PIP and education inservices completed as of 9/29/20. A review of these documents revealed the PIP had not been fully implemented and education had not been completed.	F 689		
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.	F 756		10/21/20

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	345442	A. BUILDING _____ B. WING _____	C 10/01/2020

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F 756	Continued From page 12 §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and	F 756	Resident #3 currently resides at the	

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F 756	Continued From page 13 Pharmacy Consultant interview, the facility failed to act upon recommendations made by the Pharmacy Consultant for 1 of 3 residents (Resident #3) reviewed for unnecessary medications. The findings included: Resident #3 was initially admitted to the facility on 9/22/19 and most recently readmitted on 8/10/20 with diagnoses that included dementia, psychosis, and anxiety. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed for Resident #3 on 12/22/19. She was assessed with no involuntary movements. A physician ' s order dated 7/16/20 for Resident #3 indicated Quetiapine Fumarate (antipsychotic medication) 25 milligrams (mg) twice daily for delusions. A physician ' s order dated 8/10/20 discontinued Resident #3 ' s Quetiapine Fumarate and initiated Olanzapine (antipsychotic medication) 7.5 mg in the evening for delirium. A Pharmacy Consultation Report dated 8/13/20 indicated Resident #3 received Olanzapine which could cause involuntary movements, but an Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System: Condenser User Scale (DISCUS) assessment was not documented in the medical record within the previous 6 months. The Pharmacy Consultant recommended the completion of one of these monitoring assessments (AIMS or DISCUS) now and at least every 6 months thereafter or per	F 756	facility. Pharmacy consultation was obtained and reviewed and Abnormal Involuntary Movement Scale (AIMS) was completed (10/01/2020) for Resident #3 immediately per the recommendation of the pharmacist. Director of Nursing identified during the survey was in- serviced by the Regional Nurse Consultant on following up on recommendations with the Medical Director, downloading Pharmacist Consultant reports through Omniview monthly. If follow-up not completed within the specified time frame (14 days after receiving recommendations), then notification is to be made to the Medical Director by the Director of Nursing/Executive Director to notify that physician with outstanding pharmacy recommendations. Pharmacy Consultant identified during the survey was in-service by the Regional Nurse Consultant on entering and exiting with Director of Nursing and Administrator at the end of their monthly visit. Completion 10/14/20 All residents have the potential to be affected. An audit was completed on 10-13-20 by the Director of Nursing/Nurse Manager to determine whether the Pharmacy recommendations were completed for all current residents. The results of the audit showed that all pharmacy recommendations had been completed timely. Pharmacy recommendations will be completed per Pharmacy Consultant to include reviewing and completion in a timely manner (within 21 days after	

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F 756	Continued From page 14 facility protocol as early detection of involuntary movements could prevent potentially irreversible side effects. This Pharmacy Consultant ' s recommendation was addressed to the facility ' s former Director of Nursing (DON). The form required a signature from the former DON, and the signature line was blank. The quarterly Minimum Data Set (MDS) assessment dated 9/3/20 indicated Resident #3 ' s cognition was intact, and she received antipsychotic medication on 7 of 7 days. A review of Resident #3 ' s active physician ' s orders was conducted on 9/30/20 and revealed the 8/10/20 order for Olanzapine was an active order. A review of Resident #3 ' s medical record on 9/30/20 revealed no AIMS assessment, or any other involuntary movement assessment had been completed for Resident #3 since 12/22/19. During a phone interview with the Pharmacy Consultant on 10/1/20 at 10:11 AM she reported that she 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. She explained that routine AIMS assessments for residents on antipsychotic medication were necessary due to the potential irreversible side effects of antipsychotic medications. The 8/13/20 pharmacy recommendation for an AIMS assessment to be completed for Resident #3 was reviewed with the Pharmacy Consultant. She	F 756	receiving recommendations from Pharmacy Consultant) by Director of Nursing/Nurse Manager An in-service will be completed for current licensed nurses by the Director of Nursing/Nurse Manager to include reviewing and completion in a timely manner of Pharmacy consults, follow-up on pharmacy recommendations per nursing and Medical Director within a timely manner. Completion 10/21/20. Issues identified will be corrected immediately and will also be taken to daily clinical meeting Completion 10/21/20 Director of Nursing/Nurse Manager will conduct quality improvement monitoring (audit) of pharmacy recommendations using a sample of size of 5 residents to ensure compliance with timely completion. Quality improvement monitoring will be completed 2x weekly for 1 month, then 1x weekly for 2 months and then 1x monthly for 3 months. The Director of Nursing /Nurse Manager will report the results of the quality monitoring (audits) to the Quality Assurance Improvement Committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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F 756	Continued From page 15	F 756		

stated she was not sure if the facility had acted upon her recommendation. She indicated she needed to review her records.

On 10/1/20 at 11:02 AM the Director of Nursing (DON) requested a three way conference call interview be conducted with herself and the Pharmacy Consultant. The Pharmacy Consultant and the DON revealed the 8/13/20 pharmacy recommendation for the completion of an AIMS assessment for Resident #3 had not been acted upon by the facility.
The DON explained that she began working at the facility in the beginning of August 2020 and the former DON ceased working at the facility. The Pharmacy Consultant stated that she was not aware of the DON transition, so she sent the August 2020 monthly drug regimen reviews (DRRs) and recommendations to the former DON by electronic mail. The Pharmacy Consultant and DON both indicated that they were unaware until today (10/1/20) that the August 2020 DRRs and recommendations had not been reviewed and/or acted upon. The Pharmacy Consultant explained that her September 2020 DRRs were completed on 9/3/20 and she typically gave 30 days before making a repeat recommendation, so she would have made repeat recommendations from the August 2020 DRRs (completed 8/13/20) during her October 2020 DRRs. The DON reported she expected pharmacy recommendations to be reviewed and separated into recommendations for nursing and recommendations for the physician on the date of their receipt from the Pharmacy Consultant. She indicated that she expected the nursing recommendations to then be reviewed and acted upon within the next day or two. The DON further indicated that this expectation was not met as Resident #3 ' s

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F 756	Continued From page 16 8/13/20 pharmacy recommendation for the completion of an AIMS assessment was not acted upon.	F 756		
F 758 SS=D	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 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	F 758		10/21/20

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F 758	Continued From page 17 §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 resident, staff, and Pharmacy Consultant, the facility failed to assess a resident on antipsychotic medication for extrapyramidal symptoms (EPS), a drug induced movement disorder, for 1 of 3 residents (Resident #3) reviewed for unnecessary medications. The findings included: Resident #3 was initially admitted to the facility on 9/22/19 and most recently readmitted on 8/10/20 with diagnoses that included dementia, psychosis, and anxiety. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed for Resident #3 on 12/22/19. She was assessed with no involuntary movements. A physician ' s order dated 7/16/20 for Resident #3 indicated Quetiapine Fumarate (antipsychotic	F 758	Resident #3 current resides at the facility. Resident #3 identified during the survey was immediately corrected with an updated AIMS (Identified antipsychotic medication, Side effects of antipsychotic drugs) Director of Nursing identified during the survey was in- serviced by the Regional Nurse Consultant on following up on recommendations with the Medical Director, downloading Pharmacist Consultant reports through Omniview monthly. Completion (10/14/20) All residents have the potential to be affected by this deficient practice. The DON/Nurse Manager completed a quality review (audit) for the current facility residents receiving psychotropic medications (Anti-depressants, Anxiolytics, Hypnotics and Antipsychotics) to ensure compliance with AIMS	

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F 758	Continued From page 18 medication) 25 milligrams (mg) twice daily for delusions. A physician ' s order dated 8/10/20 discontinued Resident #3 ' s Quetiapine Fumarate and initiated Olanzapine (antipsychotic medication) 7.5 mg in the evening for delirium. The quarterly Minimum Data Set (MDS) assessment dated 9/3/20 indicated Resident #3 ' s cognition was intact. She had no behaviors and no rejection of care. Resident #3 received antipsychotic medication on 7 of 7 days. Resident #3 ' s care plan, last reviewed on 9/18/20, included a focus area related to the use of antipsychotic medication. The interventions included, in part, administering the antipsychotic medication as ordered and monitoring for behavioral symptoms. A review of Resident #3 ' s active physician ' s orders was conducted on 9/30/20 and revealed the 8/10/20 order for Olanzapine was an active order. A review of the physician ' s orders for Resident #3 from admission on 9/22/19 through 9/30/20 indicated antipsychotic medication was first initiated for the resident on 7/16/20 with the order for Quetiapine Fumarate. A review of the medical record revealed no AIMS assessment, or any other involuntary movement assessment had been completed for Resident #3 since 12/22/19. An interview and observation were conducted with Resident #3 on 9/29/20 at 12:15 PM. Resident #3 was alert and oriented and reported no concerns with her medications or medication	F 758	assessments, as AIMS are to be completed on residents at the time of admission, readmission, initiation of new medication, change of medication and as per pharmacy consultant. Two additional AIMS assessments were completed during the audit, however they were within the 6 month requirement and were regularly scheduled and completed accurately and on time. (completion 10/14/20) Findings from this quality review were corrected by the DON/Nurse Manager at the time of identification. (Completion 10/14/20) An in-service will be completed for current licensed nurses by Director of Nursing/Nurse Manager to include residents receiving psychotropic medications (Anti-depressants, Anxiolytics, Hypnotics and Antipsychotics) to ensure compliance with AIMS assessments, as AIMS are to be completed on residents at the time of admission, readmission, initiation of new medication, change of medication and as per pharmacy consultant. (Completion 10/21/20) The Director of Nursing conducted training with the Interdisciplinary Team to ensure they understood that they are to conduct an AT RISK MEETING together each week to include review of residents receiving psychotropic medications (Anti-depressants, Anxiolytics, Hypnotics and Antipsychotics) to ensure compliance with AIMS assessments. Initiated as of 9/24/20	

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F 758	Continued From page 19 side effects. She was observed with no abnormal involuntary movements. A phone interview was conducted with the Director of Nursing (DON) on 10/1/20 at 9:55 AM. She stated that she began working at the facility in early August 2020. 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. The DON indicated that the AIMS assessments were located in the Electronic Medical Record (EMR). She stated the EMR automatically populated the AIMS assessment for the nurse to complete when it was due. She reported that the nurse who was working at the time the assessment populated in the EMR was responsible for its completion. Resident #3 ' s last AIMS assessment dated 12/22/19 was reviewed with the DON. The DON confirmed this was the most recent AIMS assessment completed for Resident #3. She revealed she had not known why the EMR had not automatically populated the AIMS assessment for the nurse to complete. She indicated that an AIMS assessment needed to be completed for Resident #3 as it was never completed when antipsychotic medication was initiated (7/16/20). During a phone interview with the Pharmacy Consultant on 10/1/20 at 10:11 AM she reported that antipsychotic medications could cause involuntary movement disorders. She indicated this was why it was pertinent to complete an AIMS assessment or other assessment of involuntary movement on admission for residents admitted on antipsychotic medication, on initiation of antipsychotic medication if the resident was	F 758	The Director of Nursing/Nurse Manager will conduct quality improvement monitoring to ensure compliance with AIMS assessments 2x weekly for 1 month, then 1x weekly for 2 months and then 1x monthly for 3 months. The Director of Nursing /Nurse Manager will report the results of the quality monitoring (audits) to the Quality Assurance Improvement Committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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F 758	Continued From page 20 started on the antipsychotic while at the facility, and then every 6 months thereafter as long as the antipsychotic medication was in use. She explained that routine AIMS assessments for residents taking antipsychotic medication were necessary due to the potential irreversible side effects of the medications.	F 758		