STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING ______ B. WING ______	C 08/13/2015

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UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST 5TH STREET GREENVILLE, NC 27834

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey of 08/13/2015 . Event ID # IXGC11	F 000		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility did not provide grooming services for 1 of 1 residents (Resident #41) who needed to be shaved. Findings included: The facility's undated procedure for shaving the resident noted the purpose was to remove facial hair and to improve the resident's appearance and self esteem. Resident #41 was admitted to the facility on 08/18/14 and readmitted on 12/05/14. Cumulative diagnoses included hypertension, heart failure, depression, and psychosis. Resident #41's Annual Minimum Data Set (MDS) assessment of 06/08/15 noted he was moderately impaired with decision making. He needed extensive assistance with hygiene and bathing. There were no behaviors noted in this assessment. There were no identified problems	F 312	F 312 Resident #41 was provided ADL care, including shaving by CNA on 8/13/15. Current Residents were assessed for ADL needs for grooming and shaving by the DON and Administrative Nurses. Any needed care found was completed immediately and grooming and/or shaving is completed daily and as needed as of 8/14/15. Resident care guide and care plans were reviewed by the MDS Nurse and have been updated to reflect Resident's ADL, grooming and shaving needs as of 8/28/15. CNA #4 was in-serviced on proper procedure for am care for Resident #14 which included shaving. 8/14/15	8/28/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/28/2015

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 312	Continued From page 1 with shaving noted in his care plan. Resident #41 was observed sitting in a chair in his room on 08/11/15 at 12:00 PM. He was wearing street clothes. He was noted to have several days growth of facial hair. Resident #41 was observed again on 08/12/15 at 2:25 PM. He stated he had not been shaved and would like to be shaved. He also stated he wasn't feeling well and wanted to get back into bed. Facial hair was noted to his face and neck. During another observation of Resident #41, on 08/13/15 at 10:10 AM, the facial hair remained. When questioned, he stated he would like to be shaved. On 08/13/15 at 12:15 PM, Resident #41 was observed sitting in a chair in his room with a blanket over his head. It was noted that he had been shaved. During an interview with Nurse Aide #4, on 08/13/15 at 12:20 PM, she stated she had not shaved Resident #41 until today. She stated she worked with him on Tuesday and Wednesday of this week. She stated she had planned on shaving him yesterday but she ran out of time and forgot to mention it to the second shift aide before she left. NA #4 added that she had hoped second shift would shave him but when she saw him this morning he still needed to be shaved. NA #4 also stated that Resident #41 liked to be shaved often and did not refuse care. During an interview with the Director of Nurses (DON) and the Assistant Director of Nurses (ADON), on 08/13/15 at 3:50 PM, the ADON	F 312	SDC, DON, ADON in-serviced CNA's on providing ADL care, including grooming/shaving to Residents timely. Re-training included following: ADL care, groomed/shaving is to be provided timely to all residents as needed or as requested by Resident. CNA's are to ask Resident if they want to be shaved during daily ADL care and act upon Resident's wishes. In-service training to be completed by 8/28/15. Any CNA that has not completed the training by 8/28/15 will not be allowed to work until the training is completed. ADL, grooming and shaving care will be included in the new nursing employee orientation program beginning. 8/14/15 DON and/or Administrative nurses will monitor ADL, grooming/shaving care for current Residents daily x2 weeks; weekly x6 weeks; then monthly x2 months starting 8/28/15. Any discrepancies noted will be corrected. Employee will be re-educated and counseled according to the progressive disciplinary policy. DON will compile a summary of all monitoring efforts / tools and present to monthly QAPI meeting x4 months to ensure compliance is maintained. 8/28/15	

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F 312	Continued From page 2 stated residents should be shaved during morning care. The DON stated shaving should be done whenever it was needed or upon request.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility did not provide pressure ulcer dressing changes as needed after incontinent care for one of one resident, Resident #150, who was reviewed for pressure ulcer treatment. Findings included: The facility's Wound Assessment Report dated 05/05/2015 indicated that Resident #150 had a sacral pressure ulcer identified which was acquired in-house (in the facility.) Resident #150's nursing care plan which was initiated on 05/15/2015 included a goal for the stage 4 sacral pressure ulcer to decrease in size. Interventions included providing assistance with repositioning, encouraging good nutritional intake, weekly evaluation of wound healing, monitoring	F 314	F 314 Resident #150 was provided wound care/dressing change by Treatment Nurse on 8/13/15. CNA #6 & #7 received consultation regarding incontinence care to Resident #150. Reminded the importance of notifying the Hall Nurse and/or Treatment Nurse of any changed needed for wound care, if dressing is soiled or dislodged during care to ensure dressing are changed timely if needed. 8/28/15 The DON along with The Treatment Nurse checked current residents with wound dressings to identify any other	8/28/15

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F 314	Continued From page 3 for changes in skin status, and providing wound care based upon the physician's orders. There were additional interventions in place to address the potential for skin breakdown. A review of the most quarterly Minimum Data Set (MDS) assessment dated 07/28/2015 indicated that Resident #150 was initially admitted to the facility on 04/28/2015 and that he was cognitively intact. According to the assessment, Resident # 150 had partial list of diagnoses including diabetes mellitus and quadriplegia, and was totally dependent upon staff for his personal hygiene, bathing, bed mobility, and transfers. The same assessment indicated he was totally incontinent of his bladder and bowel. The Wound Assessment Report dated 07/28/2015 indicated the unstageable sacral pressure ulcer was measuring 10 centimeters (cm) by 9.5 cm by 5.0 cm with 45% granulation and 55% slough. A review of the physician's orders revealed there was an order dated 08/07/2015 to clean the sacral wound with normal saline, apply [Brand Name] (debriding ointment) to the wound bed, and cover with a moist to dry dressing until healed. The Wound Assessment Report dated 08/04/2015 revealed the sacral pressure ulcer had become a stage 4 pressure ulcer from an unstageable wound (this meant that the pressure ulcer was improving) with measurements of 9.2 cm by 6.0 cm by 5.0 cm, with 70% granulation and 30% slough. In an observation of the sacral pressure ulcer	F 314	Resident that could have been affected by the alleged deficient practice to make sure wound dressing were not soiled or dislodged. There were no other Residents found to have wound treatment dressings that were soiled or dislodged. 8/13/15 CNA's are to report immediately to the Charge Nurse or Treatment Nurse if at any time during ADL care if wound dressing has been compromised to ensure wound treatment is obtained timely. Wound care needs have been added on care guides, care plans, and ADL books to ensure CNA's are aware of wound/treatment needs for each Resident. 8/28/15 DON and/or Administrative Nurses in serviced CNA's regarding the importance of immediate notification of charge nurse any time that a wound dressing becomes soiled or comes off during ADL care. 8/28/15 DON, Administrative Nurses will utilize daily round sheets to monitor wound dressings during ADL care randomly x4 weeks to ensure wound dressing(s) have not been compromised/soiled and changed timely if needed. 8/28/15 DON will compile a summary of all monitoring efforts / tools and present to monthly QAPI meeting x4 months to ensure compliance is maintained. 8/28/15	

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treatment on 08/12/2015 at 9:50 AM, the treatment nurse provided pressure ulcer treatment per the current order to cleanse with normal saline, apply [Brand Name] (debriding ointment), pack with wet to dry dressing daily until healed. The treatment nurse covered the dressing with dry gauze and dry cover dressing, then secured the dressing into place with tape around the edges. During the observation, the sacral ulcer was observed to extend from the sacral bone down toward the rectal area. The wound bed appeared to have healthy red granulation tissue with 30% slough, and there was no sign of infection, such as thick purulent drainage or strong odor.

In an interview with the treatment nurse after the sacral dressing changed on 08/12/2015 at 10:20 AM, she stated that the dressing was often changed more than once per day due to the location of the pressure ulcer near the rectal area. She explained that whenever the dressing was soiled from urine or stool, it needed to be changed.

A progress note dated 08/12/2015 indicated that the sacral wound continued to improve and that the wound bed consisted of 70% granulation tissue and 30% slough.

During an observation of Resident #150 on 08/12/2015 at 2:18 PM, his pants were noted to be wet around the seat as he sat up in his specialized wheelchair.

On 08/12/2015 at 2:22 PM, an observation of urinary incontinent care provided by NA #6 and NA #7 for Resident #150 was made. NA #6 and NA #& used the mechanical lift to transfer the

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resident back into his bed from his wheelchair in order to provide the incontinent care. During the provision of care, the resident's sacral pressure ulcer dressing was noted to be un-taped and loose on three sides of the outer dressing, and the wet to dry gauze portion was falling out of the gluteal fold where the pressure ulcer extended from the sacrum toward the rectal area. NA #6 pushed the urine soiled wet to dry dressing gauze back into place (into the gluteal fold) with her gloved hand as she applied a clean disposable brief. After the incontinent care was provided, NA #6 and NA #7 used the mechanical lift to get the resident back into his wheelchair.

In an interview with NA #6 following the incontinent care on 08/12/2015 at 2:45 PM, NA #6 stated she would tell the treatment nurse if the resident had had a bowel movement, or if the resident was really wet from urine so that she would know to change the dressing. She stated the resident's dressing probably wasn't sticking to his skin due to the moisture from the urine.

In an interview with the treatment nurse on 08/12/2015 at 3:25 PM, she stated she thought NA #6 had left the facility already from her 7:00 AM to 3:00 PM shift, and that NA #6 had not reported to her that Resident #150 needed to have his sacral pressure ulcer dressing checked after the incontinent care. The treatment nurse stated she would check on it.

On 08/12/2015 at 5:15 PM, the treatment nurse reported she attempted to change Resident #150 ' s sacral dressing, but refused because he was not ready to go back to bed.

On 08/12/2015 at 5:30 PM, the Assistant Director

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F 314	Continued From page 6	F 314		

of Nursing (ADON) reported that Resident #150 agreed to have his sacral pressure ulcer dressing checked after she spoke with him. The ADON explained, however, that meal trays had just arrived on his hall, so it was not possible to provide a dressing check at that time.

At 9:23 AM on 08/13/2015 an observation of a pressure ulcer dressing change provided by the treatment nurse was made. When the treatment nurse removed the resident's disposable brief, the pressure ulcer dressing was located on the resident's right ischial area rather than on the sacral site where the pressure ulcer was located. The sacral ulcer was fully exposed. The date on the dressing was 08/12/2015. The resident's wound bed appeared to have more areas of necrosis than on the previous observation on 08/12/2015 at 9:50 AM.

A review of the progress note dated 08/13/2015 by the treatment nurse indicated that the wound condition has slightly worsened since the previous day and that it was not as beefy red and granulated. In addition the note stated that there was increased depth at the center of the wound.

In an interview with the treatment nurse on 08/13/2015 at 2:17 PM, she stated that the resident never did get his sacral dressing changed after the episode of incontinence on 08/12/2015 because the resident had refused to go back to bed to receive the dressing change. The treatment nurse stated that she felt the dressing would be changed after the resident finally went back to bed for the night. In addition, she stated that when she was not present in the facility, the assigned hall nurse was responsible for the pressure ulcer dressing changes, and that

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F 314	Continued From page 7 the night nurse could have changed the dressing. The treatment nurse further explained that the dressing which was present on the right ischial area when the dressing was changed on 08/13/2015 at 9:23 AM was the same dressing she had applied, signed, and dated the day before on 08/12/2015, and that it evidently had migrated over to the ischial area since the last dressing change. Finally, the treatment nurse stated that when a dressing needed to be changed during or right after incontinent care, the nursing assistant usually would page her in order to provide the dressing change. In an interview on 08/13/2015 at 12:25 PM with Nurse #2, the nurse who was assigned to the resident on the 11:00 PM to 7:00 AM shift on 08/12/2015, she stated that she had not provided a sacral pressure ulcer change on her shift. Nurse #2 stated she relied on the nursing assistants to report to her if a resident's dressing was saturated with urine or feces in order to know whether to change the dressing. On 08/13/2015 at 12:23 PM, an attempt was made to contact Nurse #8, the 3:00 to 11:00 PM nurse assigned to Resident #150 on 08/12/2015, but the attempt was unsuccessful. Three more attempts were made on the same date. An interview with the Assistant Director of Nursing on 08/13/2015 at 2:36 PM, she stated that she would have expected for NA #6 to report to the hall nurse or the treatment nurse that the dressing was soiled and needed to be changed. The ADON also stated that she would not want the nursing assistant to push a soiled dressing back into the wound if it fell out. She added that she did not know why the nursing assistant did	F 314		

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F 314	Continued From page 8 not notify the nurse while the resident was still in bed from the incontinent care about the soiled dressing so that it could be changed at that time. In addition, she explained that there had been times when Resident #150 had refused to comply with the nurse's recommendations to go back to bed, but that the resident had been in bed all night, so the dressing should have been changed. NA #5 was interviewed on 08/13/2015 at 3:00 PM. During the interview, she stated that she routinely changed Resident #150 every 2 hours on the 3:00 PM to 11:00 PM shift on 08/12/2015, and that when she provided incontinent care on her shift on 08/12/2015, the sacral pressure ulcer dressing was intact and there was no need to inform the hall nurse that the dressing needed to be checked.	F 314		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, resident interview, staff interview, and record review the facility failed to limit the fluids it provided to 1 of 1 sampled dialysis residents (Resident #37) in order to meet the fluid restriction ordered by the physician. Findings included: Resident #37 was admitted to the facility on 10/15/10 and readmitted 05/13/15. The	F 327	F 327 Attending Physician reassessed Resident #37 and revised fluid restriction to 1200cc daily. Facility Registered Dietician completed fluid breakdown and this breakdown was added to Resident #37 tray card for all meals. MAR, CNA care guide and care plan was updated with the new orders 8/13/15.	8/28/15

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F 327	Continued From page 9 resident's documented diagnoses included end stage renal disease (ESRD) with hemodialysis, congestive heart failure (CHF), and hypertension. A 04/07/15 progress note from the registered dietitian (RD) documented Resident #37 was being placed on a fluid restriction. (However, later progress notes from the RD on 05/08/15, 05/15/15, 06/24/15, 07/10/15 did not address this fluid restriction). A 04/08/15 physician order and a 04/08/15 diet order form documented Resident #37 was being placed on a 1,000 cubic centimeter (cc) fluid restriction. On 04/11/15 " I have the potential for constipation and fluid volume deficit due to use of a diuretic, 1,000 cc/day fluid restriction and receiving dialysis three times per week" was identified as a problem in Resident #37's care plan. Interventions to this problem included offering an amount of fluid within the parameters of a 1,000 cc/day fluid restriction. On 04/11/15 "I require renal dialysis due to diagnosis of ESRD" was identified as a problem in the resident's care plan. Interventions to this problem included "Monitor my fluid intake." On 05/11/15 "I am at risk for alteration in nutrition related to dx (diagnoses): diabetes and ESRD, a therapeutic diet and r/t (in regard to) being non-compliant with my diet/fluid restriction. Diet: RCS (restricted concentrated sweets), NAS (no-added salt), Regular Texture, double eggs and meats with trays, fluid restriction 1,000 cc/day" was identified as a problem in the resident's care plan. Interventions to this problem	F 327	Attending Physician had a lengthy discussion with Resident #37 and explained to him importance of him complying to the restriction and consequences if he decides not to follow. resident #37 acknowledged that he understood but made decision to decline the fluid restrictions. There are no other Residents that have an order for fluid restrictions in the facility. 8/13/15 In the event new orders for fluid restrictions are received in future for any Resident: Physician will be contacted to verify order, RD will be contacted for fluid breakdown for Dietary and Nursing staff to follow, Resident will be made aware of fluid restriction orders with breakdown, Dietary will document fluid restrictions on tray cards & review to have fluid restrictions with Dietary staff to ensure fluid is served with meals appropirately. 8/14/15 DON and Administrative Nurses re-trained CNA's on documenting fluid intake on flow sheet for fluid intake for each meal. Charge Nurse's were re-trained on documenting on flow sheet in front of Resident's MAR for intake of fluids during Med passes. Dietary Manager in-serviced Dietary cooks/Aides on Resident with fluid restrictions: make sue they are reading tray card carefully to ensure tray cards are	

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F 327	Continued From page 10 included providing the diet as ordered and monitoring for signs of fluid overload. Resident #37's 07/06/15 quarterly minimum data set (MDS) documented his cognition was intact, he did not reject care, he was independent in eating once meal set-up was completed, he was on a therapeutic diet, and he received dialysis. At 12:50 PM on 08/12/15 Resident #37's lunch tray slip documented he was to receive two unsweet teas, chicken noodle soup, and a Glucerna shake. The tray slip did not document the resident was on a fluid restriction. Resident #37 actually received two 8-ounce cups of unsweet tea, and a 8-ounce bowl of chicken noodle soup (providing 960 cc of fluid). At 5:52 PM on 08/12/15 Resident #37's supper tray slip documented he was to receive unsweet tea only and chicken noodle soup. The tray slip did not document the resident was on a fluid restriction. Resident #37 actually received two 8-ounce cups of unsweet tea, and a 8-ounce bowl of chicken noodle soup (providing 960 cc of fluid). At this time the dietary manager (DM) stated the chicken noodle soup was a special request from the resident, and the resident was non-compliant with his fluid restriction. She explained he kept diet sodas in a cooler in his room. The DM commented she educated the resident on why it was important to limit his fluids. At 8:48 AM on 08/13/15 Resident #37's tray slip documented he was to receive apple juice, water, and milk. The tray slip did not document the resident was on a fluid restriction. Resident #37 actually received a 4-ounce cup of apple juice, eight ounces of milk, and eight ounces of water	F 327	followed accurately. 8/28/15 DON and/or Administrative Nurses will utilize daily round sheets to monitor documentation of fluid intake sheets daily x4 weeks, then weekly x2 months. to ensure continued compliance with resident fluid restrictions. DON will compile a summary of all monitoring efforts / tools and present to monthly QAPI meeting x4 months to ensure compliance is maintained. 8/28/15	

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(providing 760 cc of fluid). At this time Resident #37 stated they had talked to him at dialysis about cutting back on his fluids. However, he reported he was letting dietary keep track of that for him, and they had not said anything to him, so he assumed he was meeting dialysis fluid restrictions.

At 9:07 AM on 08/13/15 the DM stated she had not been provided with an amount of fluid which the dietary department should be providing to Resident #37 on his meal trays and with his facility-provided snacks. She reported that usually the nursing department or the physician would break out the amount of fluid to be provided by dietary and the amount to be provided by nursing when residents were placed on fluid restrictions.

At 9:50 AM on 08/13/15 the director of nursing (DON) stated Resident #37 should currently still be on a fluid restriction. She reported the fluid restriction was important for the resident because he was just in the hospital on 05/14/15 and 05/15/15 due to fluid overload with a diagnosis of CHF. She commented the RD usually determined how much fluid in the restriction was to be provided by dietary and how much was to be provided by nursing. According to the DON, since Resident #37 had a history of liking diet sodas and soups, she thought it might be of benefit to consult with the physician and dialysis center to see what should be done about the fluid restriction order.

At 10:40 AM on 08/13/15, during a telephone conversation, the RD stated she used to break down the fluid allowed in fluid restrictions according to how much was to be provided by dietary and how much was to be provided by

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F 327	Continued From page 12 nursing. However, she reported this responsibility had been removed from her, and she was told that the physician or physician assistant would make those fluid determinations. At 12:18 PM on 08/13/15 Resident #37's primary physician stated the resident was supposed to be on a fluid restriction per recommendations from the dialysis physician, and he would not consider discontinuing the resident's fluid restriction due to the resident's health concerns of CHF and ESRD. However, after conversation with Resident #37, he commented he might consider changing the amount of fluid in the restriction. The physician stated he was not aware he was supposed to break down the fluid allowed in a restriction by the amount that could be provided by dietary and then by nursing.	F 327		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		8/28/15

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drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, staff, pharmacist and physician interviews, the facility did not provide a risk versus benefit statement for the continued use of antipsychotic medications for 2 of 5 residents (Resident #10 and #41) whose medications were reviewed. Findings included:

1.Resident #10 was admitted to the facility on 01/27/11. Cumulative diagnoses included congestive heart failure, psychosis and dementia with behaviors.

The facility's Medication Monitoring policy, last revised 11/01/11, noted that when a resident's clinical condition improved or stabilized, the resident was to be evaluated for the appropriateness of a taper or gradual dose reduction (GDR) of the medication. It was noted in the antipsychotics section that if a resident was admitted on an antipsychotic medication or the facility initiated antipsychotic therapy, the facility must attempt a GDR in 2 separate quarters with at least a month between attempts within the first year unless clinically contraindicated. According to this policy, a GDR was considered clinically contraindicated if the "Target symptoms returned or worsened after the most recent attempt" and

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F 329

Attending Physician for Residents #41 and #10 reviewed their current antipsychotic medication usage and completed the risk versus benefit statement for continued or discontinued use of antipsychotic medication. 8/13/15

DON requested current list of all residents receiving antipsychotic medication from the pharmacy. DON meet with Attending Physician for these Residents and reviewed current usage needs of the antipsychotic medication. Attending Physician documented his justification for continued or discontinued use of the medication and completed the risk verses benefit statement.

DON will obtain facility Pharmacist recommendations monthly and will meet with Resident Attending Physician weekly to ensure Physician completes approval/decline(s) of antipsychotic medications, and completes risk versus benefit statement if needed. 8/28/15

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F 329	Continued From page 14 the physician documented the "clinical rationale for why any additional attempted dose reductions" would likely impair the resident's function, increase distressed behavior or cause psychiatric instability. It was also noted that a GDR was clinically contraindicated if the continued use was in accordance with relevant current practice standards and the physician documented the clinical rationale for why any additional attempted dose reductions would likely "impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder." A physician's order of 09/22/14 noted to administer Seroquel 200 mg (milligrams) at bedtime for psychosis as evidenced by paranoia. A drug regimen review of 09/24/14 noted that Seroquel was increased to 200 mg (milligrams) at bedtime for psychosis and paranoia. Resident #10's care plan identified a potential alteration in behaviors with an onset date of 12/31/14. It was noted that Resident #10 was verbally abusive, had paranoid ideations, and was resistant to care. It was noted that the pharmacy consultant would review her medication monthly. Staff were to monitor her behaviors and mood. Psychiatry referrals were to be made as needed. A progress note from psychiatry services of 01/16/15 noted Resident #10 was seen for delusions and anxiety. It was noted that she continued to have anxiety and paranoia regarding the theft of her belongings by her daughter and staff members. Staff report she had been somewhat anxious. The plan was to increase Lexapro to help with anxiety.	F 329	DON will compile a summary of all monitoring efforts / tools and present to monthly QAPI meeting x4 months to ensure compliance is maintained. 8/28/15	

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A general note of 02/09/15 from pharmacy noted follow Resident #10's mood and behaviors. It was noted no changes were made to the Lexapro or the Xanax. There were no new recommendations made. There was no request to attempt a GDR or a risk versus benefit statement for the continued use of the Seroquel.

A general note of 03/10/15 from pharmacy noted to follow Resident #10's mood and behaviors. It was noted that psychosis was the diagnosis for the use of Seroquel and it had been increased in September of 2014. There were no new recommendations made.

The Quarterly Minimum Data Set (MDS) assessment of 03/20/15 noted Resident #10 had no behaviors.

The Quarterly MDS assessment of 04/03/15 noted no behaviors for Resident #10.

A general note from pharmacy of 04/08/15 noted follow Resident #10's mood and behaviors. There were no new recommendations made.

The May 2015 behavior monitoring sheet for Resident #10 noted 2 behaviors for the month.

A general note from pharmacy of 05/12/15 noted to follow Resident #10's mood and behaviors with a diagnosis of psychosis for the Seroquel. There were no new recommendations.

A general note of 06/03/15 at 10:36 AM noted Resident #10 had increased agitation this morning while sitting in the hallway with other residents in front of her. She was asking them to

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F 329	Continued From page 16 move then pushing the resident out of her way with her wheelchair and not giving them time to move. Resident #10 was going to the dining room and saying move out of "my way" . A progress note from psychiatry services of 06/04/15 indicated Resident #10 was seen for delusions. It was noted that she continued to have a belief that her daughter and the hall nurse have taken her glasses and sold them to the drug dealer. She had no significant disruption to her daily functioning and there were no recommendations made other than to continue current psychotropic medications. The June 2015 behavior monitoring sheet for Resident #10 noted 2 behaviors which consisted of hitting and running into others. A general note from pharmacy of 06/15/15 noted to follow Resident #10's mood and behaviors. The diagnosis of psychosis was noted for the Seroquel. It was also noted that a gradual dose reduction (GDR) was not clinically appropriate at this time. There was no note that the pharmacy had provided the physician with a request for a GDR and/or a risk versus benefit for the continued use of the Seroquel. A general note of 06/30/15 at 10:12 PM noted Resident #10 had refused eye drops as she believed they were poisoned. The July 2015 behavior monitoring sheet noted Resident #10 had no behaviors. The Quarterly MDS assessment of 07/03/15 noted no behaviors for Resident #10.	F 329		

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F 329	Continued From page 17 A progress note from psychiatry services of 07/06/15 noted Resident #10 was seen as a routine follow-up for delusions. The history of present illness noted that she had a history of dementia with behavioral disturbances and psychosis, insomnia, depression and anxiety. It was noted that she was maintaining her recent level of functioning on her current psychotropic medications. It was noted that she had been treated with antibiotics for cellulitis of recent. She had no worsening paranoia. It was noted that Resident #10 remained on a low dose of Trazodone to help with sleep continuity. She was also on Seroquel at night. It was noted that the plan was to attempt reduction of night time medications and monitor her for sleep. The recommendation was to discontinue the Trazodone. A general note from pharmacy of 07/13/15 noted follow Resident #10's mood and behaviors. It was noted that per nurse notes she had exhibited increased agitation. Psychiatry consult notes of 06/04/15 noted that Resident #10 believed her glasses were stolen. The pharmacy noted that a GDR was not clinically appropriate at this time due to the recent change of Trazodone. Behaviors were noted of 3 episodes of biting and one time of running into others. It was noted that the Seroquel had been increased in September of 2014. No new recommendations were made. There was no request to the physician asking for a risk versus benefit for the continued use of the Seroquel. A general note of 07/31/15 at 11:34 AM noted that Resident #10 was taking pads from the linen cart and got upset when she was asked to wait until the laundry brought out more pads. Resident #10	F 329		

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exhibited paranoia by saying staff were trying to poison her. It was also noted that she told the writer that the drug dealer would not allow her daughter to visit.

The August 2015 physician's orders for Resident #10 noted she was receiving Seroquel 200 milligrams for psychosis and paranoia.

A general note of 08/03/15 at 8:34 PM noted that Resident #10 was seen by psychiatry services today. New orders were obtained to change Xanax 0.5 milligrams to bedtime and to hold if sedated.

During medication pass observation on 08/12/15 at 8:35 AM, Resident #10 was observed receiving medications. She was very pleasant and cooperative with nurse #6. Nurse #6 stated at 8:40 AM that she was a nice lady and had no behaviors when she worked with her.

During an interview with Nurse Aide #5 (NA #5) on 08/12/15 at 5:30 PM, she stated Resident #10 thought at times that her daughter was trying to kill her. She also reported that there was one particular nurse Resident #10 did not like and would say that she was being poisoned. NA #5 stated she was very pleasant and cooperative when she worked with her. She added that Resident #10 performed most of her own care.

During an interview with the pharmacist, on 08/13/15 at 11:10 AM, she stated she felt a gradual dose reduction (GDR) was contraindicated for Resident #10 because of her continued behaviors. She stated she did not forward any recommendations for the GDR or the risk versus benefit to the physician because she

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determined that it was not justified. The pharmacist also reported that she had documented in her notes that the GDR was clinically contraindicated. She reviewed Resident #10's old chart and stated that there had been a failed GDR back in 2012 but she could not find evidence that it had been attempted since that time. She stated she felt that she had provided the risk versus benefit for this resident.

During an interview with Resident #10's physician, on 08/13/15 at 12:00 PM, he stated Resident #10 was uncooperative and unapproachable when he attempted to examine her. He stated he would not reduce the Seroquel. He added that he would provide an addendum to include a risk versus benefit statement for the continued use of the Seroquel.

During an interview with the Director of Nurses (DON), on 08/13/15 at 3:15 PM, she stated the pharmacist reviewed residents' records on a monthly basis. She stated any recommendations made were given to her for distribution. The DON stated if the physician agreed with the recommendation she passed it on to the hall nurse for transcribing. She stated the recommendation was filed if there were no new physician's orders.

2. The facility's Medication Monitoring policy, last revised 11/01/11, noted that when a resident's clinical condition improved or stabilized, the resident was to be evaluated for the appropriateness of a taper or gradual dose reduction (GDR) of the medication. It was noted in the antipsychotics section that if a resident was admitted on an antipsychotic medication or the facility initiated antipsychotic therapy, the facility

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must attempt a GDR in 2 separate quarters with at least a month between attempts within the first year unless clinically contraindicated. According to this policy, a GDR was considered clinically contraindicated if the "Target symptoms returned or worsened after the most recent attempt" and the physician documented the "clinical rationale for why any additional attempted dose reductions" would likely impair the resident's function, increase distressed behavior or cause psychiatric instability. It was also noted that a GDR was clinically contraindicated if the continued use was in accordance with relevant current practice standards and the physician documented the clinical rationale for why any additional attempted dose reductions would likely "impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder."

Resident #41 was admitted to the facility on 08/18/14 and readmitted on 12/05/14. Cumulative diagnoses included depression, heart failure, diabetes mellitus and psychosis.

A behavior note of 10/03/14 noted Resident #41 was fixated with his rectum.

A behavior note of 10/14/14 noted Resident #41 was alert and verbal. It was noted that he was fixated with his rectum.

A behavior note of 11/14/14 noted Resident #41 continued with his fixation of his rectum.

A general note of 12/07/14 at 2:24 PM noted Resident #41 was up socializing with staff.

A physician's order of 12/08/14 noted Resident

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#41 was to receive Seroquel 25 milligrams 1/2 tablet twice daily for psychosis.

A Quarterly Minimum Data Set (MDS) assessment of 12/12/14 noted no behaviors.

A general note of 12/13/14 at 7:08 AM noted Resident #41 was alert and oriented with a pleasant mood.

A drug regimen review of 12/30/14 noted Resident #41 had no behaviors.

A drug regimen review of 01/23/15 noted Resident #41 had no behaviors. It was noted that the diagnosis for Seroquel was psychosis and the plan was to continue to follow.

A drug regimen review of 02/09/15 noted Resident #41 had no behaviors. It was noted that the diagnosis for use of Seroquel was psychosis and the plan was to continue to follow.

A physician's progress note of 02/27/15 noted that Resident #41's mood had been good and he was doing well overall. The physician listed all of the medications that Resident #41 was receiving which included Seroquel but had no mention of any behaviors. There was no rationale for the continued use of Seroquel.

A drug regimen review of 03/10/15 noted Resident #41 had no behaviors. It was also noted that the diagnosis for use of Seroquel was psychosis. The plan was to continue to follow.

A Quarterly MDS assessment of 03/12/15 noted Resident #41 had no behaviors.

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A drug regimen review of 04/07/15 noted the medical diagnosis for Seroquel was psychosis. It noted there had been no behaviors and the plan was to continue to follow the use of Seroquel.

A "Note to Attending Physician/Prescriber" of 04/08/15 from the pharmacist noted that currently Resident #41 had an order for Seroquel 25 mg 1/2 tablet daily and had been taking the medication since December 2014. It was noted there appeared to be few documented behaviors. The pharmacist noted antipsychotics were subject to periodic attempted dose reductions unless contraindicated. If a dose reduction was not clinically indicated at this time and/or this was the lowest effective dose, the pharmacist asked the physician to please provide a benefit versus risk statement below to support the continued use. The pharmacist recommended reducing the Seroquel to 25 milligrams ½ tablet every other day for one week then discontinue. The physician denied the request on 05/06/15 and did not provide a risk versus benefit for the continued use of Seroquel.

A physician's progress note of 04/10/15 noted that Resident #41's mood had been good and was doing well overall. The physician listed all of the medications Resident #41 was receiving which included Seroquel. There was no mention of any negative behaviors nor was there a rationale for the continued use of Seroquel.

A drug regimen review of 05/11/15 noted Resident #41 had no behaviors. It was noted that the physician had declined the request for a gradual dose reduction for Seroquel in May of 2015.

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The June 2015 Behavior sheet for Resident #41 noted no behaviors.

A physician's progress note of 06/03/15 noted all of the medications that Resident #41 was taking which included Seroquel. There was no rationale for the continued use of the Seroquel.

The Annual MDS assessment of 06/08/15 noted he was moderately impaired with decision making but had no behaviors.

Resident #41's care plan of 06/10/15 noted he had a diagnosis of dementia, psychosis and depression. It was noted that Resident #41 was at risk for adverse reactions due to the daily use of the psychotropic medication Seroquel. It was noted that a GDR (gradual dose reduction) was to be attempted at least every 6 months. It was also noted that referrals to mental health could be made for follow-up as needed.

A drug regimen review of 06/11/15 noted Resident #41 had no behaviors. It was noted that the GDR for the Seroquel was declined in May of 2015. It was noted the he received Cymbalta for depression and Trazodone for insomnia. There were no recommendations made for a GDR.

A physician's progress note of 07/08/15 noted all of the medications that Resident #41 was receiving which included Seroquel. There was no rationale for the continued use of the medication.

A drug regimen review of 07/09/15 noted that the use of Cymbalta and Trazodone had been addressed in February of 2015. It was noted that the GDR for Seroquel was declined in May of 2015. The pharmacist noted that Trazodone had

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been decreased in June of 2015. There were no recommendations noted.

The August 2015 physician's orders included Seroquel 25 milligrams ½ tablet twice daily.

A physician's progress note of 08/05/15 noted Resident #41 to be calm, pleasant and cooperative. The physician listed all of the medications that Resident #41 was receiving which included Seroquel but made no mention as to a risk versus benefit for the continued use of Seroquel.

A drug regimen review of 08/11/15 noted Resident #41 had been sent out to the emergency room on 08/09/15 for complaints of chest pain. The GDR request for Seroquel was declined in May of 2015. The Trazodone was decreased in June of 2015. The pharmacist noted the diagnosis for the use of the Seroquel as psychosis but made no mention of requesting a risk versus benefit for the continued use of Seroquel.

Resident #41 was observed sitting in his chair in his room on 08/11/15 at 12:00 PM. He was noted to be calm and pleasant when spoken to.

Resident #41 was observed sitting in his chair at 2:25 PM on 08/12/15. He was calm and pleasant and reported he wasn't feeling well.

During an interview with the pharmacist, on 08/13/15 at 11:20 AM, she stated she had started working with the facility in January of 2015. She stated she had felt that a GDR was warranted for Resident #41 and had requested it back in April of 2015 but the physician had refused the request.

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F 329	Continued From page 25 The pharmacist stated that she had not followed up with the physician since the refusal for the GDR. She also stated since the Trazodone was decreased she felt the GDR was no longer appropriate. She also denied following up on obtaining the risk versus benefit statement for the continued use of the Seroquel. During an interview with Resident #41's physician, on 08/13/15 at 12:00 PM, he stated he had known Resident #41 for a number of years and knew his history. He stated he would not reduce his Seroquel medication due to a history of behaviors. The physician also stated he reviewed all of Resident #41's medications monthly and that should serve as his rationale for the continued use of the Seroquel. He commented he would provide a risk versus benefit statement as an addendum. Resident #41 was observed sitting in his recliner with a blanket over his head on 08/13/15 at 12:15 PM. He was pleasant and exhibited no behaviors. The nurse aide (NA #4) who worked routinely with Resident #41 was interviewed on 08/13/15 at 12:20 PM. She stated Resident #41 had no behaviors and did not resist care. During an interview with the Director of Nurses (DON), on 08/13/15 at 3:15 PM, she stated the pharmacist reviewed residents' records on a monthly basis. She stated any recommendations made were given to her for distribution. The DON stated if the physician agreed with the recommendation she passed it on to the hall nurse for transcribing. She stated the recommendation was filed if there were no new	F 329		

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F 329	Continued From page 26 physician's orders. During an interview with Nurse #7 on 08/13/15 at 4:30 PM, she stated Resident #41 had no behaviors when she worked with him.	F 329		
F 366 SS=E	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to serve an alternate vegetable of the same nutrient value as cooked greens during 1 of 1 lunch meals. Findings included: Review of the 08/12/15 lunch menu documented ham with pinto beans, greens, and cornbread were being served. At 11:37 AM on 08/12/15, while obtaining trayline temperatures, the alternate food items on the steam table were turkey with gravy, corn, and rice. At 11:50 AM on 08/12/15 the dietary manager (DM) stated greens and corn were not of the same nutrient value because greens were a non-starchy vegetable and corn was a starchy vegetable. She reported there was the chance that a diabetic resident with greens as a documented dislike could received pinto beans, corn, and cornbread. She commented that would	F 366	F 366 No Resident was named in this area. Immediate substitution was approved by Dietary Manager and put in place for alternate vegetable before meal was served so no Resident(s)were affected. 8/13/15 Registered Dietician (RD) compiled a list of substitute vegetables of the same nutritional value to be used in the event substation is needed or meals. Dietary Manager will be responsible for using list provided by RD to ensure substitution of vegetables is of same nutrition value is provided 8/28/15 Cooks received re-training by the Dietary Manager regarding the importance that all substations have the same nutritional value.	8/28/15

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F 366	Continued From page 27 probably be too much starch for a diabetic resident. She explained that the cook usually selected the alternate food items based on resident likes and leftovers which were available, but she (the DM) usually approved them. She stated the cook had the corn on the steam table for lunch before she had a chance to suggest another non-starchy green vegetable as an alternate for the cooked greens. The DM explained as a general rule she encouraged the cook to select an alternate vegetable in the same color family as the vegetable on the regular menu.	F 366	Dietary Manager will monitor & document observation of service line prior to meal service, to ensure that nutritional value of substitutions, including vegetables, is be used, daily x2 weeks then weekly for 4 weeks. 8/28/15 Dietary Manager will compile a summary of all monitoring efforts/tools and present to the monthly QAPI meeting x4 months to ensure compliance is maintained. 8/28/15	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to prevent possible contamination of kitchenware and meal carts in the dish machine area, failed to keep vents and lighting fixtures in the kitchen clean, and failed to follow expectations to keep food and kitchenware placed in storage free from possible contamination or free from a deterioration in food quality. Findings included:	F 371	F 371 No Resident was name. Dish machine was repaired by vendor (Ecolab)to ensure sanitation and water temperature is maintained. 8/13/15 Air vents into the area of the kitchen	8/28/15

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1. From 9:05 AM until 9:18 AM on 08/12/15 seven racks were run through a low temperature dish machine with sanitizer feeding in during the rinse cycle. Manufacturer recommendations documented the minimum temperature during final rinse should be 120 degrees Fahrenheit. Final rinse temperatures for the seven racks were 108 - 115 degrees. Dietary staff only ran 2 of 7 racks (containing meal trays) back through the dish machine at a later time when the final rinse temperature exceeded 120 degrees.

At 9:18 AM on 08/12/15 a strip used to check the strength of the sanitizing solution feeding into the dish machine registered 25 parts per million (PPM) hypochlorite. Racks continued to be run through the dish machine with the strength of the sanitizing solution being checked. Strips registered 0 - 25 PPM. It was not until 9:32 AM on 08/12/15 that the strips used to check the sanitizing solution measured 50 PPM hypochlorite. At this time a dietary employee in the dish machine area stated prior to the beginning of the dish machine observation at 9:05 AM on 08/12/15 she last used a strip to check the dish machine sanitizer just a little bit after 6:00 AM, and at that time the strip registered 50 PPM, which she reported was the strength recommended by the manufacturer.

At 9:37 AM on 08/12/15, after surveyor intervention, all racks of kitchenware run through the dish machine between 9:05 AM and 9:32 AM were rewashed and resanitized.

At 9:45 AM on 08/12/15 there were five meal carts wheeled up against a wall in the kitchen. From 9:05 AM until 9:45 AM these meal carts

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housing the steam table and stoves/ovens as well as the fluorescent light panels have been cleaned. 8/13/15

Opened 24-ounce foil of gelatin mix and 5lb box of chocolate fudge icing mix, opened bags of chicken breast, and bread sticks were immediately thrown away. 8/13/15

Microwave was immediately cleaned of food particles on the inside, all items in the walk-in freezer were immediately covered with parchment paper. 8/13/15

All pan/kitchenware are air dried before being stored on top of each other, pans found to not be air dried were immediately run back through dish machine and air dried before storing. 8/13/15

Prior to meal service Dietary Aides wiped down/out meal carts once they were emptied with sanitation solution and no meal was served before meal cart was sanitized. 8/13/15

Dietary Aide will be checking water temperature of dish machine before running dishes through dish machine. If needed several cycles will be completed without dishes to determine water temperature is adequate. Once water temperature of 120 degrees F is obtained dishes and/or silverware will be run through machine. If during washing of dishes water temperature is not adequate, staff will stop process until water temperature is appropriate (120 degrees

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F 371	Continued From page 29 were observed being emptied at the dish machine without being wiped out/down. Once they were emptied an employee rolled them against the wall. At 11:20 AM on 08/12/15, just before taking food temperatures and beginning operation of the trayline, a dietary employee reported she had not wiped out/down the outside or inside of the enclosed meal carts against the kitchen wall. At 9:07 AM on 08/13/15 the dietary manager (DM) stated employees operating the dish machine were supposed to monitor the final rinse temperature continuously, and rerun any racks of kitchenware which passed through without the rinse temperature reaching 120 degrees Fahrenheit. She reported staff were instructed to use strips to check the dish machine sanitizing solution three times after each meal (once as the dish machine process began, midway through, and toward the end of the process). The DM commented a service representative inspected the dish machine today, and found that the piston in the dish machine basin was not functioning properly, sometimes allowing the solutions (dishwashing liquid, sanitizer, and drying agent) to drain out. According to the DM, meal carts were out on halls and in common areas such as the dining room so they were supposed to be sanitized after being emptied after each meal. At 10:18 AM on 08/13/15 a dietary employee stated she was trained to use three strips during the dish machine process after each meal, the first strip after 3 - 4 racks, then another strip mid-way through the process, and the last strip toward the end. She reported the strip used to check the strength of the dish machine sanitizer	F 371	F) and any items run through dish machine will be rerun through dish machine to ensure proper sanitation is provided. If needed paper produces will be used to ensure sanitation is obtained. 8/13/15 Dietary Aide is checking sanitation solution with test strips before washing any dishes to make sure PPM is 50. If PPM less than 50 dishware is not to be run through until PPM is adequate. If at any time PPM is determined not to be adequate during washing dishware any items run through machine will be rerun through dish machine once PPM is at least 50 PPM. 8/13/15 Meal carts are to be sanitized with sanitation solution after each meal before placing them up against the wall for next meal use. Carts will be taken out back to be sprayed/washed 1x week, air dried, and sanitized before being used for next meal. 8/13/15 Dietary Manager in-serviced Dietary Staff on water temperatures, PPM of sanitizer, wiping down/sanitizing meal carts after each meal, labeling/dating items in storage room and freezer, covering items in walk-in freezer, air drying pan/kitchenware before storing, cleaning of air vents light fixtures (which included maintenance Manager) to be completed by 8/28/15 Administrator, Dietary Manager, and/or designee will make daily rounds using	

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F 371	Continued From page 30 was supposed to register 50 PPM. According to the employee, if the dishes were too wet, the wash and rinse temperatures were below 120 degrees Fahrenheit, or the strips used to check the sanitizing solution registered below 50 PPM then the staff was trained to notify the DM or maintenance manager (MM) at once. She commented meal carts were supposed to be sanitized after being emptied following each meal using the bleach water at the dish machine. She also commented the meal carts were taken outside once a week, hosed down with hot water, and wiped down with bleach water. 2. During initial tour, beginning at 10:47 AM on 08/10/15, four air vents blowing into the area of the kitchen housing the steam table and stove/ovens were dusty and dirty. In addition, 2 of 7 fluorescent light panels in the kitchen were dusty and dirty. During food preparation observation, beginning at 8:57 AM on 08/12/15, four air vents blowing into the area of the kitchen housing the steam table and stove/ovens were dusty and dirty. In addition, 2 of 7 fluorescent light panels in the kitchen were dusty and dirty. At 9:07 AM on 08/13/15 the dietary manager (DM) stated when the dietary department noticed vents/lighting that needed to be cleaned the maintenance manager (MM) was notified. At 10:18 AM on 08/13/15 a dietary employee stated the MM made morning rounds, and took care of issues that he identified in the kitchen. At 4:50 PM on 08/13/15 the MM stated he did morning rounds, which included the kitchen, and	F 371	daily round sheets to monitor daily x2 weeks, then weekly x4 weeks; then monthly x1 month to ensure water temperatures are of 120 degrees F before washing dishes in dish machine, 50 PPM sanitation is accurate at time of washing dishware in dish machine, meal carts are sanitized with sanitation solution after being emptied and before placed against wall in preparation of next meal; meal carts are to be taken outside for washing, air drying, and sanitized once a week; all items are labeled/dated at time of opening and placed in storage room and freezer; all air vents and light fixtures clean/free of dust are maintained. 8/28/15 Administrator and Dietary Manager will compile a summary of all monitoring efforts/tools and present to monthly QAPI meeting x4 months to ensure compliance is maintained. 8/28/15	

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he cleaned vents and lights in the kitchen as he identified problems.

3. During the initial tour of the kitchen, beginning at 10:47 AM on 08/10/15, 3 of 5 tray pans stacked on top of one another in storage were wet inside, there were dried food particles on the inside top of the microwave, an opened 24-ounce foil pack of gelatin mix and an opened 5-pound box of chocolate fudge icing mix in the dry storage room were without labels and open dates, the gelatin/fruit cups/puree fruit on a cart pushed into the walk-in freezer were not covered, and opened bags of chicken breast and bread sticks in the walk-in freezer were without labels and open dates.

At 9:07 AM on 08/13/15 the dietary manager (DM) stated the last time dietary staff was educated specifically about the need to stack kitchenware dry was after last year's annual survey. She reported at this time the dietary staff was informed that kitchenware was to be air dried and checked for cleanliness prior to stacking in storage. The DM commented the whole microwave should be cleaned, just not the sides and bottom. According to the DM, if there was any dried food particles on the inside top of the microwave oven, as food items were heated or reheated, this food debris could fall down and contaminate the fresh food items. She stated all dietary staff were responsible for labeling and dating food items which they opened. She reported that she and her assistant tried to walk through storage areas once a week to make sure the dietary staff was compliant with labeling and dating. The DM commented carts which were pushed into the walk-ins to cool should have all the food items in them covered to prevent

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F 371	Continued From page 32 contamination, especially in the summer with the tendency for fly problems. She remarked the preferred technique discussed with dietary staff was to cover food items with pan liners (parchment paper). At 10:18 AM on 08/13/15 a dietary employee stated kitchenware was supposed to be dry before being stacked into storage because bacteria could form in trapped moisture. She reported the top, bottom, and sides of the microwave should be cleaned to prevent bacterial contamination of food and prevent the oven from catching fire. She commented dietary staff were trained to label and date all food items which they opened, and the assistant dietary manager and night shift cook checked behind to make sure it was getting done. The employee stated food items rolled into the walk-ins to be chilled should all be covered to prevent contamination.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff,	F 428	F 428	8/28/15

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F 428	Continued From page 33 pharmacist and physician interviews, the facility consultant pharmacist did not send a request to the physician requesting a gradual dose reduction and/or a risk versus benefit rationale for continued use of an antipsychotic medication for 1 of 5 residents (Resident #10) reviewed for unnecessary medications. Findings included: Resident #10 was admitted to the facility on 01/27/11. Cumulative diagnoses included congestive heart failure, psychosis and dementia with behaviors. The facility's Medication Monitoring policy, last revised 11/01/11, noted that when a resident's clinical condition improved or stabilized, the resident was to be evaluated for the appropriateness of a taper or gradual dose reduction (GDR) of the medication. It was noted in the antipsychotics section that if a resident was admitted on an antipsychotic medication or the facility initiated antipsychotic therapy, the facility must attempt a GDR in 2 separate quarters with at least a month between attempts within the first year unless clinically contraindicated. According to this policy, a GDR was considered clinically contraindicated if the "Target symptoms returned or worsened after the most recent attempt" and the physician documented the "clinical rationale for why any additional attempted dose reductions" would likely impair the resident's function, increase distressed behavior or cause psychiatric instability. It was also noted that a GDR was clinically contraindicated if the continued use was in accordance with relevant current practice standards and the physician documented the clinical rationale for why any additional attempted dose reductions would likely "impair the resident's function, increase distressed behavior, or cause	F 428	Pharmacist made recommendations to Attending Physician for Residents #10 to review Resident's current antipsychotic medication usage and completed the risk versus benefit statement for continued or discontinued use of antipsychotic medication. 8/13/15 DON requested current list of all residents receiving antipsychotic medication from the pharmacy. DON meet with Attending Physician for these Residents and reviewed current usage needs of the antipsychotic medication. Attending Physician documented his justification for continued or discontinued use of the medication and completed the risk verses benefit statement. DON will obtain facility Pharmacist recommendations monthly and will meet with Resident Attending Physician weekly to ensure Physician completes approval/decline(s) of antipsychotic medications, and completes risk versus benefit statement if needed. 8/28/15 DON will compile a summary of all monitoring efforts / tools and present to monthly QAPI meeting x4 months to ensure compliance is maintained. 8/28/15	

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psychiatric instability by exacerbating an underlying medical or psychiatric disorder."

A physician's order of 09/22/14 noted to administer Seroquel 200 mg (milligrams) at bedtime for psychosis as evidenced by paranoia.

A drug regimen review of 09/24/14 noted that Seroquel was increased to 200 mg (milligrams) at bedtime for psychosis and paranoia.

Resident #10's care plan identified a potential alteration in behaviors with an onset date of 12/31/14. It was noted that Resident #10 was verbally abusive, had paranoid ideations, and was resistant to care. It was noted that the pharmacy consultant would review her medication monthly. Staff were to monitor her behaviors and mood. Psychiatry referrals were to be made as needed.

A progress note from psychiatry services of 01/16/15 noted Resident #10 was seen for delusions and anxiety. It was noted that she continued to have anxiety and paranoia regarding the theft of her belongings by her daughter and staff members. Staff report she had been somewhat anxious. The plan was to increase Lexapro to help with anxiety.

A general note of 02/09/15 from pharmacy noted follow Resident #10's mood and behaviors. It was noted no changes were made to the Lexapro or the Xanax. There were no new recommendations made. There was no request to attempt a GDR or a risk versus benefit statement for the continued use of the Seroquel.

A general note of 03/10/15 from pharmacy noted to follow Resident #10's mood and behaviors. It

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was noted that psychosis was the diagnosis for the use of Seroquel and it had been increased in September of 2014. There were no new recommendations made.

The Quarterly Minimum Data Set (MDS) assessment of 03/20/15 noted Resident #10 had no behaviors.

The Quarterly MDS assessment of 04/03/15 noted no behaviors for Resident #10.

A general note from pharmacy of 04/08/15 noted follow Resident #10's mood and behaviors. There were no new recommendations made.

The May 2015 behavior monitoring sheet for Resident #10 noted 2 behaviors for the month.

A general note from pharmacy of 05/12/15 noted to follow Resident #10's mood and behaviors with a diagnosis of psychosis for the Seroquel. There were no new recommendations.

A general note of 06/03/15 at 10:36 AM noted Resident #10 had increased agitation this morning while sitting in the hallway with other residents in front of her. She was asking them to move then pushing the resident out of her way with her wheelchair and not giving them time to move. Resident #10 was going to the dining room and saying move out of "my way" .

A progress note from psychiatry services of 06/04/15 indicated Resident #10 was seen for delusions. It was noted that she continued to have a belief that her daughter and the hall nurse have taken her glasses and sold them to the drug dealer. She had no significant disruption to her

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daily functioning and there were no recommendations made other than to continue current psychotropic medications.

The June 2015 behavior monitoring sheet for Resident #10 noted 2 behaviors which consisted of hitting and running into others.

A general note from pharmacy of 06/15/15 noted to follow Resident #10's mood and behaviors. The diagnosis of psychosis was noted for the Seroquel. It was also noted that a gradual dose reduction (GDR) was not clinically appropriate at this time. There was no indication that the pharmacy had provided the physician with a request for a GDR and/or a risk versus benefit for the continued use of the Seroquel.

A general note of 06/30/15 at 10:12 PM noted Resident #10 had refused eye drops as she believed they were poisoned.

The July 2015 behavior monitoring sheet noted Resident #10 had no behaviors.

The Quarterly MDS assessment of 07/03/15 noted no behaviors for Resident #10.

A progress note from psychiatry services of 07/06/15 noted Resident #10 was seen as a routine follow-up for delusions. The history of present illness noted that she had a history of dementia with behavioral disturbances and psychosis, insomnia, depression and anxiety. It was noted that she was maintaining her recent level of functioning on her current psychotropic medications. It was noted that she had been treated with antibiotics for cellulitis of recent. She had no worsening paranoia. It was noted that

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Resident #10 remained on a low dose of Trazodone to help with sleep continuity. She was also on Seroquel at night. It was noted that the plan was to attempt reduction of night time medications and monitor her for sleep. The recommendation was to discontinue the Trazodone.

A general note from pharmacy of 07/13/15 noted follow Resident #10's mood and behaviors. It was noted that per nurse notes she had exhibited increased agitation. Psychiatry consult notes of 06/04/15 noted that Resident #10 believed her glasses were stolen. The pharmacy noted that a GDR was not clinically appropriate at this time due to the recent change of Trazodone. Behaviors were noted of 3 episodes of biting and one time of running into others. It was noted that the Seroquel had been increased in September of 2014. No new recommendations were made. There was no request to the physician asking for a risk versus benefit for the continued use of the Seroquel.

A general note of 07/31/15 at 11:34 AM noted that Resident #10 was taking pads from the linen cart and got upset when she was asked to wait until the laundry brought out more pads. Resident #10 exhibited paranoia by saying staff were trying to poison her. It was also noted that she told the writer that the drug dealer would not allow her daughter to visit.

The August 2015 physician's orders for Resident #10 noted she was receiving Seroquel 200 milligrams for psychosis and paranoia.

A general note of 08/03/15 at 8:34 PM noted that Resident #10 was seen by psychiatry services

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today. New orders were obtained to change Xanax 0.5 milligrams to bedtime and to hold if sedated.

Resident #10 was observed during medication pass observation on 08/11/15 at 8:55 AM. She was pleasant and cooperative.

During an interview with the pharmacist, on 08/13/15 at 11:10 AM, she stated she felt a gradual dose reduction (GDR) was contraindicated for Resident #10 because of her continued behaviors. She stated she did not forward any recommendations for the GDR or the risk versus benefit to the physician because she determined that it was not justified. The pharmacist also reported that she had documented in her notes that the GDR was clinically contraindicated. She reviewed Resident #10's old chart and stated that there had been a failed GDR back in 2012 but she found no evidence that it had been attempted since that time. She stated she felt that she had provided the risk versus benefit for this resident.

During an interview with Resident #10's physician, on 08/13/15 at 12:00 PM, he stated Resident #10 was uncooperative and unapproachable when he attempted to examine her. He stated he would not reduce the Seroquel. He added that he would provide an addendum to include a risk versus benefit for the continued use of the Seroquel.

During an interview with the Director of Nurses (DON), on 08/13/15 at 3:15 PM, she stated the pharmacist reviewed residents' records on a monthly basis. She stated any recommendations made were given to her for distribution. The DON

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F 428	Continued From page 39 stated if the physician agreed with the recommendation she passed it on to the hall nurse for transcribing. She stated the recommendation was filed if there were no new physician's orders.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		8/28/15

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F 441	Continued From page 40 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, a staff member failed to wash hands before and after providing incontinent care and failed to bag soiled linen before leaving the resident's room during incontinent care for 1 of 1 resident (Resident #141). Findings included: Resident #141 was admitted to the facility on 03/06/15 with a cumulative diagnoses including: sacral pressure ulcer stage 4, heel pressure ulcer stage 3, chronic osteomyelitis, rheumatoid arthritis, failure to thrive, and paraplegia. Resident #141's 05/25/15 Minimum Data Set (MDS) indicated that resident had no cognitive impairments, and needed extensive assistance with toilet use. Resident #141 was always incontinent of bowel and bladder. Review of facility procedure on Perineal Care (Incontinence Care) from Nursing Procedures/Certified Nursing Assistant dated 07/1997 read in part under incontinent care: 1. Remove gloves and wash hands 2. Discard soiled linen properly Review of Facility Peri Care/ Hand Washing Audit tool dated 08/13/15 read in part under incontinent	F 441	F 441 DON reviewed Resident #141 medical condition and determined Resident did not have any negative effect from alleged allegation. 8/13/15 DON and SDC meet with CNA #1 and completed one on one re-training with observation of skills performed, during ADL care for hand washing, use of gloves, and proper handling of soiled linen. 8/13/15 DON and/or Administrative Nurses completed re-training with Nursing CNA's on hand washing procedures, use of gloves, proper handling of soiled linen to be completed by 8/28/15 DON and/or Administrative Nurses will observe at least 4 CNA's a week on skills used during bed baths, use of gloves, proper handling of soiled linens to ensure proper techniques are being used/followed. 8/28/15 DSC, DON/designee will monitor daily using daily round sheets x2 weeks, then weekly x6 weeks; then monthly x2 months	

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F 441	Continued From page 41 care: 1. Staff must wash hands, gather supplies, have garbage bags ready for linen and garbage. 2. Buttock, wash sides first, then the middle. 3. STOP! Remove gloves, wash/sanitize hands and re-glove. 4. Wash hands before leaving the room, dispose of soiled linen, garbage and wash hands again. Observation of resident #141's incontinent care was made at 12:10 PM on 08/12/15. Observed CNA #1 knock when entering the resident's room, gloved, and closed the door and blinds. The observation revealed a clean dressing on one sacral pressure ulcer without drainage or odor. Observed CNA #1 first clean resident #141's front and then back side with wipes, then she dried off resident #141 with a clean sheet. After Resident #141's adult brief was changed, CNA #1 took the soiled linen out into the hall unbagged to look for a soiled linen cart. When she could not find a soiled linen cart, the CNA #1 placed the soiled linen on the resident's over bed table. Then the CNA #1 took off her gloves and put them in her hand and walked out of resident #141 room again to look for a soiled linen cart. The CNA #1 came back into resident #141's room and said "she did not have any plastic bags to put the soiled linen in". Observed the CNA #1 not washing her hands before, during, or after resident's incontinent care. Observed the CNA #1 not bag resident #141's soiled linen prior to exiting resident's room. Interview with CNA #1 on 08/12/15 at 2:40 PM revealed that she made a few mistakes during resident #141's incontinence care. CNA #1 said she was nervous and made mistakes. CNA #1 said she realized that after the incontinence care,	F 441	to ensure a safe, sanitary and comfortable environment is provided as well as prevent the development of and transmission of disease and infection. 8/28/15 DON will compile a summary of all monitoring efforts/tools and present to monthly QAPI meeting x4 months to ensure compliance is maintained. 8/28/15	

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F 441	Continued From page 42 she should have washed her hands before and then after the incontinence care, and that she should have also bagged the soiled linen, and not placed the dirty linen on the resident's over bed table. Interview on 08/12/15 at 5:00 PM with the DON revealed that it was her expectation that all CNAs' must wash hands before and after incontinent care, and to bag soiled linen before leaving the residents' rooms. Interview on 08/12/15 at 4:50 PM with Nurse #5 or (Infection Control Nurse) revealed that it was her expectation that all CNAs' must wash hands before and after incontinent care, and to bag soiled linen before leaving the residents rooms.	F 441		