STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR REHAB & HEALTHCARE CENTER	**2051 COUNTY CLUB ROAD WADESBORO, NC 28170**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159 SS=B	483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS (f)(10)(i) …If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and	F 159		4/10/17

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

Electronically Signed | 04/06/2017

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F 159	Continued From page 1 separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on a review of resident funds account list and staff interview, the facility failed to provide quarterly statements to each resident/ responsible party for two of two residents who had a resident fund account at the facility (Resident #1 and #19). The findings included: 1. Resident #1 was admitted to the facility on 8/1/15. A Quarterly Minimum Data Set dated 1/13/17 indicated Resident #1 was cognitively intact.	F 159	Preparation and submission of this plan of correction by Ambassador Rehab and Healthcare Center, LLC, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	

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F 159	Continued From page 2 On 3/13/17 at 2:50PM, an interview was conducted with Resident #1 who stated she used to bet a bank statement from the facility but not anymore. She could not remember the date she last received a bank statement. On 3/14/17 at 9:30AM, during an interview with the acting Business Office Manager (BOM), it was revealed that a packet of bank statements for the resident funds account dated 1/2/17 was still in the business office. An interview was conducted with the BOM at that time. She stated she had assumed the position in December, 2016. The BOM stated quarterly statements were given to the residents/ responsible parties on a quarterly basis and the statements come to the facility from the corporate office. She stated she had not given out the last quarterly statements. She said she had not had time to given out the last bank statements and was still learning the job. On 3/16/2017 at 8:55AM, an interview was conducted with the Administrator who stated his expectation was for the quarterly statements to be given/sent to the resident/responsible party at the time they were received at the facility. 2. Resident #19 was admitted to the facility on 4/26/13. A quarterly Minimum Data Set dated 2/24/17 indicated Resident #19 was cognitively intact. On 3/13/17 at 2:24PM, an interview was conducted with Resident #19 who stated he had not received a bank statement and did not know how much he had in his account.	F 159	F 159 1. Resident #1 received their quarterly statement on 3/17/17 from the business office. Resident #19 received their quarterly statement on 3/17/17 from the business office. 2. An audit was completed on 03/29/17 by the Regional Business Office Manager to ensure current resident/ responsible parties have received their quarterly statements as required. No additional residents were identified during this audit on 03/29/17. 3. The Business Office staff were reeducated on 3/29/17 by the Regional Business Office Manager related to ensuring quarterly statements are given to residents/ responsible parties as required. 4. The Regional Business Office Manager will complete an audit monthly for 3 months to ensure quarterly statements are given to resident/ responsible parties as required. The Regional Business Office Manager will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator and Regional Business Office Manager will be responsible for monitoring resident trust statements and follow up. Completion date: 04/10/17	

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F 159	Continued From page 3 On 3/14/17 at 9:30AM, during an interview with the acting Business Office Manager (BOM), it was revealed that a packet of bank statements for the resident funds account dated 1/2/17 was still in the business office. An interview was conducted with the BOM at that time. She stated she had assumed the position in December, 2016. The BOM stated quarterly statements were given to the residents/ responsible parties on a quarterly basis and the statements come to the facility from the corporate office. She stated she had not given out the last quarterly statements. She said she had not had time to given out the last bank statements and was still learning the job. On 3/16/2017 at 8:55AM, an interview was conducted with the Administrator who stated his expectation was for the quarterly statements to be given/sent to the resident/responsible party at the time they were received at the facility.	F 159		
F 160 SS=B	483.10(f)(10)(v) CONVEYANCE OF PERSONAL FUNDS UPON DEATH (v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to convey personal funds account	F 160	F 160	4/10/17

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F 160	Continued From page 4 balance to a resident's estate for two of three residents reviewed for conveyance of funds (Resident #64 and #42). The findings included: 1. A review of the medical record revealed Resident #64 expired on 12/12/16. A review of the personal funds account balance sheet revealed Resident #64 had a balance of $1003.05 in his account as of 3/15/17. On 3/15/17 at 3:00PM, an interview was conducted with the acting Business Office Manager (BOM) who stated she was unaware that the resident's funds had to be conveyed to their estate within 30 days of death. She said she got very little training. The prior BOM was here and new to the positon for about 2-3 months. The acting BOM said she had 2 days training before taking over the job. She stated she called corporate and learned about the 30 day window for conveyance of funds on 3/15/17. On 3/16/2017 at 8:55AM, an interview was conducted with the Administrator who stated his expectation was for conveyance of funds to the resident's estate upon death to be completed within 30 days. 2. A review of the medical record revealed Resident #42 expired on 1/16/17. A review of the personal funds account balance sheet revealed Resident #42 had a balance of $130.02 in his account as of 3/15/17. On 3/15/17 at 3:00PM, an interview was conducted with the acting Business Office Manager (BOM) who stated she was unaware that the resident's funds had to be conveyed to	F 160	1. Resident #64 funds were conveyed to the Clerk of Court on 3/20/17 by the business office. Resident #42 funds were conveyed to the Clerk of Court on 4/10/17 by the business office. 2. An audit of the personal funds deposited of discharged, evicted, or death of a resident was completed on 3/29/17 by the Regional Business Office Manager to ensure funds are conveyed within 30 days as required. 4 addition accounts were identified during this audit and funds were conveyed to the clerk of court as required. 3. The Business Office Staff was reeducated by the Regional Business Office Manager on 3/29/17 related to the requirements of personal funds for discharged, evicted, or death of a resident are conveyed within 30 days. 4. The Regional Business Office Manager will complete an audit monthly for 3 months to ensure personal funds of discharged, evicted, or death of a resident continues to be conveyed within 30 days. The Regional Business Office Manager will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator and Regional Business Office Manager will be responsible for monitoring resident trust funds/refunds	

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F 160	Continued From page 5 their estate within 30 days of death. She said she got very little training. The prior BOM was here and new to the positon for about 2-3 months. The acting BOM said she had 2 days training before taking over the job. She stated she called corporate and learned about the 30 day window for conveyance of funds on 3/15/17. On 3/16/2017 at 8:55AM, an interview was conducted with the Administrator who stated his expectation was for conveyance of funds to the resident's estate upon death to be completed within 30 days.	F 160	and follow up. Completion Date: 04/10/17	
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to offer or provide scheduled showers for 1 (Resident # 35) of 1 resident reviewed for choices. Findings included:	F 242	F 242 1. Resident #35 was given a shower on 3/17/17 by the Certified Nursing Assistant.	4/10/17

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F 242	Continued From page 6 Resident #35 was admitted 10/24/16 with cumulative diagnoses of diabetes, depression and hypertension. She was discharged home on 1/20/17 and returned to the facility on 1/22/17. Her re-admission Minimum Data Set (MDS) dated 1/29/17 indicated Resident #35 was cognitively intact with no behaviors. She was coded as requiring staff with bathing. A review of Resident #35 ' s Activity Evaluation dated 1/22/17 indicated the choice between a showers or a bed bath was very important to her. Resident #35 was scheduled to receive a shower every Tuesday and Friday on first shift according the shower schedule for the west hall. Resident #35 was care planned on 1/30/17 for assistance with her baths/showers 3 times weekly due to weakness. There was no care plan for refusal of her showers or with any aspect of the care. A review of Activities of Daily living (ADL) Record from 1/22/17 to 3/15/17 indicated she only received one shower on Friday 2/3/17 on second shift. There was no documented refusals. A review of the Behaviors Monthly Flow Sheet for February 2017 indicated Resident #35 was being monitored for agitation and anger. There was one documented agitation and anger episode on 2/1/17 and one anger episode on 2/19/17. A review of the Behaviors Monthly Flow Sheet for March 2017 indicated Resident #35 was being monitored for agitation, anger and for being	F 242	2. An audit of the current resident's bath/shower schedule was completed by the Director of Nursing on 3/23/17 to ensure bathing preference are honored per resident's request. There were no additional residents identified during this audit. 3. The Nursing Staff including weekend and prn staff was reeducated by 4/9/17 by the Director of Nursing and the Assistant Director of Nursing related to the requirements of honoring resident's bathing preferences. Nursing Staff will be required to complete reeducation prior to beginning their shift. 4. The Director of Nursing or the Assistant Director of Nursing will complete 5 residents' interviews weekly 4 weeks and monthly for 2 months to ensure bathing preferences continue to be honored as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion Date: 04/10/17	

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F 242	Continued From page 7	F 242		

uncooperative. There was one documented agitation, anger and uncooperative episode on 3/3/17, one agitation episode on 3/7/17, two episodes of anger on 3/12/17 and two episodes of being uncooperative on 3/12/17. There was two documented episodes of anger on 3/13/17.

A review of Resident #35 ' s physician orders only included a prescribed antidepressant and a prescribed hypnotic. There was no evidence of a prescribed medication for agitation.

In an interview on 3/13/17 at 4:05 PM, Resident #35 stated she had not been offered or received a shower in her recent memory. She stated her shower days were Tuesday and Fridays but she was unsure of the shift or when she ever had one.

In an interview on 3/15/17 at 8:10 AM, Nursing Assistant (NA) #3 stated Resident #35 did not receive a shower on 3/14/17 due to her refusal. NA #3 stated she informed Nurse #3 of Resident #35 ' s shower refusal.

In an interview on 3/15/17 at 8:17 AM, NA #4 stated Resident #35 did not refuse her showers but there had been occasions when she would requested to take her shower on a different shift. NA #4 stated if Resident #35 refused her shower, it would be documented on the ADL Record as it did not occur and the charge nurse would be notified.

In an interview on 3/15/17 at 8:22 AM, NA #5 stated she worked on 3/14/17 on the hall but she was not assigned Resident #35. NA #5 stated there had been occasion where she would refuse a shower or request her shower on a different

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F 242	Continued From page 8 shift. In an interview on 3/15/17 at 8:55 AM, Resident #35 stated she did not receive a shower on any shift 3/14/17 and she was not offered a shower at any point in the day or evening. She stated NA #3 came to her room and set her up a pan of water to wash off with. After she pushed her call bell, NA #3 returned to assist with washing her back. In an interview on 3/16/17 at 8:20 AM, Nurse #3 confirmed she worked first shift on 3/14/17 and was assigned Resident #35. Nurse #3 stated at no point on her twelve hour shift, did any aide report to her that Resident #35 had refused a shower. In an interview on 3/16/17 at 9:40 AM, the MDS nurse stated if the staff do not document Resident #35 ' s refusals of showers, the care plan would not reflect that behavior. She stated she also made it her practice to ask the staff about each resident and she stated the staff did not report any refusals of showers but only outburst of Resident #35 throwing things on her floor. In an interview on 3/16/17 at 10:05 AM, the Director of Nursing stated it was her expectation that Resident #35 receive her showers as scheduled and if she refused, it should be reported to the nurse and documented.	F 242		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 278		4/10/17

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F 278	Continued From page 9 (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of level 2 Preadmission Screening and Resident Review (PASRR) and urinary incontinence for 2 of 22 sampled residents (Resident #25 and #75). The	F 278	F 278 Resident #25's MDS assessment was corrected and resubmitted to include the Level 2 PASRR on 3/15/17 by the MDS Coordinator.	

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F 278	Continued From page 10 findings included: 1. Resident #25 was admitted to the facility on 7/17/15 with multiple diagnoses that included schizophrenia, psychosis and major depressive disorder. Record review indicated Resident #25 was a level 2 PASRR since admission on 7/17/15 with no expiration date. A Significant Change Minimum Data Set (MDS) dated 2/1/17 indicated a "No" to question A1500 which asked if Resident #25 had been evaluated by a level 2 PASRR and determined to have a serious mental illness and/or mental retardation on a related condition. An interview was conducted with the MDS Coordinator on 3/15/17 at 7:55AM. She stated she completed section A of the MDS and reviewed the chart for information regarding PASRR level 2 prior to completing the MDS. She reviewed the chart and stated Resident #25 should have been coded as a level 2 PASRR on the MDS dated 2/1/17. The MDS Coordinator said she was still getting used to the new computer system and had made a mistake. On 03/16/2017 at 10:50AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be coded accurately. 2. Resident #75 was admitted on 10/7/16 with multiple diagnoses that included infection, arthritis caused by an infection, abnormal heart rhythm, impaired breathing, muscle weakness, diabetes, anxiety, and high blood pressure. Resident #75	F 278	Resident #75's MDS assessment was corrected and resubmitted on 3/22/17 by the MDS Coordinator to include the resident's current continent status during the look back period. 2. An audit was completed of the current residents on 3/23/17 by the MDS Coordinator and Director of Nursing to ensure MDS are coded per the resident's status as required. There were no additional assessments identified during this audit. 3. The MDS Coordinators were reeducated on 3/31/17 by the Regional Clinical Reimbursement Specialist related to the requirements of coding MDS according to the residents' status. 4. The Regional Clinical Reimbursement Specialist, Director of Nursing and Assistant Director of Nursing will completed an audit of 4 MDS weekly for 4 weeks and monthly for 2 months to ensure MDS continue to be coded as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion Date: 04/10/17	

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was discharged to home on 1/16/17.
A review of the December, 2016 and January, 2017 Resident Activities of Daily Living (ADL) Record revealed that Resident #75 was documented as having used a urinal from December 30, 2016 through January 5, 2017. There were no incidents of urinary incontinence documented.

The quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) 1/5/17 indicated Resident #75 was always incontinent of urine during the assessment period of December 30, 2016 through January 5, 2017. Resident #75 was coded as being incontinent of urine.

During an interview that was conducted with Nursing Assistant (NA) #6, on 3/15/17 at 2:37 PM, she stated Resident #75 used a urinal in December and January. NA #6 stated Resident #75 was not incontinent of urine.

During an interview that was conducted with Nurse #4, on 3/15/17 at 2:37 PM, she stated Resident #75 used a urinal and he was not incontinent of urine. Nurse #4 stated that she did not remember a change in the resident's condition when he did not use a urinal and was incontinent of urine. Nurse #4 stated that Resident #4 used a urinal and was continent of urine from late December and through January to his discharge date.

An interview was conducted with the MDS Nurse on 3/16/17 at 10:03 AM regarding Resident #75 being coded as always incontinent of urine. The MDS nurse reviewed the Resident ADL Record and acknowledged that Resident #75 had used

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F 278	Continued From page 12 his urinal from December 30, 2016 through January 5, 2017. The MDS Nurse also acknowledged that the resident had no incidents of being incontinent of urine during that 7 day period. The MDS Nurse then reviewed a note that she had written in the medical record regarding Resident #75's urinary continence. The MDS Nurse stated she had documented that Resident #75 was continent of urine. The MDS Nurse stated she must have had made an error in coding the MDS assessment for urinary continence for the quarterly MDS assessment with an ARD of 1/5/17 and that Resident #75 was continent of urine during the period of December 30, 2016 through January 5, 2017. During an interview that was conducted with the Director of Nursing on 3/16/17 at 10:51 AM, she stated that she expected the MDS assessment to be accurate.	F 278		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and physician, dialysis and facility staff interview, the facility failed to follow the care plan for fluid restriction and dietary supplement for 1 of 1 sampled resident reviewed for dialysis (Resident	F 282	F 282 1. Resident #66 dietary card was updated on 3/17/17 to include the orders for fluid restriction and supplement by the Dietary	4/10/17

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F 282	Continued From page 13 #66). The facility also failed to follow the care plan for checking the tube placement for 1 of 2 sampled residents observed (Resident #94). Findings included: 1. Resident #66 was admitted to the facility on 1/31/17 with multiple diagnoses including End Stage Renal Disease (ESRD). The admission Minimum Data Set (MDS) assessment dated 2/7/17 indicated that Resident #66 had severe cognitive impairment and was receiving dialysis while at the facility. The care plan dated 2/7/17 was reviewed. The care plan problems included potential for alteration in fluid volume and nutrition. The goal was for the resident to maintain current body weight through the next 30 day review period. The approaches included dialysis three times per week and as needed and dietary supplements as ordered. On 2/14/17, provide "diet and fluids as ordered" was added to the approaches. On 2/13/17, Resident #66 had a physician's order for fluid restriction of 1000 milliliter (ml) per day. The order indicated that the kitchen would provide 120 ml of fluid with breakfast and 240 ml with lunch and dinner and nursing would provide 400 ml. On 3/8/17, Resident #66 had a physician's order for a dietary supplement each meal due to weight loss. On 3/15/17 at 12:30 PM, Resident #66's lunch tray was observed. The tray contained 180 ml of tea and 240 ml of milk. There was no dietary supplement on the tray. The resident was able to feed herself. The dietary card did not reflect the	F 282	Manager. Resident #94 gastrostomy tube placement was checked on 3/17/17 by the charge nurse and no concerns were noted. Nurse #1 and Nurse #5 were reeducated related to the requirements of checking gastrostomy tube placement on 3/17/17 by the Director of Nursing. 2. An audit was completed of the current resident's dietary cards by the Director of Nursing and the Dietary Manager on 3/29/17 to ensure dietary and supplement orders are followed as required. There were 7 additional residents identified in the audit and the tray cards were updated at this time by the Dietary Manager. An audit of the current residents with gastrostomy tubes was completed on 3/30/17 and 4/3/17 by the Director of Nursing to ensure tube placement is being checked by the Licensed Nurses as required with no additional concerns identified. 3. Licensed Nurses were reeducated on 3/30/17 by the Assistant Director of Nursing related to the requirements of checking gastrostomy tube placement. Licensed Nurses will be required to complete reeducation prior to beginning shift.	

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F 282	Continued From page 14 fluid restriction or the dietary supplement. On 3/16/17 at 8:10 AM, Resident #66 was observed eating breakfast in her room. The tray contained 180 ml of coffee, 120 ml of orange juice and 240 ml of milk. There was no dietary supplement on the tray. On 3/16/17 at 9:30 AM, there was a bottle of orange soda (591 ml) observed on top of the over the bed table. On 3/16/17 at 8:05 AM, the Dietary Manager (DM) was interviewed. She stated that she was not aware that Resident #66 was on 1000 ml fluid restriction or had an order for dietary supplement. The DM stated that if she had been aware of the order for fluid restriction and the dietary supplement, it should have been written on the dietary card the amount of fluid to be provided each meal and the dietary supplement. On 3/16/17 at 10:55 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to follow the care plan for the fluid restriction and for the dietary supplement. 2. Resident #94 was admitted to the facility on 1/9/17 with multiple diagnoses including Motor Vehicle Accident (MVA). The admission Minimum Data Set (MDS) assessment dated 1/16/17 indicated that Resident #94 had memory and decision making problems and was on feeding tube while a resident at the facility. The assessment further indicated that the resident was totally dependent on the staff with eating.	F 282	The dietary staff and the licensed nurses were reeducated by the Director of Nursing on 4/3/17 related to ensuring dietary cards remain updated to included dietary and supplement orders are followed as required. Dietary staff and the licensed Nurses will required to complete education prior to beginning shift. The Dietary Manager will ensure dietary cards are updated. 4. Director of Nursing and Assistant Director of Nursing will complete an audit weekly for 4 weeks and monthly for 2 months to ensure dietary cards remain updated to include current dietary and supplement orders and ensure Licensed Nurses continue to check gastrostomy tubes for placement as required. The Director of Nursing will submit a report to the Quality Assurance committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion Date: 04/10/17	

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F 282	Continued From page 15 The care plan for Resident #94 dated 1/16/17 was reviewed. The care plan problem was "requires nutrition/calorie via tube feeding." The goal was "resident will be free of complications from use of tube feedings." The approaches included check for GT placement as ordered. Resident #94 had a physician's order dated 2/15/17 for (name of tube feeding formula) 1.2 - 2 cans 4 times a day and to check tube placement every day and night shift. On 3/16/17 at 8:120 AM, Nurse # 1 and Nurse #5 were observed during the medication pass. Nurse #5 was observed to listen to Resident #94's bowel sounds using a stethoscope. The nurse was not observed to use a syringe to check for tube placement. Nurse #1 was observed to administer the resident's medications followed with 2 cans of feeding formula via the GT. On 3/16/17 at 8:35 AM, Nurse # 5 was interviewed. She stated that she checked tube placement by listening to the resident's bowel sounds using a stethoscope. Nurse #5 stated that she didn't use a syringe in checking for tube placement. On 3/16/17 at 11:30 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to check the tube placement as care planned.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that	F 309		4/10/17

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F 309	Continued From page 16 applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observation and physician, dialysis and facility staff interview, the facility failed to provide the fluid restriction and the potassium supplement as ordered by the physician and recommended by the dialysis clinic	F 309	F 309 1. Resident #66's dietary orders were clarified with the Dietary Manager to include the fluid restriction and the orange	

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F 309	Continued From page 17 for 1 of 1 sampled resident reviewed for dialysis (Resident #66). Findings included: Resident #66 was admitted to the facility on 1/31/17 with multiple diagnoses including End Stage Renal Disease (ESRD). The admission Minimum Data Set (MDS) assessment dated 2/7/17 indicated that Resident #66 had severe cognitive impairment and was receiving dialysis while at the facility. The care plan dated 2/7/17 was reviewed. The care plan problems included potential for alteration in fluid volume and nutrition. The goal was for the resident to maintain current body weight through the next 30 day review period. The approaches included dialysis three times per week and as needed. On 2/14/17, provide "diet and fluids as ordered" was added to the approaches. On 2/13/17, Resident #66 had a physician's order for fluid restriction of 1000 milliliter (ml) per day. The order indicated that the kitchen would provide 120 ml of fluid with breakfast and 240 ml with lunch and dinner and nursing would provide 400 ml. On 2/14/17, the dietary progress notes for Resident #66 was reviewed. The notes indicated that Resident #66 had been presenting with fluid weight gain between hemodialysis treatments with previous weight not reflecting a dry weight. A 1000 ml. fluid restriction had since been ordered. The hemodialysis communication form was reviewed. The form dated 2/17/17 revealed that Resident #66's potassium (mineral needed for	F 309	juice on 3/17/17 by the Unit Manager. 2. An audit was completed of the current resident's dietary cards by the Director of Nursing and the Dietary Manager on 3/29/17 to ensure dietary and supplement orders are followed as required. There were 7 additional residents identified in the audit and the tray cards were updated at this time by the Dietary Manager. 3. The dietary staff and the licensed nurses were reeducated by the Director of Nursing on 4/3/17 related to ensuring dietary orders are communicated to dietary by the Licensed Nurse and dietary cards remain updated to ensure dietary and supplement orders are followed as required. The licensed nurses will communicate changes to dietary orders to the dietary staff. The Dietary Manager will ensure dietary cards are updated. 4. The Director of Nursing or Assistant Director of Nursing will complete an audit weekly for 4 weeks and monthly for 2 months to ensure dietary cards remain update by the Dietary Manager and to ensure dietary and supplement orders continue to communicate to the dietary staff by the Licensed Nurse as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion Date: 04/10/17	

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F 309	Continued From page 18	F 309		

normal heart and muscle action) level was 2.8 (low) and the goal was 3.5 to 6.0. The dialysis clinic recommended to increase dietary potassium intake of 20 ounces (oz.) of orange juice daily.

On 2/17/17, Resident #66 had a physician's order to provide increase potassium in diet by providing 20 oz. of orange juice per day.

On 2/20/17, there was a physician's order for Resident #66 to increase potassium to 20 milli equivalent (meq.) by mouth daily from 10 meq daily.

On 3/8/17, the dietary progress notes for Resident #66 revealed that the potassium level was low with an order to provide 20 oz. of orange juice daily.

On 3/15/17 at 12:30 PM, Resident #66's lunch tray was observed. The tray contained 180 ml of tea and 240 ml of milk. There was no orange juice on the tray. The resident was able to feed herself. The dietary card did not reflect the fluid restriction or the orange juice.

On 3/16/17 at 8:10 AM, Resident #66 was observed eating breakfast in her room. The tray contained 180 ml of coffee, 120 ml of orange juice and 240 ml of milk.

On 3/16/17 at 9:30 AM, there was a bottle of orange soda (591ml) observed on top of the over the bed table.

On 3/16/17 at 8:05 AM, the Dietary Manager (DM) was interviewed. She stated that she was not aware that Resident #66 was on 1000 ml fluid

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F 309	Continued From page 19	F 309		

restriction or had an order for 20 oz. of orange juice. The DM stated that if she had been aware of the order for fluid restriction and the orange juice, it should have been written on the dietary card the amount of fluid to be provided each meal.

On 3/16/17 at 8:20 AM, Nurse #5 was interviewed. Nurse #5 was the nurse who wrote the order for the orange juice. She stated that she could not remember if she had informed dietary of the order for the orange juice. She also indicated that she had called the dialysis clinic and the dialysis nurse indicated that the 20 oz. of orange juice was included on the 1000 ml fluid restriction.

Nurse #6, who wrote the order for the 1000 ml fluid restriction, was not available for interview.

On 3/16/17 at 10:30 AM, the Physician of Resident #66 was interviewed. He stated that if the dialysis clinic had recommended fluid restriction and orange juice and he gave orders for fluid restriction and orange juice, he expected the staff to follow his orders.

On 3/16/17 at 10:40 AM, the Dialysis Nurse was interviewed. She stated that she expected the facility to follow their recommendations for fluid restriction and orange juice due to hypokalemia. She also stated that at times Resident #66 had fluid weight gain of 1 kilogram so the 1000 ml fluid restriction was important.

On 3/16/17 at 10:55 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to follow the physician's orders for the fluid restriction and for the orange

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F 309	Continued From page 20 juice.	F 309		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to check the tube placement prior to administering the medications and tube feeding via gastrostomy tube (GT) for 1 of 2 sampled residents observed (Resident # 94). Findings included: The facility policy on gastrostomy feedings dated 7/07 was reviewed. The policy read, in part, "check placement of the feeding tube to be sure it hasn't slipped out since the last feeding. Never	F 322	F 322 1. Resident #94 gastrostomy tube placement was checked on 3/17/17 by the charge nurse and no concerns were noted. Nurse #1 and Nurse #5 were reeducated related to the requirements of checking gastrostomy tube placement prior to administrating medication and tube feeding on 3/17/17 by the Director of	4/10/17

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F 322	Continued From page 21 give a tube feeding if placement is not certain. To check tube patency and position, remove the cap or plug from the feeding tube and use the syringe to inject 5 to 10 cubic centimeter of air through the tube. At the same time, auscultate the resident's stomach with the stethoscope. Listen for a whooshing sound to confirm tube positioning in the stomach." Resident #94 was admitted to the facility on 1/9/17 with multiple diagnoses including Motor Vehicle Accident. The admission Minimum Data Set assessment dated 1/16/17 indicated that Resident #94 had memory and decision making problems and was on feeding tube while a resident at the facility. The assessment further indicated that the resident was totally dependent on the staff for eating. The care plan for Resident #94 dated 1/16/17 was reviewed. The care plan problem was "requires nutrition/calorie via tube feeding." The goal was "resident will be free of complications from use of tube feedings." The approaches included check for GT placement as ordered. Resident #66 had a physician's order dated 2/15/17 for (name of tube feeding formula) 1.2 - 2 cans 4 times a day and to check tube placement every day and night shift. On 3/16/17 at 8:120 AM, Nurse # 1 and Nurse #5 were observed during the medication pass. Nurse #5 was observed to listen to Resident #94's bowel sounds using a stethoscope. The nurse was not observed to use a syringe to check for tube placement. Nurse #1 was observed to administer the resident's medications followed with 2 cans of the feeding formula via the GT.	F 322	Nursing. 2. An audit of the current residents with gastrostomy tubes was completed on 3/30/17 and 4/3/17 by the Director of Nursing to ensure tube placement is being checked by the Licensed Nurses as required with no additional concerns identified. 3. Licensed Nurses including weekend and prn licensed nursing staff were reeducated on 3/30/17 by the Assistant Director of Nursing related to the requirements of checking gastrostomy tube placement prior to administrating medication and tube feeding. Licensed nurses will be required to complete reeducation prior to beginning their shift. 4. The Director of Nursing will complete an observation audit of 5 residents weekly for 4 weeks and monthly for 2 months to ensure nurses continue to check gastrostomy tubes for placement prior to administrating medication and tube feeding as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion Date: 04/10/17	

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F 322	Continued From page 22 On 3/16/17 at 8:35 AM, Nurse # 5 was interviewed. She stated that she checked tube placement by listening to the resident's bowel sounds using a stethoscope. Nurse #5 stated that she didn't use a syringe in checking for tube placement. On 3/16/17 at 11:30 AM, the Director of Nursing was interviewed. She stated that she expected the nurses to follow the facility's policy in checking tube placement by using a stethoscope and a syringe prior to administering medications and or tube feeding.	F 322		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observations and	F 325	F 325	4/10/17

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F 325	Continued From page 23 physician and staff interview, the facility failed to provide a dietary supplement as ordered by the physician for 1 of 2 sampled residents reviewed for nutrition (Resident #66). Findings included: Resident #66 was admitted to the facility on 1/31/17 with multiple diagnoses including End Stage Renal Disease (ESRD). The admission Minimum Data Set (MDS) assessment dated 2/7/17 indicated that Resident #66 had severe cognitive impairment and was independent with eating. Review of Resident #66's weights since admission to the facility revealed the following weight loss from 2/1/17 to 3/8/17: 2/1/17 - 139 pounds (lbs.) 2/8/17 - 139 lbs. 2/15/17 - 129 lbs. 2/22/17 - 121 lbs. 3/8/17 - 118 lbs. The resident's care plan dated 2/7/17 was reviewed. The care plan problems included potential for alteration in fluid volume and nutrition. The goal was for the resident to maintain current body weight through the next 30 day review period. The approaches included to provide dietary supplement as ordered. On 3/1/17, Resident #66 had a physician's order for Marinol 2.5 milligrams (mgs.) by mouth two times a day for appetite stimulant. On 3/8/17, Resident #66 had a physician's order to change Marinol to Megace (an appetite stimulant) 40 mgs two times a day and for an order for a dietary supplement with each meal for	F 325	1. Resident #66's dietary card was updated on 3/17/17 by the Dietary Manager to include the dietary supplement as ordered. 2. An audit was completed of the current resident's dietary cards by the Director of Nursing and the Dietary Manager on 3/29/17 to ensure dietary and supplement orders are followed as required. There were 7 additional residents identified in the audit and the tray cards were updated at this time by the Dietary Manager. 3. The dietary staff and the licensed nurses including weekend and prn were reeducated by the Director of Nursing by 4/3/17 related to ensuring dietary order changes including new dietary orders are communicated to the dietary department by the Licensed Nurse and dietary cards remain updated to ensure dietary and supplement orders are followed as required. Dietary staff and licensed nurses will be required to complete this education prior to beginning their shift. The licensed nurses will communicate changes dietary orders to the dietary staff. The Dietary Manager will be responsible to ensure dietary cards are updated. 4. The Director of Nursing will complete and audit weekly for 4 weeks and monthly for 2 months to ensure dietary order changes including new dietary orders are communicated to the dietary department by the Licensed Nurse and dietary cards continue to be updated by the Dietary	

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F 325	Continued From page 24 weight loss. The dietary progress for Resident #66 dated 3/14/17 revealed that the resident was on Marinol for appetite stimulation which was later changed to Megace along with dietary supplement with each meal for nutritional support. On 3/15/17 at 12:30 PM, Resident #66's lunch tray was observed. The resident's tray did not contain the dietary supplement. The resident was able to feed herself. The dietary card, served with Resident #66's lunch meal, did not reflect the order for the dietary supplement. On 3/16/17 at 8:10 AM, Resident #66 was observed eating breakfast in her room. The resident's tray did not have a dietary supplement. The dietary card, served with Resident #66's breakfast meal, did not reflect the order for the dietary supplement. On 3/16/17 at 8:05 AM, the Dietary Manager (DM) was interviewed. She stated that she was not aware that Resident #66 had an order for a dietary supplement to be served at meals. The DM stated that if she had been aware of the order for a dietary supplement, it should have been written on the resident's dietary card to be provided with each meal. On 3/16/17 at 8:15 AM, Nurse # 7 was interviewed. She acknowledged that she wrote the order for the dietary supplement on 03/08/17 with each meal for Resident #66 due to weight loss. Nurse #7 also indicated that she had completed a communication form reflecting the order for the dietary supplement and had given the form to the dietary department.	F 325	Manager to ensure dietary and supplement orders are followed as required. The Director of Nursing will submit a report to the quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion Date: 04/10/17	

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F 325	Continued From page 25 On 3/16/17 at 10:30 AM, the Physician of Resident #66 was interviewed. He stated that he expected the staff to follow his order for the dietary supplement to be served to Resident #66 with each meal as an intervention to help the resident from experiencing further weight loss. On 3/16/17 at 10:55 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to follow the physician's orders for the dietary supplement to be served to Resident #66 at each meal.	F 325		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		4/10/17

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F 329	Continued From page 26 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observations, staff, physician, pharmacist interviews and record review, the facility failed to evaluate a prescribed hypnotic for the lowest effective dose for 1 of (Resident #45) 5 residents reviewed for unnecessary medications. Findings included: Resident #45 was admitted on 3/13/15 with cumulative diagnoses of anxiety, depression, psychosis, dementia, seizures and insomnia. A review of Resident #45 ' s physician orders indicated she was re-started on Trazodone 50 milligrams (mg) every night at bedtime on 7/8/15 for insomnia. The annual Minimum Data Set (MDS) dated 9/7/16 had a Care Area Assessment (CAA) for her psychotropic medications. Her prescribed medications included Trazodone used for sleep due to insomnia (hypnotic). The assessment did not include a CAA for documented behaviors.	F 329	F 329 1. Resident #45's physician was updated by the charge nurse and a gradual dose reduction of Trazadone was completed on 3/17/17. 2. An audit of the current residents' receiving psychotropic medications was completed on 4/3/17 by the Assistant Director of Nursing and reviewed by the Medical Director to ensure gradual dose reductions have been completed as required. No additional concerns were identified during this audit. 3. The Pharmacy Consultant was re-educated by the Pharmacy Clinical Manager by 4/6/17 related to the requirements of psychotropic medication gradual dose reductions.	

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F 329	Continued From page 27 A review of Resident #45 ' s Behavior Monthly Flow Sheet from April 2016 to 3/15/17 had no documented episodes of insomnia. A review of the monthly pharmacy notes from April 2016 to 3/15/17 did not include any mention of Resident #45 ' s Trazodone. A review of Resident #45 ' s nursing notes from July 1, 2016 to 3/14/17 did not include any notes related to insomnia on the evening or night shift. The facility was unable to provide any pharmacy recommendations for Resident #45 prior to July 2016. The provided pharmacy recommendations were as follows: -7/14/16-GDR recommendation of her seizure medication. The physician agreed and signed the recommendation on 7/14/16. -8/22/16-GDR recommendation for her antipsychotic medication. The physician agreed and signed the recommendation on 8/23/16. -11/22/16- A recommendation to discontinue her Aspirin. The physician agreed and signed the recommendation on 12/1/16. -1/24/17-GDR recommendation for her antianxiety medication and increased her cognition-enhancing medication. They physician agreed and signed the recommendations on 2/1/17. The most recent quarterly MDS dated 1/27/17 indicated Resident #45 had severe cognitive impairment, no behaviors and no trouble falling asleep. Resident #45 was last seen by the physician on 2/14/17. The progress note read no changes in	F 329	4. The Pharmacy Supervisor will an audit 15 residents monthly for 3 months to ensure gradual dose reductions continue to be completed on psychotropic medications as required. The Pharmacy Supervisor will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing and Administrator will be responsible for monitoring and follow up. Completion Date: 04/10/17	

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condition or plan of care.

Resident #45 ' s last monthly pharmacy review was 2/21/17. There was no new recommendations.

Resident #45 was care planned was last revised on 2/24/17 for the potential of adverse effects related to the use of psychotropic medications. Interventions included a monthly pharmacy review and a grade dose reduction attempt as needed and required for the psychotropic medications to include the Trazodone. There was no specific care plan for insomnia.

Resident #45 ' s psychiatric note dated 2/28/17 read there was no mood or behavioral concerns at present. She denied any concerns with sleep or appetite. The Trazodone was continued.

In an observation on 3/13/16 at 4:00 PM, Resident #45 was in bed with her sheet pulled over her head.

In an observation on 3/14/16 at 1:00 PM, Resident #45 was in bed with her sheet pulled over her head.

In an observation on 3/15/17 at 11:22 AM, Resident #45 was sitting in a high back wheelchair in the lobby holding a stuffed animal. She appeared cooperative with staff and she did not appear agitated. In an interview with Nursing Assistant (NA) #2, she stated Resident #45 was cooperative and did not have any behaviors. She stated Resident #45 always liked to cover her head with her sheet and that was not a new behavior. NA #2 stated Resident #45 was not restless but rather the opposite. She stated at

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F 329	Continued From page 29 times, she was very sleepy and did not want to participate in her activities of daily living (ADLs). NA #2 stated Resident #45 was always sleeping when she arrived and it was never reported that she had problems sleeping during the night. In a telephone interview on 3/16/17 at 8:10 AM, the consultant pharmacist stated her company started at the facility in June of 2016. She could not account for anything that occurred prior to June 2016 but she started attempting GDR ' s with the high risk medications first. She could not explain why the Trazodone prescribed for insomnia had not been considered for a GDR since it was started July 8, 2015. In a telephone interview on 3/16/17 at 9:15 AM, the psychiatric nurse practitioner stated she was new to the facility. She stated she made recommendations if warranted based on her observations, interviews and record review. If the pharmacist suggested a GDR based on the regulations, it was up to the physician to agree to disagree based on a past decompensation of Resident #45. In a telephone interview on 3/16/17 at 10:30 AM, the physician stated he would have expected a Trazodone GDR recommendation prior to now to see if a lower dose would have been effective.	F 329		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		4/10/17

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(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

(5) The facility must develop and maintain policies and procedures for the monthly drug regimen

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F 428	Continued From page 31 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 medical record review, physician and pharmacist interviews, the consultant pharmacist failed to identify and address a Gradual Dose Reduction (GDR) for an hypnotic (Trazodone) medication ordered for 1 of 5 sampled resident reviewed for unnecessary drugs (Resident #45). Findings included: Resident #45 was admitted on 3/13/15 with cumulative diagnoses of anxiety, depression, psychosis, dementia, seizures and insomnia. A review of Resident #45's physician orders indicated she was re-started on Trazodone 50 milligrams (mg) every night at bedtime on 7/8/15 for insomnia. The physician order review also indicated there was no changes regarding the Trazodone since it was re-started on 7/8/15. The annual Minimum Data Set (MDS) dated 9/7/16 had a Care Area Assessment (CAA) for her psychotropic medications. Her prescribed medications included Trazodone used for sleep due to insomnia (hypnotic). The assessment did not include a CAA for documented behaviors. A review of Resident #45 ' s Behavior Monthly Flow Sheet from April 2016 to 3/15/17 had no documented episodes of insomnia. A review of the monthly pharmacy notes from April 2016 to 3/15/17 did not include any mention	F 428	F 428 1. Resident #45's physician was updated by the charge nurse and a gradual dose reduction of Trazadone was completed on 3/17/17. 2. An audit of the current residents' pharmacy recommendations for the last 90 days were reviewed on 4/3/17 by the Assistant Director of Nursing to ensure identified irregularities are addressed by the pharmacist and reviewed by the Medical Director. No additional concerns were identified during this audit. 3. The Pharmacy Consultant was re-educated by the Pharmacy Clinical Manager by 4/6/17 related to completing Drug Regimen Reviews as required. 4. The Pharmacy Supervisor will audit 15 residents monthly for 3 months to ensure Drug Regimen Reviews continue to be completed as required. The Pharmacy Supervisor will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up. Completion Date: 04/10/17	

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of Resident #45's Trazodone.

A review of Resident #45's nursing notes from July 1, 2016 to 3/14/17 did not include any notes related to insomnia on the evening or night shift.

The facility was unable to provide any pharmacy recommendations for Resident #45 prior to July 2016. The provided pharmacy recommendations were as follows:
-7/14/16-GDR recommendation of her seizure medication. The physician agreed and signed the recommendation on 7/14/16.
-8/22/16-GDR recommendation for her antipsychotic medication. The physician agreed and signed the recommendation on 8/23/16.
-11/22/16- A recommendation to discontinue her Aspirin. The physician agreed and signed the recommendation on 12/1/16.
-1/24/17-GDR recommendation for her antianxiety medication and increased her cognition-enhancing medication. They physician agreed and signed the recommendations on 2/1/17.

The most recent quarterly MDS dated 1/27/17 indicated Resident #45 had severe cognitive impairment, no behaviors and no trouble falling asleep.

Resident #45 was last seen by the physician on 2/14/17. The progress note read no changes in condition or plan of care.

Resident #45's last monthly pharmacy review was 2/21/17. There was no new recommendations.

Resident #45 was care planned was last revised on 2/24/17 for the potential of adverse effects

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related to the use of psychotropic medications. Interventions included a monthly pharmacy review and a grade dose reduction attempt as needed and required for the psychotropic medications to include the Trazodone. There was no specific care plan for insomnia.

Resident #45's psychiatric note dated 2/28/17 read there was no mood or behavioral concerns at present. She denied any concerns with sleep or appetite. The Trazodone was continued.

In a telephone interview on 3/16/17 at 8:10 AM, the consultant pharmacist stated her company started at the facility in June of 2016. She could not account for anything that occurred prior to June 2016 but she started attempting GDR's with the high risk medications first. She could not explain why the Trazodone prescribed for insomnia had not been considered for a GDR since it was started July 8, 2015.

In a telephone interview on 3/16/17 at 9:15 AM, the psychiatric nurse practitioner stated she was new to the facility. She stated she made recommendations if warranted based on her observations, interviews and record review. If the pharmacist suggested a GDR based on the regulations, it was up to the physician to agree to disagree based on a past decompensation of Resident #45.

In a telephone interview on 3/16/17 at 10:30 AM, the physician stated he would have expected a Trazodone GDR recommendation from the consultant pharmacist prior to now to see if a lower dose would have been effective.