STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN NORTH CAROLINA BAPTIST HOME	**213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806**

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation, Event ID # 6L2Y11.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582		7/26/18

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

Electronically Signed | 08/15/2018

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F 582	Continued From page 1 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a CMS-10055 SNF ABN (Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice) prior to discharge from Medicare Part A skilled services to 2 of 4 residents reviewed for beneficiary protection notification review (Residents #21 and #25). Findings included: 1. Resident #21 was admitted to the facility on 12/26/17. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #21's Responsible Party (RP) on 01/05/18 which indicated Medicare Part A coverage for skilled	F 582	A) The CMS 10055 SNF SBN will be sent out along with all the required Medicare A information to all the Medicare A Residents prior to their discharge so that they or their family can determine whether or not to pay privately for continued therapy for the Resident. The Business Office manager forgot and neglected to send out the CMS 10055 along with the other required Medicare information. B) The Business office Manager will ensure that all Medicare A forms and information are received by the Resident/Power of Attorney and keep a log of the receipt of those forms. C) The Administrator will be responsible for implementing plan of correction and	

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F 582	Continued From page 2 services would end on 01/08/18. Resident #21 remained in the facility. A review of the medical record revealed a CMS-10055 SNF ABN was not provided to Resident #21 or their RP. An interview was conducted with the Business Office Manager (BOM) on 07/26/18 at 2:45 PM who confirmed she issued the CMS-10123 NOMNC once notified a resident's Medicare Part A coverage for skilled services was ending. The BOM added she was unaware a CMS-10055 SNF ABN was also required when a resident remained in the facility. She confirmed Resident #21's RP was not issued a CMS-10055 SNF ABN prior to Medicare Part A services ending. An interview was completed with the Administrator on 7/26/18 at 5:33 PM. He stated he would expect for the facility to follow CMS Federal guidelines and issue the required notices to residents and/or their RP when Medicare skilled services were ending. 2. Resident #25 was admitted to the facility on 03/24/18. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #25's Responsible Party (RP) on 04/05/18 which indicated Medicare Part A coverage for skilled services would end on 04/08/18. Resident #25 remained in the facility. A review of the medical record revealed a CMS-10055 SNF ABN was not provided to	F 582	will monitor the log monthly to ensure all appropriate forms have been received by the Residents and/or POAs. D) The Business Office Manager will implement the changes and will maintain the log. The Administrator will bring the logs to the attention of the Quality Assurance Team's (The Medical Director, Director of Nursing, Care Plan Coordinator, Dietary Manager, Activity Director, Pharmacy Consultant, Therapy Manager and Administrator)monthly meeting for their review and recommendations for the next 90 days. E) July 26, 2018	

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F 582	Continued From page 3 Resident #25 or their RP. An interview was conducted with the Business Office Manager (BOM) on 07/26/18 at 2:45 PM who confirmed she issued the CMS-10123 NOMNC once notified a resident's Medicare Part A coverage for skilled services was ending. The BOM added she was unaware a CMS-10055 SNF ABN was also required when a resident remained in the facility. She confirmed Resident #25's RP was not issued a CMS-10055 SNF ABN prior to Medicare Part A services ending. An interview was completed with the Administrator on 07/26/18 at 5:33 PM. He stated he would expect for the facility to follow CMS Federal guidelines and issue the required notices to residents and/or their RP when Medicare Part A skilled services were ending.	F 582		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		8/23/18

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F 584	Continued From page 4 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair stained flooring or cracked caulking around the base of toilets in resident bathrooms in 5 resident rooms (Room #Z06, #Z07, #Z09, #Z104 and #Z108) on 2 of 4 resident hallways. Findings included: a. Observations in the bathroom of resident room #Z06 on 07/23/18 at 11:40 AM revealed dark brown stains around the base of the toilet on the floor. Observations in the bathroom of resident room	F 584	A) The old caulking around all the toilets will be replaced with new caulking. All discolored tiles will be replaced with new flooring. The caulking dried up and the Maintenance Director neglected to check each and every toilet area to determine that the caulking dried up and cracked and that some of the floor tiles had stained and needed to be replaced as required. B) The Maintenance Department will replace all the old caulking around all the toilets and replace any discolored tiled	

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F 584	Continued From page 5 #Z06 on 07/24/18 at 2:29 PM revealed dark brown stains around the base of the toilet on the floor. Observations in the bathroom of resident room #Z06 on 07/25/18 at 9:28 AM revealed dark brown stains around the base of the toilet on the floor b. Observations in the bathroom of resident room #Z07 on 07/23/18 at 11:39 AM revealed dark brown stains around the base of the toilet on the floor and caulking was cracked and was partially missing. Observations in the bathroom of resident room #Z07 on 07/24/18 at 2:30 PM revealed dark brown stains around the base of the toilet on the floor and caulking was cracked and was partially missing. Observations in the bathroom of resident room #Z07 on 07/25/18 at 9:35 AM revealed dark brown stains around the base of the toilet on the floor and caulking was cracked and was partially missing. c. Observations in the bathroom of resident room #Z09 on 07/23/18 at 11:37 AM revealed dark brown stains around the base of the toilet on the floor and caulking was cracked. There was also a strong stale odor in the bathroom. Observations in the bathroom of resident room #Z09 on 07/24/18 at 2:45 PM revealed dark brown stains around the base of the toilet on the floor and caulking was cracked. There was also a stale odor in the bathroom. Observations in the bathroom of resident room #Z09 on 07/25/18 at 12:35 PM revealed dark brown stains around the base of the toilet on the floor and caulking was cracked. There was also a stale odor in the bathroom.	F 584	areas with new flooring. C) The Administrator will be responsible to implement the plan of correction is The Maintenance Director will place this task on the monthly preventative maintenance (PM) report and physically view each bathroom area to ensure any caulking and flooring that needs to be replaced is performed. The Administrator will meet monthly with the Maintenance Director to review the Report and will audit to insure compliance. D) The Administrator will be responsible to implement the plan of correction. The Maintenance Director will monitor the bathrooms and the Administrator will take the PM reports to the QA Team for their review and recommendations. E) August 23, 2018	

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F 584	Continued From page 6	F 584		

d. Observations in the bathroom of resident room #Z104 on 07/23/18 at 2:30 PM revealed dark brown stains around the base of the toilet on the floor and caulking was cracked.
Observations in the bathroom of resident room #Z104 on 07/24/18 at 9:03 AM revealed dark brown stains around the base of the toilet on the floor and caulking was cracked.
Observations in the bathroom of resident room #Z104 on 07/25/18 at 12:39 PM revealed dark brown stains around the base of the toilet on the floor and caulking was cracked.

e. Observations in the bathroom of resident room #Z108 on 07/23/18 at 2:45 PM revealed dark brown stains around the base of toilet on the floor and there was no caulking around the base of the toilet.
Observations in the bathroom of resident room #Z108 on 07/24/18 at 9:18 AM revealed dark brown stains around the base of the toilet on the floor and there was no caulking around the base of the toilet.
Observations in the bathroom of resident room #Z108 on 07/25/18 at 12:41 PM revealed dark brown stains around the base of the toilet on the floor and there was no caulking around the base of the toilet.

During an interview and environmental tour on 07/26/18 at 2:07 PM, the Maintenance Director explained they used a work order system and he had 2 maintenance staff who worked with him. He stated the work orders were kept at the time clock and anyone could complete a work order and there was a slot for staff to put the work orders in after they filled them out. He explained they checked the work orders every morning and

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F 584	Continued From page 7	F 584		

throughout the day as they made their rounds. He stated he reviewed the work order process with employees during orientation and they were expected to complete a work order for any kind of repair or request and he was generally pleased with the requests staff wrote on the work orders. He explained they had no major projects or renovation going on at the present time. During the environmental tour he stated they did not use grout around the base of toilets but they used silicone caulking. He explained the dark stains around the base of the toilet in Room #Z06 looked like rust stains and they needed to be removed or the floor replaced. He stated in the bathroom of resident room #Z09 the caulking around the base of the toilet needed to be fixed and stains removed from the floor and he was unaware of the damaged caulking or the condition of the floor. He confirmed in the bathrooms of resident room #Z07 and #Z104 the floor around the base of the toilet needed to be repaired. He stated in the bathroom of #Z108 the floor at the base of the toilet needed to be repaired and it did not appear that caulking had been done around the base of the toilet. He further stated he did not have a schedule for checking resident bathrooms and did not go in and check them on a routine basis.

During an interview on 07/26/18 at 4:23 PM, the Director of Nursing stated she and the Administrator had recently started making hall rounds but stated they did not make regular environmental rounds to look at things such as bathroom floors.

During an interview on 07/26/18 at 6:04 PM, the Administrator stated it was his expectation for bathroom floors to be clean and caulking around

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F 584	Continued From page 8 the base of toilets. He further stated it should be as good as it can get.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to revise or update a resident's care plan with an intervention of padding of oxygen tubing at a	F 657	A) The Care Plans and any revisions were updated immediately upon identification of current residents. Any updates and revisions will be updated	8/23/18

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F 657	Continued From page 9 resident's ear for 1 of 3 care plans reviewed for oxygen therapy (Resident #21). Findings included: Resident #21 was admitted to the facility on 12/26/17 with diagnoses which included hypothyroidism, generalized muscle weakness, high blood pressure, osteoarthritis and dementia. A review of the most recent quarterly Minimum Data Set (MDS) dated 06/07/18 revealed Resident #21 was cognitively intact for daily decision making. The MDS also revealed Resident #21 required extensive assistance for bed mobility, dressing, toileting and hygiene and oxygen therapy was indicated. A review of a physician's order dated 06/19/18 revealed in part Resident #21 had a stage 2 pressure ulcer on her right ear. A review of a care plan dated 06/19/18 revealed in part Resident #21 had impaired skin integrity related to pressure related to lying on right side in bed and presence of oxygen tubing. The care plan further revealed Resident #21 insisted on only lying on her right side when in bed. The goal indicated the pressure ulcer would reduce in size or heal by 08/19/18 and the approaches were listed in part for the Nurse to measure and monitor wound status progression or deterioration every week, keep pressure off of right ear area as much as possible, encourage resident to alternate lying on her left side and back when in bed and padded tubing for nasal cannula at ears. A review of a wound and skin assessment dated 07/19/18 revealed in part a partial thickness	F 657	immediately upon identification for all future residents. The Resident did not want the padding on the oxygen tubing but the Care Plan Coordinator was unaware of the Residents preference and neglected to make the appropriate changes to the Residents care plan as required. B) The Staff will be in-serviced to immediately pass on any revisions regarding the care of the Resident to the Care Plan Coordinator so they can update those revisions as soon as possible. C) The Care Plan Coordinator will bring any and all updates to the weekly Q/A Meeting so the Q/A members can review and make any recommendations. D) The Director of Nursing will be responsible to implement the plan of correction. The Care Plan Coordinator will meet with the Director of Nursing to implement and review any revisions to the Resident's care plans for the next 90 days. E) August 23, 2018	

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F 657	Continued From page 10	F 657		

wound and stage 2 pressure ulcer of Resident #21's right ear.

During an observation on 07/23/18 at 2:54 PM Resident #21 was seated in a recliner next to her bed with a nasal cannula in place and the tubing was looped over each ear and connected to an oxygen concentrator with oxygen on at 2 liters per minute. There was no padding of the oxygen tubing at her right or left ears.

During an observation on 07/24/18 at 5:24 PM Resident #21 was seated in a recliner next to her bed with a nasal cannula in place and the tubing was looped over each ear and was connected to an oxygen concentrator with oxygen on at 2 liters per minute. There was no padding of the oxygen tubing at her right or left ears.

During an observation and interview on 07/25/18 at 2:49 PM Resident #21 was seated in a recliner next to her bed with a nasal cannula in place and the tubing was looped over each ear and was connected to an oxygen concentrator with oxygen on at 2 liters per minute. There was no padding of the oxygen tubing at her right or left ears. Resident #21 explained she just woke up one morning recently and there was blood from her right ear. She stated she did not know where the blood came from but one of the staff said the oxygen tubing had caused it. She stated they put padding on it for a while but it had been awhile since anyone had put any padding on it.

During an interview on 07/26/18 at 2:45 PM, Nurse Aide (NA) #1 stated she took Resident #21 to the bathroom earlier this afternoon and when she walked Resident #21 back to her recliner she put Resident #21's oxygen tubing back in her

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nose and over her ears. She stated she did not see any padding on the oxygen tubing. She explained a few weeks ago Resident #21 had a sore on her right ear and had a dressing and some kind of ear pieces around the tubing but she had not seen them since then.

During an interview on 07/26/18 at 3:07 PM, Nurse #1 stated Resident #21 complained of difficulty breathing at times and wore oxygen all the time. She explained Resident #21 slept on her right side and did not want to turn off that side and then developed a pressure ulcer on her right ear a few weeks ago. She stated she saw Resident #21 earlier today and looked at her ear but did not see any padding around the tubing at her right or left ears. She stated she was not aware the padding of the oxygen tubing was still listed on the care plan as an intervention.

During an interview on 07/26/18 at 4:03 PM, Nurse #2 who was responsible for Resident Assessments explained when an area was identified such as the pressure ulcer on Resident #21's ear staff told her and she initiated the care plan for the foam to be applied to her oxygen tubing at her ears. She stated nurses and NAs usually reported when things changed but no one had told her Resident #21 was not wearing the foam protectors and it had not occurred to her to go back and check on it. She explained Resident #21's care plan should have been revised and updated since she was not wearing the foam ear protectors. She stated they should have discussed Resident #21's care plan interventions and whether she needed the foam protectors on the oxygen tubing.

During an interview on 07/26/18 at 4:45 PM, the

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WESTERN NORTH CAROLINA BAPTIST HOME	213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806

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F 657	Continued From page 12 Director of Nursing (DON) stated Resident #21 did not like the foam padding on the oxygen tubing at her ears and did not want to wear them. She explained it was her expectation for staff to talk about whether interventions were effective at weekly team meetings and they should either make changes to the interventions or discontinue them. She further stated it was her expectation Resident #21's care plan should have been revised.	F 657		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		8/23/18

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F 758	Continued From page 13 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Consultant Pharmacist, and physician interviews the facility failed to ensure a physician's order for as needed (PRN) antidepressant and anxiolytic (anxiety reducing) medication was time limited in duration or had justification for continued use for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #34). Findings included: Resident #34 was admitted to the facility on 10/24/17 with diagnoses that included Lewy-Body dementia (abnormal protein deposit in brain), depression and anxiety disorder.	F 758	A) In-Service the Medical Director on the regulation for the 14-day rule for PRN psychotropic medications and begin using electronic medication administration review (EMar) stop dates, when a short dated order is given by the physician. The Medical Director and the nursing staff neglected to set a 14 day stop date for PRN psychotropic medications as required. B) The Physician/Medical Director will only prescribe a 14 day dosage for all initial PRN psychotropic medications. This will be documented properly in the EMar. Designated nursing staff will utilize	

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F 758	Continued From page 14 The quarterly Minimum Data Set (MDS) assessment dated 06/28/18 indicated Resident #34 was cognitively impaired. The MDS indicated Resident #34 received antidepressant and anxiolytic medication on 7 of 7 days. A physician's order for Resident #34 dated 05/09/18 indicated Trazodone (antidepressant medication) 50 milligram (mg) 1/2 tablet (25 mg) by mouth every 4 hours PRN (as needed) for anxiety/agitation and Trazodone 50 mg 1 tablet by mouth at bedtime as needed for insomnia (difficulty falling asleep). There was no 14 day duration indicated on the physician's order for Resident #34's PRN Trazodone 25 mg for anxiety/agitation and Trazodone 50 mg for insomnia. A physician's order for Resident #34 dated 06/16/18 indicated Lorazepam (anxiolytic) 0.5 mg via intermuscular (IM) every 8 hours PRN for agitation that would be harmful to self or others. There was no 14 day duration indicated on the physician's order for Resident #34's PRN Lorazepam. A review of the medication administration record (MAR) revealed Resident #34 received PRN Trazodone 25 mg as follows: 17 doses in May, 13 doses in June, and 10 doses in July 2018. Resident #34 received PRN Trazodone 50 mg as follows: 9 doses in May, 10 doses in June, and 3 doses in July 2018. Resident #34 received PRN Lorazepam 0.5 mg IM as follows: 1 dose in July 2018. Resident #34's MAR revealed for the month of May, June, and July no indication of a limited duration for PRN Trazodone 25 mg, Trazodone 50 mg, and Lorazepam 0.5 mg. A review of the physician's progress notes indicated the physician saw Resident #34 on	F 758	EMar reports weekly to monitor for PRN psychotropic medications and stop dates. C) The Director of Nursing will perform weekly audits to ensure our compliance for the next 90 days. These audits will be brought to the weekly Q/A meeting for review and recommendations. D) The Medical Director and the Director of Nursing will be responsible to implement the plan of correction. The Director of Nursing and the Care Plan Coordinator will QAPI(Quality Assurance Performance Improvement) this process for the next three months to insure compliance and bring this to the monthly Q/A team meetings for the next 90 days. E) August 23, 2018	

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05/10/18, 05/23/18, 06/16/18, and 07/18/18 and did not indicate a limited duration or document justification/rationale for continuing PRN Trazodone 25 mg, Trazodone 50 mg, and Lorazepam 0.5 mg.

On 05/11/18 the Consultant Pharmacist (CP) reviewed the PRN order for Trazodone 25 mg 1 tablet by mouth every 4 hours for anxiety/agitation and Trazodone 50 mg 1 tablet by mouth at bedtime for insomnia. The CP recommended to the physician per new regulations per Centers of Medicare & Medicaid Services (CMS) that PRN antidepressant and anxiolytic medication required a limited duration of 14 days or documentation for justification/rational for continued use beyond 14 days. The CP recommended per the new regulations that the physician should indicate a 14 day stop date for PRN Trazodone 25 mg and Trazodone 50 mg unless a clinical justification/rationale was provided for continuing PRN Trazodone greater than 14 days. On 06/18/18 the CP wrote a pharmacy progress note for the physician and did not indicate a recommendation for duration limit for PRN Trazodone 25 mg and Trazodone 50 mg or request justification/rationale for continued use. On 07/13/18 the CP note to the physician requested that the physician provide duration limit or document justification/rational for continued use of PRN Trazodone 25 mg, Trazodone 50 mg, and Lorazepam 0.5 mg per CMS regulations.

On 07/25/18 at 8:32 AM an interview was conducted with the physician who stated he was aware of the new regulation from CMS for PRN psychotropic medication (antidepressant and anxiolytic) that required a 14 day duration unless he documented justification/rationale to continue.

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The physician stated he did not write a duration for PRN psychotropic medication and relied on the CP to remind him of when he needed to rewrite the PRN order for psychotropic medication or document justification/rationale for continued use. The physician stated he could do a better job of writing PRN psychotropic medication orders with adding a stop date after 14 days or document a justification/rationale for continued use after 14 days and not rely on the CP to remind him.

On 07/25/18 at 2:49 PM an interview was conducted with the Consultant Pharmacist who stated she was aware of the new regulation form CMS that indicated PRN psychotropic medication required a time limit duration of 14 days or the physician had to document justification/rationale for continued use beyond 14 days. The CP stated on 05/11/18 she sent a pharmacist to physician note inquiring if the physician wanted to continue PRN Trazodone 25 mg every 4 hours for anxiety/agitation and Trazodone 50 mg at bedtime for insomnia beyond 14 days or document justification/rationale for continued use. The CP stated the physician responded on 5/20/18 that he would discuss with the CP regarding the duration of the PRN Trazodone medication. The CP stated the physician discussed Resident #34's PRN Trazodone with her and she explained the new regulation requiring limit of 14 day duration for PRN psychotropic medication or the physician could document justification/rationale for continued use beyond 14 days. The CP stated after the discussion the physician did not indicate a limited duration or provide documentation for continued use of PRN Trazodone 25 mg and Trazodone 50 mg for Resident #34. The CP stated she did not

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know if it was an oversight that the physician did not write a limited time duration or document justification/rationale for Resident #34's PRN Trazodone after their discussion. The CP stated on 6/18/18 she provided the physician with a pharmacist to physician note and she forgot to address with the physician Resident #34's PRN Trazadone 25 mg 1 tab every 4 hours and Trazodone 50 mg 1 tab at bedtime. The CP stated the physician placed Resident #34 on PRN Lorazepam 0.5 mg IM every 8 hours for agitation on 06/16/18. The CP stated the physician did not include a time limit duration of 14 days for the PRN Lorazepam for Resident #34. The CP stated she provided a pharmacist to physician note to the physician on 07/13/18 that recommended per new regulations that PRN Trazodone 25 mg 1 tab every 4 hours for anxiety/agitation, PRN Trazodone 50 mg 1 tab bedtime for insomnia, and PRN Lorazepam 0.5 mg IM every 8 hours for agitation required limited duration of time or physician documentation that provided justification/rationale for continued use. The CP stated the physician had not yet responded to her recommendation because the CP request was still in process. The consultant pharmacist verified Resident #34 continued receiving PRN Trazodone 25 mg and PRN Trazodone 50 mg since 05/9/18 and PRN Lorazepam since 06/16/18 without limited duration or documentation of justification/rationale for continued use.

On 07/25/18 at 3:57 PM an interview was conducted with the Administrator who stated his expectation was that the physician would have followed the new CMS regulation that required limited duration of 14 days for PRN psychotropic medication or would have documented

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F 758	Continued From page 18 justification/rationale for continued use of PRN Trazodone and PRN Lorazepam for Resident #34	F 758		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure a café cook covered facial hair during a lunch meal service for 1 of 1 meal service observations. Findings included: Observations in the kitchen of the tray line during lunch meal service on 07/25/18 at 11:15 AM revealed a café cook had no covering of facial hair and he was standing behind the tray line at a food preparation table. Continued observations	F 812	A) Facial hair will be covered with a beard restrictor. The dietary aide did not wear the beard guard as instructed and required. B) The Dietary Staff will be in-serviced as to the proper wearing of all beard restrictors and the facility will have them available at all times. C) The Dietary Manager will ensure the availability of the beard restrictors and will	8/20/18

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F 812	Continued From page 19 on 07/25/18 at 11:34 AM revealed the café cook was stirring a container of corn chowder then ladled it into bowls and carried the bowls to the end of the serving line and were placed on resident trays and he did not have facial hair covered. Observations on 07/25/18 at 11:44 AM revealed the café cook placed 4 slices of sandwich bread in toasters and did not have facial hair covered. Continued observations on 07/25/18 at 11:47 AM revealed the cafe cook was making bacon, lettuce and tomato sandwiches at the food preparation table and did not have facial hair covered. During an interview on 07/25/18 at 12:24 PM, the café cook stated he was aware of wearing a cover over facial hair but he forgot to wear a cover over facial hair today. During an interview on 07/25/18 at 12:27 PM the Food Service Director stated her general rule was that if an employee had facial hair longer than eyebrows they should wear a covering but it was open to interpretation. She further stated she probably should change her policy so that if an employee had facial hair they were required to wear a hair guard and that would be less complicated for them to follow. During an interview on 07/26/18 at 6:04 PM, the Administrator stated kitchen staff wore baseball caps or other hair covering and it was his expectation for them to wear hair covering or keep hair closely cropped.	F 812	monitor the staff five days a week as to their proper wearing of beard guards while in the kitchen. D) The Dietary Manage will be responsible to implement the plan of correction. The Dietary Manager will bring the information to the quarterly Q/A meetings for the Q/A team's review and recommendations for the next 90 days. E) August 20, 2018	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		8/23/18

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(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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F 842	Continued From page 21 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and physician interviews the facility failed to maintain a complete and accurate medical record for 1 of 5 residents reviewed for unnecessary medication (Resident #17). The findings included: Resident #17 was admitted to the facility on 03/06/18 with diagnoses that included dementia, depression, and anxiety disorder. The most recent quarterly minimum data set	F 842	A) In-service the Medical Director on the requirement of 60-day in person evaluation of the Residents and their medications and document that assessment in the Medical Record. The Medical Director neglected to document his progress note in the Residents electronic medical record as required. B) The Medical Director will coordinate with the Care Plan Coordinator using a calendar in order to delineate the 60 day time frame for all residents to be seen and	

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F 842	Continued From page 22 (MDS) dated 05/31/18 indicated Resident #17 was cognitively impaired. A review of the medical record revealed no physician progress notes in the medical record since 04/04/18. On 07/25/18 at 3:33 PM a telephone interview was conducted with the physician who stated he had seen Resident #17 on 06/06/18 but did not document a physician progress note in the computer. The physician stated he must have forgotten to document his progress note in the computer and was an oversight. The physician stated he did not have a progress note for the 06/06/18 visit for Resident #17's medical record. On 07/25/18 at 3:43 PM an interview was conducted with the Administrator who stated his expectation was that the physician would have completed a progress note for the medical record per facility policy to indicate he had visited Resident #17 on 06/06/18.	F 842	their individual evaluations documented in their Medical Record in order to maintain an accurate and up to date Medical Record for each and every resident. C) The Director of Nursing and the Care Plan Coordinator will review all the Residents electronic calendars and communicate with the Medical Director in order to track and review the Medical Records for timeliness and accuracy. D) The Medical Director and the Director of Nursing will be responsible to implement the plan of correction. The Director of Nursing and Care Plan Coordinator will present their findings to the Q/A Team on a monthly basis for the next 6 months for their review and recommendations. E) August 23, 2018	