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	345419	A. BUILDING _____ B. WING _____	C 01/07/2019

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LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

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F 000	INITIAL COMMENTS The survey team entered the facility on 12/17/18 to conduct a recertification and complaint investigation survey and exited on 12/20/18. Additional information were obtained on 1/7/19. Therefore, the exit date was changed to 1/7/19.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		1/19/19

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

Electronically Signed | 01/16/2019

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, Nurse Practitioner interview, Physician interview, and record review, the facility failed to notify the physician and the responsible party of Resident #372 being lowered to the floor. The resident sustained a fractured right femur. The facility failed to notify the physician of Resident #36 of significant weight loss. This was evident in 2 of 4 residents reviewed for physician notification. Findings included: 1. Resident #372 was admitted to the facility on 7/1/15 with diagnoses of anxiety, aphasia, and weakness. Her most recent Quarterly Minimum Data Set Assessment dated 11/9/18 revealed she was cognitively intact and required extensive assistance with moving about in bed and toileting, and limited assistance for transferring from the bed and wheelchair. The assessment also	F 580	This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center□s allegation of compliance. All alleged deficiencies have been, or will be completed by the dates indicated. F580 How corrective action will be accomplished for those residents found to have been affected by the deficient practice; " The charge nurse failed to notify the	

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F 580	Continued From page 2 revealed she had no falls since the previous assessment. An incident report dated 11/25/18 at 3:59 pm revealed Nurse #1 was called to Resident #372's bathroom by Nurse Aide #1. Nurse Aide #1 stated Resident #372 got weak during a transfer to the toilet and was slid down to the floor. Nurse #1 documented Resident #372 was on the floor in front of the toilet with her legs in front of her. An interview on 12/20/18 at 11:32 am with Nurse #1 revealed at approximately 9:00 am on 11/25/18 Nurse Aide #1 told her Resident #372 had been lowered to the floor in the bathroom. Nurse #1 stated the resident had no obvious deformities and she denied any pain. Nurse #1 stated she checked Resident #372's range of motion in her extremities, asked if she was having any pain, and got her vital signs. Nurse #1 stated Resident #372 sat up in her wheelchair after the incident and had not complained of pain when she checked on her two times before the end of the shift. Nurse #1 stated she forgot to document everything before she went home that day, but when Nurse #3 called her she came back to the facility and documented the incident. Nurse #1 stated she did not notify the physician or the family member of the incident. Nurses Progress Note dated 11/25/18 at 7:41 pm written by Nurse #3 revealed Resident #372's right knee was "swollen and painful" and the right knee was 7 centimeters larger than the left knee on assessment. Nurse #3 also documented Resident #372 complained of lower back pain. Nurse #3 notified the physician on call of her assessment and obtained orders for pain medication and x-rays. Her note further revealed the mobile imaging company arrived and an x-ray of the right knee revealed clear evidence of a fracture. Nurse #3 notified the provider on call	F 580	family and medical provider of resident #372 fall when the fall happened. They were notified during the next shift. Resident #372 is no longer in our facility. " The physician was not notified of resident #36 significant weight loss. The provider was notified on 12/20/2018 of significant weight loss. Resident #36□s weight is trending up at this time. How the facility will identify other residents having the potential to be affected by the same deficient practice; " Facility Action □ all falls for the past 30 days were reviewed to ensure that family and medical provider were notified of the fall on January 9, 2019. " Facility Action □ All current residents were reviewed by the Registered Dietician (RD) for significant weight loss within the last 30 days and the physician or nurse practitioner were notified of the weight loss on January 9, 2019. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur; " All licensed staff will be educated by the Director of Nursing (DON), Staff Development Coordinator (SDC), or designee on who to notify of a fall. They will also be educated on notifying the provider of significant weight loss. " All new licensed staff will be educated by the Staff Development Coordinator (SDC) or designee during orientation.	

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F 580	Continued From page 3 and orders were obtained to send Resident #372 to the hospital. Resident #372 was transferred to the hospital at approximately 6:00 pm. An interview on 12/19/18 at 4:45 pm with Nurse #3 revealed she had reported to work on 2nd shift (2:00 pm to 10:00 pm) on 11/25/18 and stated shortly after she arrived for her shift Resident #372's family member came to the Nurse's Desk and asked her why she had not been notified that Resident #372 had fallen that morning. The family member told Nurse #3 that Resident #372 had told her she had fallen in the bathroom that morning. Nurse #3 stated the 1st shift (6:00 am to 2:00 pm) nurse, Nurse #1, had not notified her during report that Resident #372 had fallen. Nurse #3 stated she called Nurse #1 and asked her if Resident #372 had fallen that morning and Nurse #1 told her Resident #372 was lowered to the floor around 9:00 am and she had not called the family member or the physician. Nurse #3 stated she assessed Resident #372 and found her right knee was 7 centimeters larger than her left knee and the resident was complaining of right knee and lower back pain. Nurse #3 stated she called the physician on call and asked for an x-ray which showed a spiral fracture of the right femur. A telephone interview with Nurse Aide #3 on 12/20/18 at 11:28 am revealed she and Nurse Aide #4 had worked 2nd shift (2:00 pm to 10:00 pm) on 11/25/18 and when she came in at 2:00 pm Resident #372 was in her wheelchair and Nurse Aide #4 transferred her to the bed. Nurse Aide #3 stated Resident #372 was in a lot of pain and was saying "oh, oh, oh" after Nurse Aide #4 transferred her to the bed. A telephone interview with Nurse Aide #4 on 12/20/18 at 11:30 am revealed he was asked by Resident #372's family member to transfer her to	F 580	How the facility plans to monitor its performance to make sure that solutions are sustained; " The DON or designee will review up to five falls weekly to ensure proper notification for four weeks, and five falls monthly for five months. " The RD, DON, or designee will review up to five residents with significant weight loss weekly to ensure proper notification for four weeks, and 5 residents with significant weight loss monthly for five months " The findings will be reviewed at the quarterly QAPI meetings. Date of compliance is January 19, 2019 The Administrator is responsible for implementing the acceptable plan of correction.	

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the bed when he first arrived for his shift on 11/25/18 at 2:00 pm. Nurse Aide #4 stated he noticed Resident #372 was rocking back and forth in her chair, but she did not say she was in pain or acted like she was in pain when he transferred her to the bed. Nurse Aide #4 stated he stood and pivoted Resident #372 to the bed. He stated after Resident #372 was in the bed she complained of pain in her right knee. Nurse Aide #4 stated he told the family member he would let the nurse know and reported the pain to Nurse #3. Nurse Aide #4 stated he got report from Nurse Aide #1 after the transfer and was told Resident #372 was lowered to the floor that morning.

An interview with the Nurse Practitioner on 12/20/18 at 9:55 am revealed Resident #372 had a spiral fracture of her right femur which would not be treatable in a resident of Resident #372's age, 100 years old. She stated due to Resident #372's age and the need for narcotic pain medications to control her pain she was admitted to a hospice house.

On 12/20/18 at 3:55 pm an interview with the Physician revealed he was notified by the Nurse Practitioner that Resident #372 had fallen on 11/25/18 in the morning and the staff had not reported the fall until later that day. He stated his expectation was the staff would report falls to the Responsible Party and the Physician or Nurse Practitioner as soon as they occur.

2. Resident #36 was admitted to the facility on 5/22/2018 with diagnoses that included hypertension, cerebral infarction and dysphagia.

A review of a quarterly MDS assessment dated 11/9/2018 revealed Resident #36 was cognitively intact and required supervision and physical assist of one person for eating. The MDS further

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revealed Resident #36 required a mechanically altered diet, was 70 inches tall and weighed 148 pounds (lbs).
A review of the care plan dated 5/22/2018 focused on nutritional risk related to impaired cognition, requiring assistance with by mouth intake. Goals for Resident #36 were to avoid significant weight change through next review of 11/20/2018. Approaches to meet the goal was to provide diet as ordered, monitor intake and record each meal, offer substitute when intake less than 50% and weights as ordered.
A review of physicians orders dated 8/29/2018 revealed Resident #36 received a diabetic diet with level 6 soft and bite sized texture and regular liquids. There was also and ordered dated 9/5/2018 to give Med Plus 1.7 Nutritional Supplement 2 ounces three times a day for nutrition.
A review of a progress note dated 9/4/2018 revealed Resident #36 had a 12.50% one-month comparison weight loss.
A review of a progress note dated 10/15/2018 revealed Resident #36 had a 19.2% weight loss in comparison to baseline weight on 5/23/2018.
A review of a progress note dated 11/4/2018 revealed Resident #36 had a 15.2% six-month comparison weight loss.
A review of a malnutrition screening dated 5/28/2018 for Resident #36 revealed a score of zero, indicated no risk of malnutrition.
A review of a weight warning note dated 11/4/2018 revealed a weight warning of 125.5 lbs. with 15.2 % loss. The note written by the Registered Dietitian (RD), further revealed Resident #36 was receiving a diabetic bite sized diet with supplemental shakes, staff would continue to encourage by mouth intake and supplements for weight stability/trend upward and

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that the physician (MD) was notified.
A review of the last medical provider visit dated 10/17/2018 did not address weight loss or nutritional status.
An interview on 12/18/2018 at 5:48 PM with NA #3 revealed Resident #36 only ate 25% of his meal. She revealed Resident #36 would request his supplement when he did not eat much and he usually ate 50% or more of all his meals.
An interview on 12/20/2018 at 12:52 PM with Resident #36 revealed he was aware of his weight loss, had not experienced any difficulty eating or been seen by the MD for his weight loss.
An interview on 12/19/2018 at 5:24 PM with the RD revealed she was aware of Resident #36's weight loss and added a house shake to his diet in August. She further revealed in September Resident #36 continued to lose weight and another supplement was added. She noticed his weight began to trend back up in October.
An interview on 12/20/2018 at 12:28 PM with the Unit Nurse Manager revealed Resident #36 was weighed monthly and she followed up with Resident #36's responsible party regarding his weight loss. The Unit Nurse manager further revealed she had not placed Resident #36 on the MD's book for evaluation of his weight loss.
An interview on 12/20/2018 at 12L49 PM with NA #2 revealed Resident #36 needed cueing when eating and usually ate 75% of his meals.
An interview on 12/20/2018 at 3:12 PM with the RD revealed that she printed off her notes monthly and left her notes for the MD but was unsure what was done about Resident #36 weight loss. The RD further revealed she had never received any recommendations or follow up communication from the MD regarding Resident #36's weight loss.

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F 580	Continued From page 7 An interview on 12/20/2018 at 4:59 PM with the Director of Nursing (DON) revealed Resident #36 weight loss was discussed at a meeting in September. The DON further revealed the MD and a nurse practitioner (NP) were present. An interview on 12/20/2018 at 3:44 PM with the MD revealed he was not aware and had not been notified of Resident #36's severe weight loss. The MD further revealed that if he had been notified he would have evaluated and assessed Resident #36. An interview on 12/20/2018 at 5:30 PM with the DON revealed she expected residents who experienced weight loss would be reviewed weekly with medical providers and the recommendations from the medical providers implemented.	F 580		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623		1/29/19

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F 623	Continued From page 8 (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State	F 623		

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F 623	Continued From page 9 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with resident's family and staff, the facility failed to	F 623	F623	

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F 623	Continued From page 10 provide written notification for the resident or responsible party of the reason for discharge for 1 of 4 residents reviewed for discharge from the facility. (Resident #370). Findings included: Resident #370 was admitted to the facility on 4/9/18 with diagnoses of lung disease, anemia, paranoid schizophrenia, weakness, and heart disease. His most recent Minimum Data Set Admission Assessment dated 4/16/18 revealed he was cognitively intact. Resident #370 was discharged from the facility on 5/10/18 with a return not anticipated. An interview with the Discharge Planner on 12/18/18 at 10:55 am revealed he had left a message for Resident #370's Guardian/Family Member on Tuesday, 5/8/18, about his pending discharge and transfer to another facility on 5/10/18 because he was unable to reach them by phone. The Discharge Planner stated he had not given the resident or the resident's guardian a written explanation of discharge. He stated the facility had not given any residents that were discharged a written explanation of discharge. The discharge planner stated Resident #370 did not require skilled level of care any longer. A telephone interview with the Discharge Planner on 1/7/19 at 3:31 pm revealed Resident #370 was discharged to an Assisted Living Facility. On 12/19/18 at 11:00 am, a telephone interview was conducted with Resident #370's Family Member. She stated the facility had not given her a written notice of discharge before his discharge. She also stated she had not received a phone	F 623	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; " Resident #370 was discharged from facility How the facility will identify other residents having the potential to be affected by the same deficient practice: " On 1/28/19 residents who were transferred in the last 7 days were reviewed by the Discharge Planner to ensure written notices were provided. Corrections were made as necessary. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur; " Nursing Administration, Discharge Planning were educated regarding requirement to send written notices of transfer. " The discharge planner will issue the discharge transfer notice to residents and/or responsible party when being discharged or transferred from our facility. How the facility plans to monitor its performance to make sure that solutions are sustained; " DON will review weekly X 4 to ensure completion and notices were sent. Any issues will be addressed immediately at the time of identification. " The findings will be reviewed at the quarterly QAPI meetings for one quarter.	

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F 623	Continued From page 11 call or voicemail message from the Discharge Planner regarding the discharge. An interview with the Director of Nursing on 12/18/18 at 4:41 pm revealed the facility sent a copy of the Transfer/Discharge report and a copy of the Medication Administration Record with Resident #370 when he was discharged on 5/10/18 but he was not given a written explanation of discharge.	F 623	Date of compliance is January 29, 2019 The Administrator is responsible for implementing the acceptable plan of correction.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Level II Preadmission Screening and Resident Review (PASARR) conditions, nutrition and behaviors for 3 of 22 residents reviewed for MDS accuracy (Residents #51, #36 and #30). The findings included: 1.Resident #51 was admitted to the facility 7/28/2017 with diagnoses that included Parkinson's Disease, major depressive disorder and anxiety disorder. A review of an annual admission MDS assessment dated 7/20/2018 revealed "No" to Section A1500 for Level II PASARR conditions. A review of the care plan dated 7/30/2017	F 641	F641 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: " Per 2567, Residents # 51 7/20/18 Annual Minimum Data Set (MDS) revealed No to Section A 1500 for Level II Preadmission Screening and Resident Review (PASARR) conditions. A new onset diagnosis of schizophrenia was noted in 2018. A Level II PASARR was filed and issued by NC Department of Health and Human Services on 12/20/18 which was after the Assessment Reference Date (ARD) of the 7/10/18 Annual MDS in question. " Residents #36 11/9/18 Quarterly MDS was incorrectly coded as No to Question	1/19/19

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F 641	Continued From page 12 focused on psychotropic medications. Goals for Resident #51 were to remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review dates listed as 10/30/2017 and 7/30/2018. Nursing interventions to meet the goal for Resident #51 was listed as monitor for side effects and effectiveness. An interview on 12/19/2018 at 11:37 AM with the MDS Coordinator revealed he coded Section A1500 for Resident #51 and submitted the MDS for completion. The MDS Coordinator further revealed that he was aware of all the Level II PASARR conditions Resident #51 had but did not know what to do with the information. An interview on 12/19/2018 at 10:44 AM with the Administrator revealed he expected the MDS Coordinator would code the MDS correctly for residents with Level II PASARR conditions. 2.Resident #36 was admitted to the facility on 5/22/2018 with diagnoses that included hypertension, cerebral infarction and dysphagia. A review of a quarterly MDS assessment dated 11/9/2018 revealed "No" to Section K0300 for loss of 5% in the last month or loss of 10% or more in the last 6 months. A review of the care plan dated 5/22/2018 focused on nutrition risk related to impaired cognition, requiring assistance with by mouth intake. Goals for Resident #36 were to avoid significant weight change through next review	F 641	K0300 in Section K for weight loss of 5% in the last month or loss of 10% or more in the last 6 months, The MDS was modified on 01/10/19 to correctly code Yes to both weight loss of 5% in the last month or loss of 10% or more in the last 6 months. " Residents # 30 11/2/18 Quarterly MDS was incorrectly coded as No for Physical Behaviors E200A and Rejection of Care E0800 in Section E. The MDS was modified on 12/21/18 Quarterly to correctly code behaviors. How the facility will identify other residents having the potential to be affected by the same deficient practice: " All current residents MDS considered by the state level II PASARR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition will be reviewed for correct coding according to the documentation from the residents medical records. Any issues identified as being coded incorrectly, will be modified by the Minimum Data Set Coordinator (MDSC)/Discharge Planner. This was completed by the MDSC consultant on 1/16/19. " All current residents weights in the last 30 days, as of 1/9/19, will be reviewed by Dietician and MDSC consultant to determine if their current MDS is coded correctly for question K0300 in Section K, weight loss of 5% in the last month or loss of 10% of more in the last 6 months, according to the documentation from the residents medical records. Any issues	

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dated listed as 11/20/2018. Approaches to meet the goal was to provide diet as ordered, monitor intake and record each meal, offer substitute when intake less than 50% and weights as ordered.

A review of the weight summary dated 9/4/2018 revealed Resident #36 had a 12.50% one-month comparison weight loss.
A review of the weight summary dated 10/15/2018 revealed Resident #36 had a 19.2% weight loss in comparion to baseline weight on 5/23/2018.

A review of the weight summary dated 11/4/2018 revealed Resident #36 had a 15.2% six-month comparison weight loss.

An interview on 12/20/2018 at 12:28 PM with the Dietitian revealed Resident #36 had a weight loss of 11.8% in the last six-month, as of 11/4/2018. The Dietitian further revealed that Section K0300 should have been coded at "Yes" for loss of 5% or more in the last month or loss of 10% or more in the last six-months.

An interview on 12/20/2018 at 2:11 PM with the Dietary Manager (DM) revealed she was responsible for coding Section K of the MDS. The DM further revealed she was aware that Resident #36 had weight loss.

Additionally, she reported that should have coded K0200 at "Yes" for loss of 5% or more in the last month or loss of 10% or more in the last 6 months.

An interview on 12/20/2018 at 5:30 PM with the Director of Nursing (DON) revealed she expected

identified as being coded incorrectly, will be modified by the MDSC/Dietician/Dietary Manager.
" All current residents with documented behaviors in the last 30 days will be reviewed to ensure Section E of their MDS are correctly coded according to the documentation from the residents medical records. Any issues identified as being coded incorrectly, will be modified by the MDSC/Discharge Planner. This was completed by the MDSC on 1/16/19.

Measures put into place or systemic changes made to ensure that the deficient practice will not recur:
" Education was provided to the MDSC and Discharge Planner on 12/21/18 by the MDSC Regional Consultant on the Resident Assessment Instrument (RAI) requirements for coding Question A1500 Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition? All new MDSC employees will be educated during orientation on proper coding of the Level II PASARR in Section A.
" Education was provided Dietary Manager on 12/20/18 by the MDSC on the RAI requirements for coding weight loss in Section K. All new MDSC employees will be educated during orientation on proper coding of Weight Loss in Section K.
" Education was provided to MDSC and Discharge Planner on 12/21/18 by the MDSC Regional Consultant on the RAI

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F 641	Continued From page 14 Section K of the MDS to be completed based on the information per the Resident Assessment Instrument guidelines. 3. Resident # 30 was admitted to the facility on 08/03/2017 with diagnoses that included dementia, depression, insomnia, psychosis and muscle weakness. A review of a quarterly Minimum Data Set (MDS) dated 11/02/2018 revealed that Resident # 30 was moderately cognitively impaired and that section E 0200 A physical behavioral symptoms directed toward others was not coded with behaviors documented on 10/28/2018 and section E 0800 rejection of care- presence and frequency was not coded with care rejection recorded on 11/01/2018. A behavior note dated 10/28/2018 at 8:44 PM reveled that Resident # 30 approached the medication cart during the night and Resident # 30 had a back scratcher with her. Resident # 30 used the back scratcher on herself and then Resident # 30 approached the nurse with the back scratcher and began to use the back scratcher to touch the nurse on the back side below the nurse's belt line. The nurse asked Resident # 30 to stop, but Resident # 30 proceeded to scratch the nurse on her front side and laughed at the nurse. The nurse had a nurse assistant (NA) take Resident # 30 back to her room. A health status note dated 11/01/2018 at 4:20 PM revealed that Resident # 30 informed the Nurse Practitioner (NP) that she would take her medications that day, but that Resident # 30 refused her medications when she was	F 641	requirements for coding Behaviors in Section E. All new MDSC employees will be educated during orientation on proper coding of Behaviors in Section E. How facility plans to monitor its performance to make sure that solutions are sustained: " The MDS Consultant or designee will audit 5 residents MDS to ensure Question A1500 Is the resident currently considered by the state level II PASARR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related conditions are correctly coded in Section A once weekly for 4 weeks, twice a month for one month, and monthly x 1 month. The findings will be reviewed at the quarterly Quality Assurance and Performance Improvement (QAPI) meetings. " The Center will provide the MDS Consultant, Regional Dietician or designee a list of current residents with weight loss of 5% in the last month or loss of 10% of more in the last 6 months to be used in auditing 5 residents MDS to ensure weight loss is correctly coded in Section K once weekly for 4 weeks, twice a month for one month, and monthly x 1 month. The findings will be reviewed at the quarterly QAPI meetings. " The MDS Consultant or designee will audit 5 residents MDS to ensure behaviors are correctly coded in Section E once weekly for 4 weeks, twice a month for one month, and monthly x 1 month. The findings will be reviewed at the	

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F 641	Continued From page 15 scheduled to receive them. On 12/20/2018 at 11:47 AM an interview was conducted with the MDS coordinator and the medical record of resident # 30 was reviewed during the interview. The MDS coordinator revealed that the behaviors of Resident # 30 should have been coded on the quarterly MDS by the Discharge Planning Director and that the MDS coordinator should have reviewed the entire MDS coding prior to signing for completion and transmission of the MDS to make certain that the MDS was coded appropriately. On 12/20/2018 at 11:54 AM an interview was conducted with the Discharge Planning Director during the interview, the Discharge Planning Director revealed that he must have just overlooked the documented behavior and medication rejection in the medical record of Resident # 30 during the MDS review period. The Discharge Planning Director revealed that he always reviewed all medical record documentation and that he did not have a reason why he did not code the behaviors of Resident # 30 on 10/28/2018 and on 11/01/2018. An interview was conducted with the Director of Nurse (DON) conducted on 12/20/2018 at 3:54 PM 12/20/18 03:54 PM revealed that the expectation was that all sections of the MDS be completed as accurately as possible prior to the MDS being signed and transmitted.	F 641	quarterly QAPI meetings. The MDSC Consultant is responsible for implementing the acceptable plan of correction by 1/19/19	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the	F 644		1/19/19

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F 644	Continued From page 16 pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to refer a resident with a new diagnosis of a mental disorder for a Preadmission Screening and Resident Review (PASARR) Level II evaluation for 1 of 1 residents reviewed for PASARR (Resident #51). The findings included: Resident # 51 was admitted to the facility on 7/28/2017 with diagnoses that included Parkinson's Disease, major depressive disorder and anxiety. A new onset diagnosis of schizophrenia was noted on 2/1/2018. A review of Resident #51's annual Minimum Data Set (MDS) dated 7/20/2018 revealed "No" to section A1500 for Level II PASARR conditions. Further review of the MDS to Section I revealed schizophrenia as a diagnosis. Additionally,	F 644	F644 How corrective action will be accomplished for those residents found to have been affected by the deficient practice; " Resident #51 received a new psychiatric diagnosis of schizophrenia while in the facility and a new Preadmission Screening and Resident Review (PASARR) screen was not requested. A new PASARR was requested and a Level II was issued on 12/20/18. How the facility will identify other residents having the potential to be affected by the same deficient practice;	

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F 644	Continued From page 17 Resident #51 had taken antipsychotics 7 of 7 days during the look back period and was seen by a psychiatrist. A review of the resident's current care plan focused on psychotropic medications. Goals for Resident #51 were to remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review dates listed as of 10/30/2017 and 7/30/2018. Nursing interventions to meet the goal for Resident #51 was listed as to monitor for side effects and effectiveness. A review of December 2018 Medication Administrator Record (MAR) revealed Resident #51 had received Seroquel 400 milligrams (mg) by mouth every day in the evening for schizophrenia. An interview on 2/19/2018 at 2:35 PM with Resident #51 revealed he was told by a family member that he had schizophrenia this year. Resident #51 further revealed that he had frequent outburst that sometimes got out of control, took medications to help with his mental disorder and he was being seen by a psychiatrist. An interview on 12/18/2018 at 3:20 PM with the Admissions Coordinator revealed she was unaware where to locate the PASARR letters. She further revealed that PASARR information was retrieved upon admission and continued with the discharge coordinator. An interview on 12/19/2018 at 10:13 AM with the Discharge Coordinator revealed he was	F 644	" Facility Action □All resident□s were reviewed on 12/18/18 and were referred for PASARR screening if they had received a new psychiatric diagnosis of schizophrenia since admission by the Discharge Planner. Any residents that receive a new psychiatric diagnosis will be discussed during morning meetings. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur; " Education provided to Discharge Planner, Minimum Data Set Coordinator (MDSC), and administrative nurses on January 9, 2019 regarding the need to refer residents for a PASARR screening when a new psychiatric diagnosis other than depression or anxiety is given to a resident. " The Interdisciplinary Team will review residents during their Assessment Reference Date (ARD) for new psychiatric diagnosis other than depression or anxiety and if a resident is found to have one the Discharge Planner will refer them for a PASARR screening. How the facility plans to monitor its performance to make sure that solutions are sustained; " The Administrator or designee will monitor up to five residents that were identified to have new psychiatric diagnosis monthly for six months to ensure that the discharge planner referred them for a new PASARR screening. This will be completed weekly during the care plan meetings for 6 months.	

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F 644	Continued From page 18 responsible for submitting information for expiring PASARRs. The Discharge Coordinator further revealed that Resident #51 had a non-expiring Level I. Additionally, he reported that he did not submit any information for residents with new mental disorder diagnoses. A subsequent interview on 12/19/2018 at 10:32 AM with the Admissions Coordinator revealed the Admissions Director was responsible for obtaining all PASARR information. On 12/19/2018 at 11:37 AM and interview with the MDS Coordinator revealed he coded Sections A, Section I and submitted the MDS for completion. The MDS Coordinator further revealed that he was aware Resident #51 had a new diagnosis of schizophrenia but did not know what to do with the information. An interview on 12/19/2018 at 10:44 AM with the Administrator revealed Resident #51 was admitted with a Level I PASARR. The Administrator further revealed that once a resident is in the facility, such as Resident #51, it was the responsibility of the Admissions Director to submit the information for all PASARR Level II conditions. Additionally, the Administrator disclosed that he expected nursing to share new diagnosis of mental disorders in the morning so the Discharge Coordinator would have known to initiate screenings for Level II PASARR screenings.	F 644	" The findings will be reviewed at the quarterly QAPI meetings. Date of compliance is January 19, 2019 The Administrator is responsible for implementing the acceptable plan of correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		1/19/19

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implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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F 656	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, facility failed to develop a care plan for a triggered care assessment area of urinary incontinence for 1 of 1 residents reviewed for bladder and bowel incontinence (Resident #6). The findings included: Resident #6 was admitted to the facility on 11/14/2015 with diagnoses that included repeated falls, muscle weakness and other abnormalities of gait and mobility. A review of an annual Minimum Data Set dated 1/19/2018 revealed Resident #6 was cognitively intact, required supervision with no physical assist with toileting and was always steady moving on and off the toilet. The MDS further revealed Resident #6 was frequently incontinent of urine, always incontinent of bowel and had no trial of toileting program. Review of the care assessment area (CAA) of urinary incontinence and indwelling catheter dated 1/25/2018, triggered for a care plan. The CAA summary read in part, "will cp (care plan) for monitoring and management/prevention of incontinence of BB (bowel and bladder)". Review of Resident #6's care plan did not indicate a focus on urinary incontinence. An interview on 12/17/2018 at 3:33 PM with Resident #6 revealed she utilized pull on incontinence briefs due to nightly urinary incontinence. She further revealed that she was unsure how and when she became incontinent.	F 656	F656 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to develop a care plan for a triggered care assessment area (CAA) of urinary incontinence for resident #6. Resident bowel and bladder function assessed by Minimum Data Set Coordinator (MDSC) on 12/19/18 and she was found to have occasional urinary incontinence and was always continent of bowel. Care plan was developed for resident #6 on 12/19/18 for urinary incontinence but was not needed for bowel because she was always continent. She was put on a restorative toileting program on 12/19/18. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents were reviewed for urinary continence by the MDSC Consultant on 1/18/19. Care plans were updated to reflect Bowel and Bladder status at that time. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur; The MDSC Consultant provided education to the MDSC on ensuring a care plan is developed for each resident with urinary incontinence on December 21, 2018 as	

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F 656	Continued From page 21 An interview on 12/18/2018 at 9:51 AM with Resident #6 revealed that she was not incontinent when she first was admitted to the facility. Resident #6 further revealed that she also did not wear incontinence briefs upon admission and the facility gave them to her to use. Additionally, she reported that she had never been offered to participate in a bladder training program. An interview on 12/19/2018 at 9:09 AM with NA 3# revealed that Resident #6 took herself to the bathroom but had urinary leakage. NA #3 further revealed Resident #6 was independent to toileting and changing her own incontinence brief and was not in a toileting training program. According to NA #3, Resident #6 would be a candidate for toileting training. An interview on 12/19/2018 at 9:25 AM with Nurse #5 revealed that he believed Resident #6 had overflow incontinence and confirmed she was not taking any medication for the condition. Nurse #5 further revealed that Resident #6 was not currently in a toileting program or had ever been. An interview on 12/19/2018 at 5:00 PM with the MDS Coordinator revealed he completed the CAA summary and just missed doing the care plan for incontinence of bowel and bladder for Resident #6. An interview on 12/19/2018 at 5:12 PM with the Administrator revealed he expected staff would complete the care plans for residents.	F 656	indicated by the Care Area Assessment, when completing a comprehensive Minimum Data Set. How the facility plans to monitor its performance to make sure that solutions are sustained: The MDS Consultant or designee will audit 5 current residents□ comprehensive Minimum Data Sets, who triggered for urinary incontinence to ensure the item was care planned if the CAA addressed that the item will be care planned, 1 week for 4 weeks, 2 times a month for 1 month, and monthly for 1 month. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC. Results of the audit will be presented at the quarterly QAPI meeting. The MDSC Consultant is responsible for implementing the acceptable plan of correction by January 19, 2019	
F 684 SS=G	Quality of Care CFR(s): 483.25	F 684		1/19/19

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F 684	Continued From page 22 § 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. This REQUIREMENT is not met as evidenced by: Based on staff interview, Nurse Practitioner interview, and record review, the facility failed to provide ongoing assessment for injury for 1 of 2 residents who was lowered to the floor and did not receive care for a fractured right femur until a family member notified the next shift facility's staff of the incident. (Resident #372). Findings included: Resident #372 was admitted to the facility on 7/1/15 with diagnoses of anxiety, aphasia, and weakness. Her most recent Quarterly Minimum Data Set Assessment dated 11/9/18 revealed she was cognitively intact and required extensive assistance with moving about in bed and toileting, limited assistance for transferring from the bed and wheelchair. The assessment also revealed she had no falls since the previous assessment. An incident report dated 11/25/18 at 3:59 pm revealed Nurse #1 was called to Resident #372's bathroom by Nurse Aide #1. Nurse Aide #1 stated Resident #372 got weak during a transfer to the toilet and was slid down to the floor. Nurse #1 documented Resident #372 was on the floor in front of the toilet with her legs in front of her. She	F 684	F684 How corrective action will be accomplished for those residents found to have been affected by the deficient practice; " The charge nurse failed to chart her ongoing assessment of resident #372 post fall. Resident #372 is no longer in facility. How the facility will identify other residents having the potential to be affected by the same deficient practice; " Facility Action □ Educated all licensed staff on charting assessments for falls started on 1/9/19. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur; " All licensed staff educated by the Director of Nursing (DON), Staff	

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F 684	Continued From page 23 also documented Resident #372 stated, "I don't know what happened, I just need someone to help me up". An interview on 12/20/18 at 11:32 am with Nurse #1 revealed at approximately 9:00 am on 11/25/18 Nurse Aide #1 had come to the Nurse's Station and told her Resident #372 had been lowered to the floor in the bathroom. She stated she went to Resident #372's bathroom and she was on the floor with her legs straight out in front of her. Nurse #1 stated the resident had no obvious deformities and she denied any pain. Nurse #1 stated she checked Resident #372's range of motion in her extremities, asked if she was having any pain, and got her vital signs. Nurse #1 stated Resident #372 sat up in her wheelchair after the incident and had not complained of pain when she checked on her two times before the end of the shift. Nurse #1 stated she forgot to document everything before she went home that day but when Nurse #3 called her she came back to the facility between 3:30 pm and 4:00 pm (on 11/25/18) and documented the incident. Nurse #1 stated when she returned to the facility she called the Supervisor on Call and told her what happened. Nurse #1 stated she did not notify the physician or the Family Member of the incident. On 12/20/18 at 12:09 pm an interview with Nurse Aide #1 revealed she was transferring Resident #372 to the toilet by herself when the resident's legs "gave out" and she yelled for help. She stated Nurse Aide #2 came to the bathroom and helped her lower Resident #372 to the floor. Nurse Aide #1 stated Nurse #1 assessed Resident #372 for injuries and took her vital signs before she and Nurse Aide #2 transferred the	F 684	Development Coordinator (SDC), or designee on assessment/documentation for falls to be completed by 1/19/19. All new licensed staff will be educated during orientation " All falls will be reviewed by the DON or designee the following day to ensure that assessments are completed at the time of the fall. Ongoing education or corrective action will be completed as needed. How the facility plans to monitor its performance to make sure that solutions are sustained; " The DON or designee will review up to five falls weekly to ensure proper documentation of resident assessment for four weeks, and five falls monthly for five months. " The findings will be reviewed at the quarterly QAPI meetings. Date of compliance is January 19, 2019 The Administrator is responsible for implementing the acceptable plan of correction.	

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F 684	Continued From page 24	F 684		

resident back to her wheelchair. Nurse Aide #1 stated Resident #372 stated she was not having any pain and had not acted like she was in pain throughout the rest of her shift.
An interview with Nurse Aide #2 on 12/20/18 at 10:50 am revealed she was in the adjacent room that shared a bathroom with Resident #372's room when she heard Nurse Aide #1 calling out for help. She stated she entered the bathroom and assisted Nurse Aide #1 with lowering Resident #372 to the floor. She stated Resident #372 did not cry out in pain and stated she was not in pain. Nurse Aide #2 stated Nurse #1 was called to the room and she assessed Resident #372 before they moved her back to her wheel chair. Nurse Aide #2 stated Resident #372 did not call out in pain or act like she was in pain during the transfer back to her wheelchair.

Nurses Progress Note dated 11/25/18 at 7:41 pm, written by Nurse #3, revealed Resident #372's right knee was "swollen and painful" and the right knee was 7 cm larger than the left knee on assessment. Nurse #3 also documented Resident #372 complained of lower back pain. Her note further revealed the mobile imaging company arrived and an x-ray of the right knee revealed clear evidence of a fracture. Nurse #3 notified the provider on call and orders were obtained to send Resident #372 to the hospital. Resident #372 was transferred to the hospital at approximately 6:00 pm (on 11/25/18).

An interview on 12/19/18 at 4:45 pm with Nurse #3 revealed she had reported to work on 2nd shift (2:00 pm to 10:00 pm) on 11/25/18 and stated shortly after she arrived for her shift Resident #372's family member came to the Nurse's Desk and asked her why she had not been notified that

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F 684	Continued From page 25	F 684		

Resident #372 had fallen that morning. The family member told Nurse #3 that Resident #372 had told her she had fallen in the bathroom that morning. Nurse #3 stated the 1st shift (6:00 am to 2:00 pm) nurse, Nurse #1, had not notified her during report of the fall or notified the family member of the fall. Nurse #3 stated she called Nurse #1 and asked her if Resident #372 had fallen that morning and Nurse #1 told her Resident #372 was lowered to the floor around 9:00 am and she had not called the family member or the physician. Nurse #3 stated she assessed Resident #372 and found her right knee was 7 centimeters larger than her left knee and the resident was complaining of right knee and lower back pain. Nurse #3 stated she called the physician on call and asked for an x-ray which showed a spiral fracture of the right femur.

An X-ray of the right knee dated 11/25/18 revealed Resident #372 had an acute spiral fracture of the distal femur with medial displacement.

A telephone interview with Nurse Aide #3 on 12/20/18 at 11:28 am revealed she and Nurse Aide #4 had worked 2nd shift (2:00 pm to 10:00 pm) on 11/25/18 and when she came in at 2:00 pm Resident #372 was in her wheelchair. Nurse Aide #3 stated after Resident #372 was put to bed by Nurse Aide #4 she was in a lot of pain and was saying "oh, oh, oh".

A telephone interview with Nurse Aide #4 on 12/20/18 at 11:30 am revealed he was asked by Resident #372's family member to transfer her to the bed when he first arrived for his shift on 11/25/18 at 2:00 pm. Nurse Aide #4 stated he noticed Resident #372 was rocking back and

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F 684	Continued From page 26 forth in her chair, but she did not say she was in pain or act like she was in pain when he transferred her to the bed. Nurse Aide #4 stated he stood and pivoted Resident #372 to the bed. He stated after Resident #372 was in the bed she complained of pain in her right knee. Nurse Aide #4 stated he told the family member he would let the nurse know and reported the pain to Nurse #3. Nurse Aide #4 stated he got report from Nurse Aide #1 after the transfer and was told Resident #372 was lowered to the floor that morning. Review of the hospital record of 11/25/18 revealed Resident # 372 had a history of osteopenia, osteoporosis and prosthetic right knee joint. X-ray of the right thigh/femur showed acute oblique, mildly comminuted periprosthetic fracture of the distal right femur with total knee arthroplasty, about 2 cm posterior displacement, about 1.5 cm medial displacement and up to 2 cm override of the dominant distal fracture fragment. In view of the resident's advanced age and multiple comorbid conditions, it was decided to manage her non-surgically. The resident was admitted to the hospital for further management. An interview with the Nurse Practitioner on 12/20/18 at 9:55 am revealed Resident #372 had a spiral fracture of her right femur which would not be treatable in a resident of her age, 100 years old. She stated due to Resident's age and the need for narcotic pain meds to control her pain she was admitted to a hospice house and passed away.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		1/19/19

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F 690	Continued From page 27 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to maintain a resident's urinary continence and failed to assess	F 690	F690 How corrective action will be	

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F 690	Continued From page 28 and address a resident's urinary incontinence for 1 of 1 residents reviewed for bladder and bowel incontinence (Resident #6). Findings included: Resident #6 was admitted to the facility on 11/14/2015 with diagnoses that included repeated falls, muscle weakness and other abnormalities of gait and mobility. A review of an annual Minimum Data Set dated 1/19/2018 revealed Resident #6 was cognitively intact, required supervision with no physical assistance with toileting and was always steady moving on and off the toilet. The MDS further revealed Resident #6 was frequently incontinent of urine, always incontinent of bowel and had no trial of toileting program. A quarterly MDS dated 7/6/2018 revealed Resident #6 was frequently incontinent of urine, always continent of bowel and had not trial of toileting program. A quarterly MDS dated 9/28/2018 revealed Resident #6 was frequently incontinent of urine, always continent of bowel and had no trial of toileting program. Review of the care assessment area (CAA) dated 1/25/2018 revealed a trigger for a care plan of urinary incontinence. The CAA summary read in part, "will cp (care plan) for monitoring and management/prevention of incontinence of BB (bowel and bladder)". Review of Resident #6's care plan did not indicate a focus on urinary incontinence.	F 690	accomplished for those residents found to have been affected by the deficient practice; " Resident #6 was admitted to facility 11/14/15 and was continent of bowel and bladder. Resident #6 currently chooses to wear pull-ups due to occasional overflow incontinent episodes. Resident is now on a restorative toileting program which began on 12/20/18. How the facility will identify other residents having the potential to be affected by the same deficient practice: " Facility Action □ All current alert and oriented residents were assessed by nursing for urinary incontinence on 1/18/19. The Interdisciplinary Team evaluated the residents affected for the appropriateness of a toileting program or referral to a medical provider to evaluate cause of incontinence. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur; " All licensed staff educated by the Director of Nursing (DON), Staff Development Coordinator (SDC), or designee on maintaining urinary continence in residents began on 1/9/19 and was completed on 1/18/19. All new licensed staff will be educated during orientation. " All new admissions bowel and bladder function will be assessed on admission by	

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F 690	Continued From page 29 An interview on 12/17/2018 at 3:33 PM with Resident #6 revealed she utilized pull on incontinence briefs due to nightly urinary incontinence. She further revealed that she was unsure how and when she became incontinent. An interview on 12/18/2018 at 9:51 AM with Resident #6 revealed that she was not incontinent when she first was admitted to the facility. Resident #6 further revealed that she also did not wear incontinence briefs upon admission and the facility gave them to her to use. Additionally, she reported that she had never been offered to participate in a bladder training program. An interview on 12/19/2018 at 9:09 AM with NA 3# revealed that Resident #6 took herself to the bathroom but had urinary leakage. NA #3 further revealed Resident #6 was independent to toileting and changing her own incontinence brief and was not in a toileting training program. According to NA #3, Resident #6 would be a candidate for toileting training. An interview on 12/19/2018 at 9:25 AM with Nurse #5 revealed Resident #6 was not currently in a toileting program or had ever been. An interview on 12/20/2018 at 5:20 PM with the Director of Nursing (DON) revealed she was aware that Resident #6 used incontinence briefs and could not recall when she became incontinent. The DON further revealed that she was not aware of what caused Resident #6 to become incontinent of urine. An interview on 12/19/2018 at 5:00 PM with the MDS Coordinator revealed he just missed doing	F 690	the admitting nurse. " The Interdisciplinary Team will review residents during their ARD for new episodes of incontinence and make referrals for toileting programs or provide evaluation as needed. How the facility plans to monitor its performance to make sure that solutions are sustained; " The DON will audit up to five residents with new episode of incontinence monthly for six months to ensure recommended interventions are in place. " The findings will be reviewed at the quarterly QAPI meetings. Date of compliance is January 19, 2019 The Administrator is responsible for implementing the acceptable plan of correction.	

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F 690	Continued From page 30 the care plan for incontinence of bowel and bladder for Resident #6. An interview on 12/19/2018 at 5:12 PM with the Administrator revealed he expected staff would not allow residents to get to the point of being incontinent without trying to restore their urinary functions.	F 690		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(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- §483.25(g)(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; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(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, staff interviews, Nurse Practitioner interview, and Physician interview, the facility failed to prevent dehydration by addressing Resident #371's poor food and fluid	F 692	F692 How corrective action will be accomplished for those residents found to	1/19/19

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F 692	Continued From page 31 intake resulting in increased sodium level, decline in condition and hospitalization. This was evident in 1 of 3 sampled residents reviewed for hydration status. Findings included: Resident #371 was admitted to the facility on 1/30/15. Her current diagnoses included Epilepsy, Kidney Disease, Dementia, Anxiety, Psychotic Disorder, Depression, and Heart Disease. Review of Resident #371's Medical Orders for Scope of Treatment (MOST) form dated 12/19/17 revealed she requested "limited additional interventions" not "comfort measures". The MOST form also noted Resident #371 had requested intravenous fluids if indicated for medical intervention. There was not an order for comfort measures found in the medical record. A review of Resident #371's laboratory results revealed she had a Sodium level of 146 on 4/5/18. The normal range for Sodium level is 135 to 145 milliequivalents per liter (mEq/L). A review of Resident #371's Minimum Data Set Assessment dated 9/28/18 revealed she was moderately cognitively impaired. It also revealed she required extensive assistance of one staff member for eating. Review of the Communication Log for Nurse Practitioner #1 revealed there were no issues or concerns recorded from 10/7/18 to 10/29/18 for Resident #371. A Nurse's Progress Note dated 10/16/18 at 10:01	F 692	have been affected by the deficient practice; " Resident #371 had poor PO intake resulting in dehydration, hypernatremia, decline in function and hospitalization. Resident #371 is no longer in facility. How the facility will identify other residents having the potential to be affected by the same deficient practice; " Facility Action □ The Director of Nursing (DON) reviewed documentation for residents eating less than 50% for all three meals in a day for the last 7 days. Any residents that had eaten less than 50% for all three meals were assessed by DON or designee for s/s of dehydration, hypernatremia, and decline in function. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur; " All nursing staff educated on reporting a decrease in resident intake to charge nurse. All licensed staff educated on completing a Change in Condition and residents with decreased PO intake and notifying the provider. Education completed by the Director of Nursing (DON), Staff Development Coordinator (SDC), or designee. How the facility plans to monitor its performance to make sure that solutions	

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F 692	Continued From page 32 am revealed a Family Member expressed concerns related to Resident 371's condition. The note revealed Nurse Practitioner #1 was in the facility and ordered bloodwork to be drawn on 10/18/18. A Nurse's Progress Note dated 10/18/18 at 5:52 pm revealed Resident #371's Sodium level was 173, she was very slow to respond, and her extremities were mottling. The Family Member requested Resident #371 be sent to the hospital. A review of Resident #371's laboratory results revealed a Sodium level of 170 on 10/18/18. The normal range for Sodium level is 135 to 145 milliequivalents per liter (mEq/L). An interview with Nurse #1 on 12/19/18 at 10:35 am revealed she had talked to Resident #371's Family Member on 10/14/18 and they had requested bloodwork be drawn. Nurse #1 stated she had filled out the Communication Form and placed it in Nurse Practitioner #1's book. She stated 10/14/18 was a Sunday and the next day the laboratory would visit would be Thursday 10/18/18. She also stated Nurse Practitioner #1 should have visited the facility on Monday, 10/15/18. An interview with Nurse #2, the Unit Manager, on 12/19/18 at 11:10 am revealed she received orders on 10/16/18 for bloodwork for Resident #371. She stated the orders were not "stat" so they put the orders on the next lab day which was 10/18/18. Nurse #1 stated she looked at Resident #371 on 10/18/18 and she (the resident) was very confused and restless, and she was eating less. Nurse #2 stated she noticed a big decline in Resident #371 on 10/17/18 and	F 692	are sustained; " The DON, Unit Coordinator, or designee will review alerts five times a week for four weeks, three times a week for four weeks, two times a week for four weeks, and weekly for 3 months for any residents that have intake less than 50% for three meals in a day and ensure that the charge nurse completed a Change in Condition Assessment and notified the provider. " The findings will be reviewed at the quarterly QAPI meetings. Date of compliance is January 19, 2019 The Administrator is responsible for implementing the acceptable plan of correction.	

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10/18/18, but she did not notify the Nurse Practitioner of the decline.

An interview with Nurse Aide #6 on 12/19/18 at 4:12 pm revealed Resident #371 did not eat or drink anything for two days before she went out to the hospital. Nurse Aide #6 stated normally Resident #371 would drink all the fluids on her tray which would be three cups of liquid. She stated two days before she discharged to the hospital Resident #371's Family Member took her to the nurse's station from the dining room because she was sitting at the dining table and food and drink were sitting in her mouth and she wasn't swallowing it. Nurse Aide #6 stated she told the Nurse Resident #371 was not drinking but did not remember which nurse she told.

Nurse Aide #7 was interviewed on 12/19/18 at 4:35 pm and stated she worked with Resident #371 on 10/16/18 and 10/17/18 and she did not drink or eat anything either day. She stated Resident #371 slept the whole shift she worked (2nd shift) on both days. Nurse Aide #7 stated Resident #371 became more confused on 10/16/18 and continued to decline.

A Progress note dated 10/18/18 by Nurse Practitioner #1 stated, "Member appears dehydrated nursing reports no intake in last 48 hours."

On 12/19/18 at 11:55 am Nurse Practitioner #1 stated in a phone interview she did not see Resident #371 until 10/18/18. She stated she gave orders for bloodwork on 10/16/18 she was in the facility but did not assess Resident #371 because she was not told by staff she was not eating or drinking until 10/18/18 when the

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F 692	Continued From page 34 abnormal sodium level was reported to her. Nurse Practitioner #1 stated Resident #371 was severely dehydrated. She stated if she had known on 10/16/18 she was not eating or drinking she would have ordered intravenous fluids at that time. Nurse Practitioner #1 stated she spoke with the Family Member on 10/18/18 after she received the bloodwork results and the decision was made to make the resident comfort care but when the Family Member arrived at the facility she decided to send her to the hospital. An interview with the Physician on 12/20/18 at 3:50 pm revealed he was not aware Resident #371 was not eating or drinking prior to being sent to the hospital on 10/18/18. He stated Nurse Practitioner #1 was following Resident #371 and the staff did not inform her Resident #371 was not eating and drinking until 10/18/18, he stated Nurse Practitioner #1 would have ordered intravenous fluids if she had known Resident #371 was not drinking. The History and Physical from the hospital dated 10/18/18 revealed Resident #371 had acute encephalopathy related to hypernatremia, urinary tract infection, and stroke. The History and Physical also stated Resident #371 seemed very dehydrated.	F 692		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		1/19/19

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F 756	Continued From page 35 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, physician interview, and pharmacist interview, the pharmacist failed to identify the need to address a required 14-day stop date for as needed psychotropic medication for 2 of 3 residents reviewed for unnecessary medication (Resident	F 756	F756 How corrective action will be accomplished for those residents found to have been affected by the deficient practice;	

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F 756	Continued From page 36 #43 and #56), and failed to identify and address an ongoing, prophylactic antibiotic for 1 of 1 residents reviewed for urinary tract infection (Resident #371). Findings included: 1. Resident #43 was admitted to the facility on 11/11/18 with the diagnoses of diabetes and anxiety. A review of the resident's admission Minimum Data Set dated 11/17/18 revealed the resident had an intact cognition. The resident required extensive assistance for all his activities of daily living. The active diagnoses were diabetes and anxiety. The resident had a physician order dated 11/19/18 for Ativan 0.5 milligrams (mg) every four hours as needed with an "indefinite" stop date. The resident's care plan dated 11/23/18 had goals and interventions for psychotropic medication and diabetes. A review of the pharmacist's monthly medication review of Resident #43's medications in December 2018 revealed there was not a stop-date or justification recommendation for the resident's Ativan which was ordered on an as needed basis. On 12/20/18 at 1:55 pm an interview was conducted with the facility pharmacist who stated he was aware that an as needed antipsychotic medication required a 14-day stop date with review or a justification for longer timeframe and review. The pharmacist reviewed his notes for the resident and stated there was no	F 756	" Resident #43 and #56 had as needed psychotropic medication without stop date or justification with review date and there was not a review done by the consultant pharmacist. " Resident #371 had an order for a prophylactic antibiotic and there was not a review done by the consultant pharmacist. " Resident #43, #56, and #371 have been reviewed by pharmacist/provider and stop dates implemented as recommended. How the facility will identify other residents having the potential to be affected by the same deficient practice: " Facility Action □ All residents with PRN psychotropic medications or prophylactic antibiotics were referred to provider for stop date or justification with review date. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur; " The Pharmacy Consultant was educated by the Director of Nursing (DON) regarding the need for review of as needed psychotropic medications and antibiotic with no stop date. How the facility plans to monitor its performance to make sure that solutions are sustained; " The DON or designee will run a list of	

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F 756	Continued From page 37 recommendation made for an Ativan stop date and there should have been one completed. On 12/20/18 at 3:40 pm an interview was conducted with the resident's physician who stated he was aware that as needed psychotropic medication required a 14-day stop date or justification with future re-evaluation. The physician stated that he expected the psychiatrist and pharmacist to assist with the re-evaluation of psychotropic medication. The physician further stated that he was not aware of an indefinite timeframe for the resident's Ativan. The physician thought his Nurse Practitioner had written the order and would speak with her. The Nurse Practitioner was not available for interview. 2. Resident #56 was admitted to the facility on 11/11/18. The resident was admitted for physical therapy short stay. Admitting diagnosis was above the knee amputation of the right leg. A review of the resident's admitting Minimum Data Set dated 11/16/18 revealed the resident had an intact cognition and required supervision for activities of daily living. Active diagnoses were end-stage renal disease and diabetes. The resident's care plan dated 11/18/18 had goals and interventions for self-care deficit. The resident had a physician order dated 11/19/18 for Alprazolam 0.5 mg every 12 hours as needed for anxiety with an "indefinite" timeframe. A review of the pharmacist's monthly medication review from 11/18/18 to 12/20/18 revealed there was no recommendation documented that the	F 756	all as needed psychotropic medication and antibiotics without a stop date when the pharmacy consult does his monthly review and ensure that he issues any needed recommendations regarding these medications for 6 months. " The findings will be reviewed at the quarterly QAPI meetings. Date of compliance is January 19, 2019 The Administrator is responsible for implementing the acceptable plan of correction.	

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resident's as needed antipsychotic medication required a stop date or justification to continue.

On 12/20/18 at 1:55 pm an interview was conducted with the facility pharmacist who stated he was aware that an as needed antipsychotic medication required a 14-day stop date with review or a justification for longer timeframe and review. The pharmacist reviewed his notes for the resident and stated there was no recommendation made for an Alprazolam stop date and there should have been one completed.

On 12/20/18 at 3:40 pm an interview was conducted with the resident's physician who stated he was aware that as needed psychotropic medication required a 14-day stop date or justification with future re-evaluation. The physician stated that he expected the psychiatrist and pharmacist to assist with the re-evaluation of psychotropic medication. The physician further stated that he was not aware of an indefinite timeframe for the resident's Alprazolam. The physician thought his Nurse Practitioner had written the order and would speak with her. The Nurse Practitioner was not available for interview.

3. Resident #371 admitted to the facility on 1/30/15. Her diagnoses included seizures, kidney disease, dementia, anxiety, depression heart disease, and hypertension.

The most recent Minimum Data Set Quarterly Assessment dated 9/28/18 revealed Resident #371 was moderately cognitively impaired.

A review of Resident #371's medical record

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F 756	Continued From page 39 revealed a monthly drug regime review had not been completed by the facility's consultant pharmacist since 9/30/18. A review of the Pharmacist's Notes from the monthly drug regime review dated 9/30/18 revealed no medication changes were recommend and no drug irregularities were identified. A review of Resident #371's physician orders revealed she had an order to receive a prophylactic antibiotic (Cephalexin 250 milligrams by mouth at bedtime for urinary tract infection prophylaxis) which was ordered on 4/9/18. During an interview with the facility's consultant Pharmacist on 12/20/18 at 2:04 pm he stated he should have completed a monthly Medication Regimen Review for Resident #371 during the months of October and November 2018 and a Physician's Consultation should have been recommended since Resident #371 was on a prophylactic antibiotic. On 12/20/18 at 4:01 pm an interview with the Physician revealed he was aware Resident #371 was on a prophylactic antibiotic for Urinary Tract Infections. He was not aware Resident #371 had a Urinary Tract Infection when she was admitted to the hospital on 10/18/18. The Physician stated he would be monitoring for residents receiving prophylactic antibiotics.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		1/19/19

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affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§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.

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F 758	Continued From page 41 §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 interviews, and physician interview, the facility failed to ensure there was a required 14-day stop date or justification with review date for as needed psychotropic medication for 2 of 3 residents reviewed for unnecessary medication (Resident #43 and #56). Findings included: 1. Resident #43 was admitted to the facility on 11/11/18 with the diagnoses of diabetes and anxiety. A review of the resident's admission Minimum Data Set dated 11/17/18 revealed the resident had an intact cognition. The resident required extensive assistance for all his activities of daily living. The active diagnoses were diabetes and anxiety. The resident had a physician order dated 11/19/18 for Ativan 0.5 milligrams (mg) every four hours as needed with an "indefinite" stop date. The resident's care plan dated 11/23/18 had goals and interventions for psychotropic medication and diabetes.	F 758	F758 How corrective action will be accomplished for those residents found to have been affected by the deficient practice; " Resident #43 and #56 had as needed psychotropic medication without stop date or justification with review date. Provider has reviewed medications and added stop dates or justification for both residents. How the facility will identify other residents having the potential to be affected by the same deficient practice; " Facility Action □ The Director of Nursing reviewed eleven residents that had PRN psychotropic medications and they were referred to provider for stop date or justification with review date. All were either discontinued or given stop dates. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur; " All licensed staff educated by the Director of Nursing (DON), Staff	

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F 758	Continued From page 42 A review of the resident's December 2018 medication administration record (MAR) revealed the resident received 10 doses of Ativan on 9 separate days. On 12/19/18 at 8:50 am Resident #43 was sitting up in his bed finishing breakfast. The resident was alert and oriented and had no signs of anxiety. On 12/19/18 at 8:50 am an interview was conducted with the resident who was alert and oriented and stated that he occasionally had anxiety and would ask the nurse for medication. The resident had no concerns with his care. On 12/19/18 at 9:00 am an interview was conducted with Nurse #4 who stated the resident was a recent new admission. The resident had an as needed Ativan order for anxiety and had received Ativan regularly as requested. The resident was admitted with a history of anxiety and requested the medication when needed. Nurse #4 stated she was not aware that an as needed psychotropic medication required a 14-day stop date or timeframe with justification. She was also not aware that an as needed psychotropic medication could not have an order for indefinite timeframe. On 12/19/18 at 9:36 am an interview was conducted with the Director of Nursing (DON) who stated she was aware of the required 14-day stop date for as needed psychotropic medication. The DON expected as needed psychotropic medications to have a stop date or justification with review date with the order as required.	F 758	Development Coordinator (SDC), or designee on needing stop dates for as needed psychotropic medications. How the facility plans to monitor its performance to make sure that solutions are sustained; " The DON or designee will review all new orders for as needed psychotropic medications weekly for three months for stop dates or justification with review date. If there are residents with as needed psychotropic medications the DON or Designee will refer them to the MD/NP for a stop date or justification for use. " The findings will be reviewed at the quarterly QAPI meetings. Date of compliance is January 19, 2019 The Administrator is responsible for implementing the acceptable plan of correction.	

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On 12/20/18 at 3:40 pm an interview was conducted with the resident's physician who stated he was aware that as needed psychotropic medication required a 14-day stop date or justification with future re-evaluation. The physician stated that he expected the psychiatrist and pharmacist to assist with the re-evaluation of psychotropic medication. The physician further stated that he was not aware of an indefinite timeframe for the resident's Ativan. The physician thought his Nurse Practitioner had written the order and would speak with her. The Nurse Practitioner was not available for interview.

2. Resident #56 was admitted to the facility on 11/11/18. The resident was admitted for physical therapy short stay. Admitting diagnosis was above the knee amputation of the right leg.

A review of the resident's admitting Minimum Data Set dated 11/16/18 revealed the resident had an intact cognition and required supervision for activities of daily living. Active diagnoses were end-stage renal disease and diabetes.

The resident's care plan dated 11/18/18 had goals and interventions for self-care deficit.

The resident had a physician order dated 11/19/18 for Alprazolam 0.5 mg every 12 hours as needed for anxiety with an "indefinite" timeframe.

A review of the resident's December 2018 medication administration record revealed the resident received two doses of the as needed Alprazolam.

On 12/18/18 at 4:30 pm an interview was

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conducted with the resident who stated he was at the facility for short-term physical therapy. The resident stated that he did not have anxiety and was looking forward to going home this week.

On 12/19/18 at 9:00 am an interview was conducted with Nurse #4 who stated the resident was a recent new admission. The resident had an as needed Alprazolam order for anxiety and had occasionally received the Alprazolam as requested. The resident was admitted with a new diagnosis of above the knee amputation and the Alprazolam was ordered after admission to the facility. The resident was oriented and requested the medication when needed. Nurse #4 stated she was not aware that an as needed psychotropic medication required a 14-day stop date or timeframe with justification. She was also not aware that an as needed psychotropic medication could not have an order for indefinite timeframe.

On 12/19/18 at 9:36 am an interview was conducted with the Director of Nursing (DON) who stated she was aware of the required 14-day stop date for as needed psychotropic medication. The DON expected as needed psychotropic medications to have a stop date or justification with review date with the order as required.

On 12/20/18 at 3:40 pm an interview was conducted with the resident's physician who stated he was aware that as needed psychotropic medication required a 14-day stop date or justification with future re-evaluation. The physician stated that he expected the psychiatrist and pharmacist to assist with the re-evaluation of psychotropic medication. The physician further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 01/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(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 758	Continued From page 45 stated that he was not aware of an indefinite timeframe for the resident's Alprazolam. The physician thought his Nurse Practitioner had written the order and would speak with her. The Nurse Practitioner was not available for interview.	F 758		
F 812 SS=E	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 discard expired food items and date food items when opened in the kitchen reach-in refrigerators for 2 of 4 reach-in refrigerators. Findings included:	F 812	F812 1. F812 How corrective action will be accomplished for those residents found to have been affected: The facility failed to store, and discard expired foods found in reach-in refrigerator. The facility failed to label and	1/19/19

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F 812	Continued From page 46 On 12/17/18 at 10:00 am an initial tour of the kitchen was completed with the Dietary Manager (DM), and two of the four reach-in refrigerators were observed with expired and undated food items and beverages stored inside. Observations of foods and beverages stored in the two kitchen reach in refrigerators revealed the following expired or undated item; a container of canned apples had an expired expiration date of 12/09/18 and a container with canned fruit cocktail had an expired expiration date of 12/10/18. An opened container of thickened liquid was not dated. A container of thickened lemon-flavored water had an expiration date of 12/10/18. A plastic bag of demi-glaze for meat was not dated. A package of smoked turkey had an expired expiration date of 12/10/18. The DM observed and agreed food and drink were not dated or expired and discarded these items. On 12/17/18 at 11:22 am an interview was conducted with the DM who stated that she was responsible to discard expired food and drink items and to ascertain that opened, refrigerated items were dated. Kitchen staff was not responsible to check the refrigerator daily. On 12/20/18 at 2:30 pm an interview was conducted with the Director of Nursing (DON) who stated that she expected the Dietary Manager to monitor refrigerated expired food and drink items.	F 812	date food and beverages found in the reach-in refrigerator. On 12/17/18, a container of canned apples, a container of canned fruit cocktail, a container of thickened lemon-flavored water, a container of opened thickened liquid, a plastic bag of demi-glaze for meat and a package of smoked turkey found expired or unlabeled in the reach-in refrigerator were immediately removed and discarded at the time of observation. F812 How the facility will identify other residents having the potential to be affected by the same deficient practice: All Dining Services employees were in-serviced by the Registered Dietician or Dietary Manager regarding proper procedures for discarding expired food items and labeling and dating items. (12/17/18) F812 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur A sanitation inspection will be conducted by Corporate Registered Dietician weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure compliance with corrective actions and sanitation standards. Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. All new hires will receive in-service	

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F 812	Continued From page 47	F 812	education by Dietary Services Manager on proper procedures for discarding expired food, labeling and dating items when received and opened. F812 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Findings from sanitation inspections will be brought by the Dietary Manager to be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. Completion date January 19, 2019	