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	345532	A. BUILDING _____ B. WING _____	C 02/28/2019

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E 000	Initial Comments An unannounced recertification survey was conducted on 2/25/19 through 2/28/19. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness. See Event ID # RP9J11.	E 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		4/12/19

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

Electronically Signed | 03/20/2019

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to treat a resident with dignity and respect during the provision of incontinent care for 1 of 2 residents (Resident #4) reviewed for dignity. This failure caused Resident #4 to cry and to feel as if he was "a bother". The findings included: Resident #4 was admitted to the facility on 6/26/18 with diagnoses that included Post-Traumatic Stress Disorder (PTSD), major depressive disorder, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 11/22/18 indicated Resident #4' s cognition was fully intact. He had no behaviors and no rejection of care. Resident #4 required the extensive assistance of 1 for personal hygiene, toileting, and dressing. He had functional impairment with range of motion on 1 side of his upper and 1 side of lower extremities. Resident #1 was occasionally incontinent of bowel and bladder.	F 550	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take actions set forth in this Plan of Correction. The Plan of Correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated: F550 Residents Rights/Exercise of Rights Based on observation, record review, resident interview, and staff interview, the facility failed to treat a resident with dignity and respect during the provision of incontinent care for 1 of 2 residents (Resident #4) reviewed for dignity. This failure caused Resident #4 to cry and to feel as if he was "a bother". 1. Address how the corrective action will be accomplished for those residents	

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F 550	Continued From page 2 The active care plan for Resident #4 included the focus area of occasional incontinence (initiated on 7/9/18). The interventions included assistance with incontinent care (initiated on 7/9/18). An interview was conducted with Resident #4 on 2/25/19 at 11:40 AM. Resident #4 was alert and oriented with no impaired cognition noted. He indicated he had impaired range of motion on one side of his upper and lower extremities and he needed assistance with Activities of Daily Living (ADLs). He reported that this included assistance with incontinent care. Resident #4 stated that a couple of weeks ago he had an episode of incontinence and he needed staff to change his brief. He reported that Nursing Assistant (NA) #6 was working with him that day and provided his incontinent care. He stated that NA #6 was "snatching me around" during incontinent care. Resident #4 explained that he felt NA #6 was "rough" with him. He shared that NA #6 said something to him about being "childish" and he thought she was talking about him being incontinent. He revealed this incident made him very depressed because there were times that he had no control over his incontinence. Resident #4 further revealed he cried about this incident after NA #6 left his room. He indicated he had not informed the Administrator about the incident as he felt like every time he complained about something that things got worse. Resident #4 stated NA #6 had worked with him after this incident and she had not apologized. An interview was conducted with the Social Worker (SW) on 2/27/19 at 10:00 AM. She stated she was familiar with Resident #4. She indicated his cognition was intact, and he had no behavioral issues. The SW was asked if	F 550	found to have been affected by the deficient practice: For resident #4,a corrective action was obtained on 02/28/2019 when CNA#6 was re-educated by the Director of Nursing, on the resident's right to dignity, respect and the right to make choices. A complaint form was initiated by the Administrator after interviewing the resident and the resident's responsible party on 03/27/2019. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to have been affected by the deficient practice All Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants will be educated on the Resident's Right by the Director of Nursing or the Support Nurse to include dignity, respect and the right to make choices by 03/24/2019. Staff not trained by 03/30/2019 will not be allowed to work until training is completed. Residents with a BIMS above 12 were interviewed by the social worker for any concerns related to resident rights or dignity issues on 3/27/19 with no other incidents reported. On 3/27/19 Grievances and Resident Council Reports for February/March were reviewed by the administrator for any concerns related to resident rights or	

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Resident #4 had reported any issues with his care. She revealed that on 2/26/19 Resident #4 reported to her that an incident had occurred with NA #6 during incontinence care. She indicated that Resident #4 spoke about NA #6 being rough with him and making him feel like he was a bother to her. The SW stated she had not written a grievance about this yet, but she was planning on writing it today. She reported she had not spoken to NA #6 yet as she was not working yesterday, and she had not had a chance to call her by phone.

An interview was conducted with the Administrator on 2/27/19 at 10:30 AM. She stated the SW had just reported to her the statement Resident #4 made regarding care by NA #6. She reported that the SW was in the process of writing a grievance form at this moment. The Administrator stated NA #6 had the tendency to speak very loudly to all people, including the residents. She explained that it was possible that this loud tone of voice used by NA #6 could be misinterpreted as her yelling, being impatient, or something along those lines. She indicated she was aware that NA #6 was not as "compassionate" as some of the other NAs, but she had never had any concerns reported to her about NA #6 being "rough" with any resident.

A grievance report form dated 2/26/19 completed by the SW on 2/27/19 indicated Resident #4 reported that while receiving incontinent care that NA #6 was rough while tuning and repositioning him. This form indicated that Resident #4 stated that some NAs gave 110% and others walked in and asked what he needed in a tone of voice that "makes me feel like a bother".
A phone interview was conducted with NA #6 on dignity issues with no other reports found.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 3/18/19 the Director of Nurses began education of all full time, part time, as needed staff on resident rights, maintaining dignity and reporting resident concerns.
The Director of Nurses will ensure that any of the above identified staff who do not complete the in-service training by 3/29/19 will not be allowed to work until the training is completed.

Effective 03/18/2019, the Director of Nursing or the Social Worker will utilize the Quality Assurance Tool for Recognizing the Resident's Right for dignity, respect and to make choices by interviewing three (3) clinical staff and two (2) non-clinical staff two (2) times per week, Monday thru Friday and include weekends for two (2) weeks then monthly times three (3) months.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The DON/Administrator will monitor this issue using the Resident Rights Quality Assurance Tool for Monitoring with the Social Worker interviewing four alert and oriented residents with a BIMS of 12> to assess any concerns related to resident

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F 550	Continued From page 4 2/28/19 at 8:35 AM. She stated she was familiar with Resident #4. She indicated his cognition was intact, he had no behavioral issues, and he needed assistance with ADLs including incontinent care. NA #6 revealed she had spoken with the Administrator by phone about Resident #4 ' s report. She stated she was unable to remember ever being "rough" with Resident #4 or saying something to him about being "childish". She additionally stated she had not known Resident #4 was upset by her. NA #6 stated she was going to apologize to Resident #4 for upsetting him the next time she saw him. A follow up interview was conducted with Resident #4 on 2/28/19 at 9:00 AM. Resident #4 was lying in bed in his room. He was alert and oriented. He stated he reported the information about NA #6 to the SW and the Administrator. He reiterated his report and provided the same information as in the interview conducted on 2/25/19 at 11:40 AM. An interview was conducted with the Administrator on 2/28/19 at 10:39 AM. She indicated it was her expectation for all residents to be treated with dignity and respect.	F 550	rights. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses or in the absence of the Director of Nursing the Sociial Worker to ensure corrective action is initiated as appropriate. This will be completed weekly times 2 weeks then monthly times 3 months or until resolved by Quality Assurance (QA) Committe Reports will be reviewed by the weekly Quality Assurance for corrective action to be initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager, Social Worker and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 04/12/2019	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group,	F 565		4/12/19

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F 565	Continued From page 5 to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with residents and staff, the facility failed to resolve repeat concerns with food palatability reported during Resident Council meetings for 6 of 6 consecutive months. The findings included:	F 565	F565 Resident/Family Group Response Based on record review, and interviews with residents and staff, the facility failed to resolve repeat concerns with food palatability reported during Resident Council meetings for 6 of 6 consecutive months.	

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F 565	Continued From page 6 Review of the monthly Resident Council meeting minutes dated 9/4/18 included, in part, concerns related to cold breakfast food, hard grits, and bacon not being thoroughly cooked. These minutes were recorded by the Activities Director and copies were noted to be sent to the Administrator and Dietary Manager (DM). Review of the monthly Resident Council meeting minutes dated 10/2/18 included, in part, the repeat concern of cold breakfast food and the new concern of pork chops and BBQ beef being tough to chew. These minutes were recorded by the Activities Director and copies were noted to be sent to the Administrator and DM. Review of the monthly Resident Council meeting minutes dated 11/6/18 included, in part, the repeat concerns of cold breakfast food and pork chops and BBQ beef being tough to chew. These minutes were recorded by the Activities Director and copies were noted to be sent to the Administrator and DM. Review of the monthly Resident Council meeting minutes dated 12/4/18 included, in part, the repeat concerns of cold breakfast food and some meats still being tough to chew. These minutes were recorded by the Activities Director and copies were noted to be sent to the Administrator and DM. Review of the monthly Resident Council meeting minutes dated 1/4/19 included, in part, the repeat concerns of cold breakfast food and some meats still being tough to chew. These minutes were recorded by the Activities Director and copies were noted to be sent to the Administrator and DM.	F 565	1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 03/05/2019, the Dietary Services Director met with the Resident Council to follow up on all Resident Council meal service concerns. Preferences were updated for tray cards for those with food issues. Squash, Pork Chops and Zucchini were discontinued from menu. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. All dietary staff were in-serviced on 03/20/2019 regarding serving palatable food appropriate for the resident's diet at the appropriate temperature, honoring resident meal preferences and following up on residents concerns regarding food quality. The Dietary Services Director or the Registered Nurse Supervisor will monitor breakfast delivery schedules and prompt tray service to residents three (3)times a week for two (2) weeks, then weekly times four (4) weeks and interview 3 residnets per week for food issues. The Dietary Services Manager or the Cook scheduled for the day, will monitor the temperature of breakfast trays on the tray line three (3) times a week for two (2) weeks, then monthly times four (4) weeks.	

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Review of the monthly Resident Council meeting minutes dated 2/5/19 included, in part, the repeat concerns of cold breakfast food and some meats still being tough to chew. These minutes were recorded by the Activities Director and copies were noted to be sent to the Administrator and DM.

A Resident Council meeting was conducted on 2/26/19 1:15 PM with 11 alert and oriented residents who were active participants in the facility's Resident Council. The residents reported that they had repeat concerns over the past several months with cold breakfast food and with meats being tough to chew. The meeting attendees all stated that these concerns had not been resolved. When asked what the facility ' s response was to them regarding these repeat concerns the group indicated they had not received any response to these concerns.

An interview was conducted with the Activities Director on 2/26/19 at 1:45 PM following the Resident Council meeting. She confirmed she was aware that the resident council had repeated concerns with breakfast food being cold and meats being tough to chew. She stated that after each of the resident council meetings she gave a copy of the minutes to all department heads as well as the Administrator. She indicated that at the next meeting she asked about each previously reported concern to see if they had been resolved. The Activities Director revealed that if the concern had not been resolved she indicated that it was a repeat issue on the minutes.

An interview was conducted with the

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The Dietary Services Manager has asked and been given permission to meet with the Resident Council monthly to review grievances concerning food. In the absence of the Dietary Services Manager, the Cook assigned for the day will meet with the Resident Council.

Grievances received by the Dietary Services Manager will be followed up on within five (5)days of receiving complaint per policy.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The Dietary Services Manager or the Cook in the absence of the Dietary Manager, will bring to the weekly Quality Assurance meeting the results of the audits for breakfast delivery times, temperature of breakfast foods on the tray line, and Resident Council monthly meeting minutes for review and corrective action to be initiated as appropriate.

The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager, social Worker and the Activity Director.

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F 565	Continued From page 8 Administrator on 2/26/19 at 4:00 PM. She confirmed she received a copy of the resident council minutes after each meeting. She revealed she was aware of repeated concerns voiced at the resident council meetings related to food palatability. She stated she had spoken with DM on multiple occasions related to food concerns reported at the resident council meetings. The Administrator was unable to explain why the resident council ' s repeat concerns related to food had not been resolved and/or improved upon. An interview was conducted with the DM on 2/26/19 at 4:22 PM. She confirmed she received a copy of the resident council minutes after each meeting. She revealed she was aware there were repeated concerns voiced at the resident council meetings related to food palatability. The DM stated that after she reviewed the minutes she went and spoke to the specific resident who reported the concern individually to try to resolve the issue. She revealed she had not followed up with all the resident council attendees to ensure that the concern was resolved for all members of the resident council. She acknowledged that she should be addressing the group as a whole and stated that she was going to ask the resident council if she could attend their next meeting.	F 565	The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 04/12/2019	
F 623 SS=C	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	F 623		4/12/19

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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.
(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;

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(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 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

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F 623	Continued From page 11 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 staff interview, the facility failed to notify the Ombudsman of a transfer to the hospital for 1 of 2 resident's reviewed for hospitalizations. (Resident #5). The findings included: Resident #5 was admitted to the facility on 3/29/18 and readmitted to the facility from the hospital on 11/15/18 with cumulative diagnoses of Cerebral Vascular Accident and Dysphagia. Review of a nursing note dated 11/8/18 read the resident was sent to the hospital on 11/8/18 due to an elevated temperature and abdominal pain. She was readmitted to the facility on 11/15/18. Resident #5's quarterly Minimum Data Set dated 11/22/18 indicated moderate cognitive impairment and exhibited no behaviors. She was coded as requiring extensive assistance with her activities of daily living. During an interview on 2/27/19 at 4:50 PM, the Social Worker (SW) stated that she notified the regional Ombudsman of discharges to home at least every month but that she was not aware that	F 623	F623 Notice Requirements Before Transfer/Discharge Based on record review and staff interview, the facility failed to notify the Ombudsman of a transfer to the hospital for 1 of 2 resident's reviewed for hospitalization. 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: For resident#5, a corrective action was obtained on Sunday, March 10,2019 when the Social Worker sent information of discharge on 11/08/2018. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to have been affected by the deficient practice A review of discharges from 01/01/18	

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F 623	Continued From page 12 she had to notify the Ombudsman of the hospital discharges. She stated she had not been notifying the regional Ombudsman, but she began doing it on 2/27/19. Two attempt were made to interview the regional ombudsman via phone. The surveyor left voice messages for the ombudsman to return call. There was no return call. During an interview on 2/28/19 at 10:40 AM, the Administrator stated it was her expectation that the SW notify the regional Ombudsman of any resident hospitalization.	F 623	thru 02/28/2019 was conducted by the Administrator and Social Worker on 03/01/2019 and three (3) residents were discharged to the hospital in January, five (5) in February, and nine (9) discharges in March which all have been sent to the Omsbudsman as discharged to the hospital or home on 03/004/2019. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Social Worker or in the absence of the Social Worker, the Admissions Director will bring the list of residents discharged daily to the weekly Quality Assurance meeting for review. The Social Worker or in the absence of the Social Worker, the Admissions Director will send the list of discharged residents to the Ombudsman prior to the weekly Quality Assurance meeting. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Reports will be reviewed weekly by the Quality Assurance committee and corrective action initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager, Social Worker	

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F 623	Continued From page 13	F 623	and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. 04/12/19	
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 interview, the facility failed to code the Minimum Data Set assessment accurately in the area of behaviors for 1 of 2 residents (Resident #4) reviewed for behavioral and emotional status. The findings included: Resident #4 was admitted to the facility on 6/26/18 with diagnoses that included Post-Traumatic Stress Disorder (PTSD), major depressive disorder, and anxiety disorder. A nursing note dated 11/22/18 indicated Resident #4 exhibited the verbal behavior of cursing at staff. The quarterly Minimum Data Set (MDS) assessment dated 11/22/18 indicated Resident #4 ' s cognition was fully intact. He was assessed with no behavioral symptoms.	F 641	F641 Accuracy of Assessments Based on record review and staff interview, the facility failed to code the Minimum Data Set assessment accurately in the area of behaviors for 1 of 2 residents (Resident #4) reviewed for behavioral and emotional status. 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The specific deficiency was corrected on 3/19/19 by modifying the Minimum Data Set assessment with an ARD of 11/22/18 and correcting the answer for question EO200B (Verbal behavioral symptoms directed towards others) in order to accurately reflect documented episode of verbal behavior/cursing at	3/20/19

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F 641	Continued From page 14 An interview was conducted with the Social Worker (SW) on 2/27/19 at 11:15 AM. She stated she coded Resident #4 ' s 11/22/18 quarterly MDS in the area of behaviors. The 11/22/18 nursing note that indicated Resident #4 had the verbal behavior of cursing at staff was reviewed with the SW. She revealed that she must have missed this 11/22/18 nursing note when she coded Resident #4 ' s 11/22/18 MDS. The SW stated this MDS for Resident #4 was coded inaccurately for behaviors. An interview was conducted with the Administrator on 2/28/19 at 10:39 AM. She stated that she expected the MDS to be coded accurately.	F 641	staff. This was completed by the Regional Minimum Data Set Nurse Consultant. Corrected Minimum Data Set assessment was re-submitted to State Database in Batch #1216 and accepted on 3/19/19. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 3/18/19, the Regional Minimum Data Set Consultant completed 100 % audit of the most recent completed Minimum Data Set assessment for current residents in order to validate that the presence of any behaviors during the Assessment Reference Date lookback period were accurately coded in Section E. Audit results are: 56 of 56 assessments audited had accurate coding of Section E. 0 of 56 assessments audited had inaccurate coding of Section E. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/20/19, the Regional Minimum Data Set Consultant completed an in service training for the facility Social Services Director and Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record	

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F 641	Continued From page 15	F 641		

prior to completion of Section E of the Minimum Data Set assessment.

This information has been integrated into the standard orientation training for new Social Services Directors and Minimum Data Set Coordinators.

On 3/25/19, the Director of Nursing or Minimum Data Set Nurse will begin auditing coding of behaviors in Section E of the Minimum Data Set Assessment using the quality assurance survey tool entitled Accurate Coding of Section E (Behaviors) Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements.

This will be done weekly times four(4) weeks and then monthly times two(2) months.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate.

The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary

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F 641	Continued From page 16	F 641	Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 04/12/2019	
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 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 observations, staff and resident interviews and record review, the facility failed to refer a resident with a possible serious mental disorder for a level 2 Preadmission Screening and Resident Review (PASARR). This was for 2 (Resident #15 and resident #26) of 3 residents	F 644	F644 Coordination of PASARR and Assessments Based on observations, staff and resident interviews and record review, the facility failed to refer a resident with a possible	4/12/19

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F 644	Continued From page 17 reviewed for PASARR. The findings included: 1. Resident #15 was admitted to the facility on 12/14/11 with cumulative diagnoses of End Stage Renal Failure and Cerebral Vascular Accident. Review of her cumulative diagnoses included Post-Traumatic Stress Disorder (PTSD) added as a new diagnosis on 5/1/17. A significant change Minimum Data Set was completed on 3/29/18 which included the diagnosis of PTSD with no PASARR level 2. She was not coded as taking any antipsychotic medications but was coded for taking antidepressants. Review of Resident #15's most recent quarterly Minimum Data Set dated 12/20/18 revealed she was cognitively intact and exhibited no behaviors. She was coded as having received an antidepressant. During an interview and observation on 2/25/19 at 9:52 AM, Resident #15 was dressed and prepared to leave for dialysis. She verbalized the correct month ad year and aware of her surrounding along with living situation. She exhibited no mood or behavior concerns. She reported no issues or concerns related to her care at the facility. During an interview on 2/26/19 at 12:20 PM, the Health Information Management (HIM) supervisor stated she could find no evidence of documentation regarding the addition of PTSD to Resident #15's diagnoses on 5/1/17. Review of a Psychotherapy note dated 2/23/19 indicated Resident #15 was experiencing	F 644	serious mental disorder for a level 2 Preadmission Screening and Resident Review (PASARR). This was for 2 (Resident #15 and resident #26) of 3 residents reviewed for PASARR. 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Specific deficiency for Resident #26 was resolved on 3/19/19 by the Social Services Director who submitted a new request for review via NCMUST. Specific deficiency for Resident #15 was resolved on 03/05/19 by the facility Medical Director, Timothy Beittel, MD CMD CPE, by stating that the diagnosis for Post Traumatic Stress Disorder was not appropriate for Resident #15, as there is no evidence of past or current treatment for Post Traumatic Stress Disorder. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 3/19/19, the Regional Minimum Data Set Nurse Consultant completed 100 % audit of all residents who have had a new diagnosis assigned to them in the past 6 months from 9/1/18 □ 3/1/2019 in order to validate that the State Mental Health Authority was notified and a new resident	

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symptoms of depression and anxiety and recommended continuation of psychotherapy.

Review of Resident #15's February 2019 Physician Orders did not include any prescribed psychotropic medications.

Review of Resident #15's care plan last revised 2/5/19 did not include a care plan for PASARR.

Review of Resident #15's nursing notes from 9/1/18 to 2/27/19 did not include any concerns related to her mood or behaviors.

During an interview on 2/27/19 at 9:40 AM, Nursing Assistant (NA) #1 stated Resident #15 was cooperative and she exhibited no mood or behaviors concerns.

During an interview on 2/27/19 at 9:50 AM, Nurse #1 stated Resident #15 was pleasant and exhibited no mood or behaviors concerns. She stated she thought Resident #15 was receiving psychological services.

During an interview on 2/27/19 at 10:05 AM, the Social Worker (SW) stated she was not aware of a new diagnosis of PTSD on 5/1/17. She stated Resident #15 was not referred for a level 2 PASARR screen because nobody made her aware of the diagnosis of PTSD. She stated she was uncertain of the process or system in place of letting her know of newly diagnosed mental illness.

During an interview on 2/27/19 at 10:40 AM, the Administrator stated the SW attended the weekly meeting where any new diagnoses was reviewed and discussed. She stated it was her expectation

review request was sent through the NCMUST system for any resident who received a new diagnosis of Severe Mental Illness or Intellectual Disability/Mental Retardation

Audit results are:

" 20 residents were identified as having been assigned a new diagnosis of Serious Mental Illness and/or Intellectual Disability.
" 3 of the 20 residents were noted to have been screened and assigned a Level II PASRR number already.
" 4 of 20 were noted to have PASRR screenings that are up to date.
" 16 of 20 were noted to not have up to date PASRR screening.

On 3/20/19, the 16 residents who had been identified as not having an up to date PASRR screening had new requests for reviews sent to NCMUST. This was completed for all 16 residents by the facility Social Services Director

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

All residents who receive a diagnosis of a Serious Mental Illness or Intellectual Disabilities/Mental Retardation have the potential to be impacted.

Beginning on 3/26/19, the facility Social Services Director will begin running and

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F 644	Continued From page 19 that Resident #15 receive a referral for a level 2 PASARR screening. During a second interview on 2/27/19 at 11:15 AM, the SW confirmed she attended the weekly meetings where new diagnoses were discussed. She stated as of 2/27/19, the Minimum Data Set Nurse reiterate any new diagnoses related to mental illness. She stated she had referred a resident for a level 2 PASARR screen recently but apparently missed sending a referral for Resident #15. The SW confirmed it was her responsibility to make all referral for level 2 PASARRs. 2. Resident #26 was admitted to the facility on 3/26/18 with cumulative diagnosis of Cerebral Vascular Accident and hemiplegia. Review of her cumulative diagnoses included Psychosis was added as a new diagnosis on 5/15/18. Review of Resident #26's admission Minimum Data Set dated 4/2/18 indicated she was coded for Depression. She was coded as receiving an antipsychotic medication. Review of Resident #26's annual Minimum Data Set dated 1/2/19 indicated severe cognitive impairment and she exhibited no mood or behaviors. She was coded for Psychotic Disorder. She was coded as receiving an antipsychotic medication. Review of Resident #26's Psycho/Social Care Area Assessment dated 1/2/19 read she had a history of a stroke and Psychosis. Due to her current medical status, her psycho/social well-being was compromised. She felt restless and her appetite was poor. She was unable to fully verbally communicate her needs. She was at	F 644	reviewing a New Diagnosis Report from Point Click Care weekly in order to identify any resident who has been diagnosed with a Serious Mental Illness or Intellectual Disabilities/Mental Retardation during the past 7 days. Any resident who has received a Serious Mental Illness or Intellectual Disabilities/Mental Retardation diagnosis during the past 7 days will be reviewed to validate that a request for new review has been submitted to NCMUST. Any resident who has not had a new request for review since receiving recent diagnosis as stated above will have one sent to NCMUST by the facility Social Services Director. On 3/20/19, the Regional Minimum Data Set Consultant completed an in service training for the facility Social Services Director and Minimum Data Set Coordinator that included the importance of the importance of thoroughly reviewing each resident□s medical record in order to identify whether or not the resident has a diagnosis of a severe mental illness or intellectual disability/mental retardation. The education also included the importance of ensuring that the state mental health authority is notified via NCMUST of all residents who have received these diagnoses and/or if these residents have a significant change in status. This information has been integrated into the standard orientation training for new Social Services Directors and Minimum Data Set Coordinators.	

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F 644	Continued From page 20 risk for experiencing further psycho social concerns. Review of Resident #26's care plan last revised 2/25/19 did not include a care plan for PASARR but did include a care plan initiated 3/26/18 for Psychosis. Review of Resident #26's nursing notes from 9/1/18 to 2/27/19 did not include any concerns related to her mood or behaviors. Review of Resident #26's February 2019 Physician Orders included orders for Abilify (an antipsychotic medication) daily for Psychosis. During an interview on 2/26/19 at 12:20 PM, the Health Information Management (HIM) supervisor stated she could find no evidence of any psychological referrals or psychological treatments but noted that the diagnosis of Psychosis was found on her medication administration record for March 2018 while Resident #26 was residing at another facility and first noted on a Physician progress note dated 5/4/18. During an observation and attempted interview on 2/26/19 at 2:30 PM, Resident #26 was lying in bed. She was alert and did not exhibit any mood or behaviors concerns. She was able to only answer yes/no questions, but the validity of her responses was questionable. During an interview on 2/27/19 at 9:40 AM, Nursing Assistant (NA) #1 stated Resident #26 was cooperative and she exhibited no mood or behaviors concerns.	F 644	4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: On 3/25/19, the Director of Nursing or Minimum Data Set Nurse will begin auditing residents who have a diagnoses of a severe mental illness or intellectual disabilities/mental retardation to ensure that state mental health authority is notified via NCMUST system anytime that they have a significant change in status or are newly diagnosed with above diagnoses, using the quality assurance survey tool entitled PASRR Screening Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager, Social Worker and the Activity Director. The title of the person responsible for implementing the acceptable plan of	

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F 644	Continued From page 21 During an interview on 2/27/19 at 9:50 AM, Nurse #1 stated Resident #26 was cooperative, and she had not observed any evidence of psychosis but rather frustration at her inability to speak. During an interview on 2/27/19 at 10:05 AM, the Social Worker (SW) stated she was not aware of a new diagnosis of Psychosis on 5/15/18. She stated Resident #26 was not referred for a level 2 PASARR screen because nobody made her aware of the diagnosis of Psychosis. She stated she was uncertain of the process or system in place of letting her know of newly diagnosed mental illness. During an interview on 2/27/19 at 10:40 AM, the Administrator stated the SW attended the weekly meeting where any new diagnosis was reviewed and discussed. She stated it was her expectation that Resident #26 receive a referral for a level 2 PASARR screening. During a second interview on 2/27/19 at 11:15 AM, the SW confirmed she attended the weekly meetings where new diagnoses were discussed. She stated as of 2/27/19, the Minimum Data Set Nurse reiterate any new diagnoses related to mental illness. She stated she had referred a resident for a level 2 PASARR screen recently but apparently missed sending a referral for Resident #26. The SW confirmed it was her responsibility to make all referral for level 2 PASARRs.	F 644	correction; Administrator and /or Director of Nursing. Date of Compliance: 04/12/2019	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		4/12/19

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F 656	Continued From page 22 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. This REQUIREMENT is not met as evidenced by:	F 656		

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F 656	Continued From page 23 Based on record review, observation, staff, and social work interview the facility failed to implement the resident ' s care plan interventions for suicidal ideation (Resident #37) for 1 of 2 residents reviewed for suicidal ideation. Findings included: Resident #37 was admitted on 4/13/18 for adult failure to thrive and altered mental status. A review of Resident #37 ' ' s quarterly Minimum Data Set dated 1/18/19 revealed the resident had adequate hearing, clear speech, was understood and understands. The resident had a severely impaired cognition (the resident was alert & oriented to self and situation with fair short-term memory). The resident ' s mood was scored as having had insomnia, was depressed, was feeling tired, and had a poor appetite every day. The resident required extensive assistance of 2 staff for all transfers and bed mobility and of 1 staff for all other activities of daily living. The current diagnoses were Non-Alzheimer's dementia, anxiety, depression, adult failure to thrive, and insomnia. A review of Resident #37 ' s care plan dated 4/13/18 revealed a focus problem of "I am at risk for suicide and/or injuries related to suicidal ideation related to depression. The goals were "my overall mood will remain stable." The interventions were as follows: "Always take any of my statements seriously and report to the nurse, I would be better off dead, I am going to end this, and my family/friend would be better off without me. Assess the resident for suicidal ideations. Inspect my room every shift and remove any sharp objects from my room that could possibly be used to harm myself such as sharp objects,	F 656	F656 Develop/Implement Comprehensive Care Plan Based on record review, observation, staff, and social work interview the facility failed to implement the resident ' s care plan interventions for suicidal ideation (Resident #37) for 1 of 2 residents reviewed for suicidal ideation. 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #37 expired from complications related to diagnosis of Congestive Heart Failure, Renal Disease and Chronic Obstructive Pulmonary Disease on 3/1/19 prior to Plan of Correction being developed. The Minimum Data Set Nurse Consultant audited all current residents to identify all residents who are care planned as being at risk for suicide or who have suicidal ideation/verbalizations. This was completed by reviewing the care plans of all current residents. Once it was determined who was care planned as being at risk for suicide, including having interventions in place to maintain resident safety, Tasks communicating these safety interventions were fired to the CNA□s through Point Click Care. These tasks will require CNA documentation that the task was completed. The Tasks will be an additional way to ensure that CNA□s see what is already communicated to them on the resident□s Kardex. This was	

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F 656	Continued From page 24 medications, plastic bags, belts/straps/rope-like objects, etc. Notify the kitchen not to send silverware, only provide plastic utensils." A review of Resident #37 ' s nursing assistant kardex (NA care plan) dated 4/13/18 revealed it had the same goals and interventions as nursing ' s care plan (they were electronically linked). A review of the resident ' s physician note dated 6/8/18 revealed suicidal ideation and that the depression was severe and recurring, A review of Resident #37 ' s record revealed she received psychotherapy with psychiatry social work each week and was seen by the psychiatry nurse practitioner twice a month since August 2018. A review of the resident ' s nurse practitioner psychiatry note dated 1/25/19 revealed the resident self-reported hospitalizations 6 times for suicidal attempts of pill overdose. The resident wished for death but maintained she was not suicidal. The resident ' s significant other was recently deceased, and the resident had lost her independence. The resident had no family support. One local friend occasionally visited. The resident was needy with attention seeking and somatic (overly attentive to her sicknesses). A review of the resident ' s nurse practitioner psychiatry note dated 2/4/19 revealed "talk therapy" with psychiatry social worker documented the resident was depressed with crying, anger, wishes to die, worthlessness, sadness, low motivation, and agreed to remain safe by informing staff of self or others.	F 656	completed on 3/20/2019. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 3/20/19, the Minimum Data Set Nurse Consultant and Nurse Managers initiated education to all full time and part time nursing staff including RN□s, LPN□s, CNA□s and Medication Tech□s/Aides. " How Nurses are able to access resident Care Plans and Interventions. " How for CNA□s to access the Kardex for assigned residents in order to view specific interventions to maintain resident safety as well as how to view and document on specific tasks in Point Click Care. " The Minimum Data Set Coordinator will be responsible for updating each resident□s care plan/Kardex and Tasks list as needed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses, nurse aides, and medication tech□s and will be reviewed by the Quality Assurance process to verify that the change has been sustained. In-service education will continue until all required staff have been trained and staff will not be allowed to work after 3/23/19 until training has been received. 3. Address what measures will be put into place or systemic changes made to	

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F 656	Continued From page 25 On 2/25/19 at 8:30 am an observation was done of the resident ' s meal tray and metal silver ware was present and used by the resident. On 2/26/19 at 9:20 am an interview with Nurse #4 assigned to Resident #37 revealed the nurse was very familiar with the resident and her psychiatric history. Nurse #4 stated that the resident preferred to stay in bed and verbalized that she did not feel well secondary to depression and loss. Nurse #4 was familiar with the resident ' s depression but was not familiar with the care plan for suicidal interventions for assessment, to check the room for objects, and to provide plastic ware. The resident has had a history of stating that she" would be better off dead." Nurse #4 stated the resident's room was not assessed for potential items to be used for suicide or assessed for suicidal ideation. Nurse #4 confirmed she did not implement the care planned interventions because she was not familiar with what the interventions were. On 2/27/19 at 9:30 am an interview was conducted with psychiatry social worker who stated she had been providing Resident #37 psychotherapy since August 2018. A year ago, the resident had self-reported suicide attempt (before admission to facility) by medication overdose and also medication non-compliance. The resident was admitted to the facility July 2018 due to an inability to care for herself. The interview further revealed the resident had benefited from psychotherapy and had remained stable and not out of control with her depression and behaviors. Suicide precautions would need to be continued with this resident On 2/27/19 at 10:10 am an interview was	F 656	ensure that the deficient practice will not recur: The Minimum Data Set Coordinator or Director of Nursing will audit all residents who have been identified as being at risk for suicide to ensure that appropriate safety interventions have been fired to the CNA□s as tasks, are on Kardex and that tasks are being documented on as required. The Quality Assurance tool entitled Communication and Implementation of Safety Interventions QA Tool will be completed weekly for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager,Social Worker, Activities Director and the Dietary Manager. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Reports will be presented to the weekly Quality Assurance committee by the Administrator or the Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting.	

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F 656	Continued From page 26 conducted with the facility social worker who was familiar with Resident #37 and met one-on-one with the resident. The facility social worker stated that she was aware of the resident ' s history of self-reported suicide attempt and was care planned for suicide precaution. The resident had been sick for a long time before she had come to the facility and lost her independence. The resident was angry and hurting when she arrived. The resident's mood and behavior varied by day. The resident required much emotional support and reassurance. The resident had few visitors. The resident had continued grieving from her significant other loss. On 2/28/19 at 9:10 am an interview was conducted with Nurse #5 who was assigned to Resident #37 and was aware of the resident's history of depression, loss of significant other, and suicidal ideation. The nurse stated that the resident's depression was improved and believed that the resident was no longer suicidal. Nurse #5 was not aware of the suicidal interventions on the care plan but did assess the resident during medication pass for mood and depression, but suicidal ideation was not asked. On 2/28/19 at 9:40 am an interview was conducted with Nursing Assistant #8 (NA) who was assigned to Resident #37 and stated he was not aware of the resident's prior history of self-reported suicide attempt or ideation. NA #8 indicated the resident had plastic ware for her utensils in the past but not at this time. The NA was not aware until he read the resident ' s kardex (NA care plan) during interview that it required him to check for sharp objects or items that could be used for suicide attempt and to use plastic ware utensils for meals. The resident was	F 656	The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, Social Worker,Activities Director and the Dietary Manager. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Date of Compliance: 04/12/2019	

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F 656	Continued From page 27 currently receiving metal silver ware. NA #8 commented that he was not always able to read the kardex before providing care. NA #8 also commented that he knew the resident had depression which had improved, and the resident had good and bad days. On 2/28/19 at 11:00 am an interview was conducted with the Director of Nursing who stated she was aware of Resident ' s #37 ' s suicidal ideation history and behavior, current treatment plan, and care plan interventions and expected the staff to review and be familiar with and implement the resident ' s care plan which included statements about not wanting to live and checking the resident ' s room for harmful items.	F 656		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		3/1/19

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F 688	Continued From page 28 by: Based on observations, staff and resident interviews and record review, the facility failed to apply splints to residents with contractures as ordered. This was for 2 (Resident #26 and Resident #41) of 4 residents reviewed for range of motion. The findings included: 1. Resident #26 was admitted 3/26/18 with cumulative diagnosis of Cerebral Vascular Accident and hemiplegia. Review of her cumulative diagnoses included Psychosis was added as a new diagnosis on 5/15/18. Review of Resident #26's annual Minimum Data Set (MDS) dated 1/2/19 indicated severe cognitively impairment and she exhibited no mood or behaviors. She was coded for total assistance with her activities of daily living except for supervision with eat and coded for impairment to her upper and lower extremities on one side. Review of Resident #26 care plan dated initiated 1/24/19 read she was to wear a right-hand splint 2-3 hour daily and a left knee brace 2-4 hour daily. There was no care plan for refusal of her splint or brace. Review of Resident #26's undated electronic Kardex for the aides to follow indicated they were to apply her right-hand splint twice daily for 2-3 hours and her left knee brace for 2-4 hours daily Review of Resident #26's February 2019 Physician orders read she was to wear right hand splint for 2-3 hours twice per day originally ordered 10/12/18 and she was to wear a left knee brace 2-4 hour per day originally ordered 1/4/19.	F 688	F688 Increase/Prevent Decrease in ROM/Mobility Based on observations, staff and resident interviews and record review, the facility failed to apply splints to residents with contractures as ordered. This was for 2 (Resident #26 and Resident #41) of 4 residents reviewed for range of motion 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: For residents #26 and #41 corrective action was obtained on 2/27/19. The MDS Coordinator added the placement of ordered splints to the certified nursing assistant daily tasks for each of the identified residents. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to have been affected by the deficient practice On 2/27/19 the MDS Coordinator audited all current residents with ordered splints to ensure that all splints were indicated on the daily tasks for the certified nursing assistants. One other resident was affected and the MDS Coordinator corrected the daily task list to reflect splint application on 2/27/19.	

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F 688	Continued From page 29 During an observation on 2/26/19 at 10:00 AM, Resident #26 was lying in bed. Her left knee brace was observed lying in a straight back chair in her room and her right-hand splint was observed lying on top of her dresser. Resident #26 was noted with an obvious right-hand contracture and left knee contracture. During another observation on 2/26/19 at 11:45 AM, Resident #26 was lying in bed. Her left knee brace was observed lying in a straight back chair in her room and her right-hand splint was observed lying on top of her dresser. During another observation on 2/26/19 at 2:30 PM, Resident #26 was lying in bed. Her left knee brace was observed lying in a straight back chair in her room and her right-hand splint was observed on her left hand. During an interview on 2/26/19 at 2:40 PM, Nursing Assistant (NA) #2 confirmed she was assigned Resident #26. She stated she applied Resident #26's left knee brace earlier today before lunch and that she recently applied her hand splint. When NA #2 was questioned regarding which hand was the splint to be applied to, she stated she thought it was her left hand. She stated she was not aware that she was to wear the splint on her right hand. NA #2 stated she reviewed the electronic Kardex for all her residents to ensure she knows how to care for them. During an interview on 2/26/19 at 2:45 PM, the Rehabilitation Director stated the splint in Resident #26's rooms was intended to be worn of the right hand and she did not exhibit any evidence of contractures to her left hand. He	F 688	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 2/27/19, the Director of Nurses began education of all full time, part time, as needed Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants on splint application, use of the kardex and documentation of compliance utilizing the daily task list. The in-service will be completed by 3/20/19 at which time all Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants must be in-serviced prior to working. The Director of Nurses will monitor compliance utilizing the Splint Application Quality Assurance Tool weekly for two (2) weeks then monthly for three (3) months. The Director of Nursing will monitor all residents with splint orders to ensure compliance with splint application and documentation of the task. The Director of Nurses or Support Nurse will observe 3 residents weekly on random shifts and random days of the week(to include weekends) to assure compliance. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate.	

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F 688	Continued From page 30 stated the left knee brace was to be worn 2-4 hours daily. During an interview on 2/27/19 at 8:20 AM, NA #1 stated she was aware that Resident #26 had a right-hand splint and left knee brace, but she never applied it. She stated she thought therapy of responsible for applying her splint and brace daily. NA #1 stated she looked at the electronic Kardex to know what she was responsible for when caring for her residents. She confirmed no refusals of care except the occasional refusal of a shower. During an interview on 2/27/19 at 11:50 AM, the Director of Nursing (DON) and the MDS Nurse stated that the splint and brace appeared of the electronic Kardex as a FYI, but it was not added as a task to remind the aides to apply her splint and brace daily. The DON verified splints were to be applied the Resident #26 during waking hours and she stated it was her expectation that staff apply Resident #26's right hand splint and left knee brace daily as ordered. During an observation on 2/27/19 at 11:55 AM, Resident #26's right hand splint was lying on top of her dresser and her left knee brace was in the straight back chair. Her room-mate stated staff had not applied her splint or brace so far today. During an interview on 2/27/19 at 2:27 PM, NA #3 stated she was not aware that Resident #26 was to wear a right-hand splint or a left knee brace. She stated she did not apply any splint or brace to Resident #26 on 2/27/19. During an observation on 2/28/19 at 9:25AM, Resident #26 was lying in bed. Her right-hand splint was lying on top of her dresser and her left	F 688	Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 4/12/19	

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knee brace was sitting in a straight back chair.

During an interview on 2/28/19 at 9:30 AM, Nurse #2 stated she thought the aide put on her splint and knee brace daily for a few hours after lunch.

During an interview on 2/28/19 at 10:40 AM, the Administrator and DON stated it was their expectation that the aide apply Resident #26' right hand splint 2-3 hours daily while awake and left knee brace 2-4 hours daily while awake as ordered.

2. Resident #41 was admitted 4/17/18 with cumulative diagnoses of Cerebral Vascular Accident and left side hemiplegia.

Review of Resident #41's care plan initiated 7/11/17 and dated last revised 1/3/19 read she was to wear her left-hand splint 4-6 hours daily.

There was no care plan for refusal of her splints.

Review of Resident #41's undated electronic Kardex for the aides to follow indicated they were to apply her splint according to the schedule.

Review of Resident #41's quarterly Minimum Data Set (MDS) dated 1/22/19 indicated she was cognitively intact and exhibited verbal aggression and rejection of care. The was coded for limited to total assistance with her activities of daily living and she was coded with impairment upper and lower extremities on one side.

Review of Resident #41's February 2019 Physician orders read she was to wear her left-hand splint for 4-6 hours daily.

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During and observation and interview on 2/26/19 at 10:04 AM, Resident #41 was lying in bed and her left-hand splint was lying in her wheelchair. She stated nobody had been applying her splint in "a long time." Resident #41 was observed with an obvious left-hand contracture.

During another observation on 2/26/19 at 11:45 AM, Resident #41 was sitting up in her wheelchair in her room. She was not wearing her left-hand splint and it was observed lying on her dresser.

During another observation on 2/26/19 at 2:30 PM, Resident #41 was lying in bed. She left hand splint was lying on her dresser. She stated staff had not offered to apply her splint today.

During an interview on 2/26/19 at 4:15 PM, Nursing Assistant (NA) #4 stated she had been out of work for a few months but she was aware that Resident #41 was to wear her left-hand splint daily and it was put on her during first shift. NA #4 stated when she worked on first shift in the past, Resident #41 would refuse her splint at times. NA #4 stated she reviewed the electronic Kardex to know how to care for her residents.

During an interview on 2/27/19 at 8:20 AM, NA #1 stated Resident #41 would tell her if she wanted to wear her splint, but she did not routinely ask Resident #41 if she wanted to wear her splint daily.

During an interview on 2/27/19 at 11:50 AM, the Director of Nursing (DON) and the MDS Nurse stated that the splint and brace appeared of the electronic Kardex as a FYI, but it was not added as a task to remind the aides to apply her splint daily. The DON verified splint was to be applied

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F 688	Continued From page 33 the Resident #41's during waking hours and she stated it was her expectation that staff apply Resident #41's left hand splint daily as ordered unless she refused. During another interview and observation on 2/27/19 at 12:00 PM, Resident #41 was in the main dining room waiting for lunch. She stated the aide did not mention wearing her left-hand splint and she did not ask for the aide to put in on. During an interview on 2/27/19 at 2:27 PM, NA #3 stated Resident #41 would complain of left hand pain while wearing the splint, but she offered to apply the splint daily. NA #3 stated Resident #41 would sometimes refuse to ear her left-hand splint. During another observation and interview on 2/28/19 at 9:25 AM, Resident #41's left hand splint was lying on top of her dresser. She stated staff did apply her splint for "a little while" last night. During an interview on 2/28/19 at 9:25 AM, nurse #2 stated Resident #41 was known to refuse her splint but she would normally wear it when she was gotten up from her bed and into her wheelchair. During an interview on 2/28/19 at 10:40 AM, the Administrator and DON stated it was their expectation that the aide apply Resident #41' left hand splint 4-6 hours daily while awake as ordered and if she refused to wear her splint, the floor staff should report Resident #41's refusals.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		4/12/19

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F 689	Continued From page 34 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to ensure residents deemed safe smokers secured their cigarettes and lighters in a locked location in their rooms. This was for 2 (Resident #44 and Resident #9) of 2 safe smokers reviewed. The findings included: Review of the facility policy titled "Smoking Policy" dated last revised 6/16 read in part as follows: Alert and oriented residents can keep cigarettes and lighters in a locked box in their room. The box must be locked always and must not be accessible to confused residents. If items were found not locked up, then the items must be stored at the nursing station. 1. Resident #44 was admitted to the facility on 8/30/18 with cumulative diagnoses of Chronic Obstructive Pulmonary Disease (COPD), chronic pain and nicotine dependence. Review of Resident #44's most recent Smoking Assessment dated 12/31/18 read smoking supplies must be locked in her room. Review of Resident #44's quarterly Minimum Data Set (MDS) dated 1/10/19 indicated she was	F 689	F689 Free of Accident Hazards/Supervision/Devices Based on observations, staff and resident interviews and record review, the facility failed to ensure residents deemed safe smokers secured their cigarettes and lighters in a locked location in their rooms. This was for 2 (Resident #44 and Resident #9) of 2 safe smokers reviewed. 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: For residents#44, and #9 an in-service was held by the Social Services Director to review the policy on smoking and the residents understanding of the policy. Lock boxes for the residents identified as independent smoking were checked for security and keys provided for each resident on 03/04/2019. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 689	Continued From page 35 cognitively intact and exhibited no behaviors and coded for supervision with her activities of daily living. Review of Resident #44's smoking care plan initiated 10/1/18 and last revised 2/22/19 read for staff to provide her smoking items on request. The care plan did not state Resident #44 may keep her smoking items locked in her room. During an observation on 2/25/19 at 10:00 AM, Resident #44 was in the smoking area alone. There was not observed safety concerns. Once she finished smoking she placed a brown case in the back of her wheelchair and returned into the facility. During an interview on 2/25/19 at 10:32 AM Resident #44 stated she went outside to smoke at her leisure. When asked where she kept her cigarettes and lighter, she reached around and pulled a brown case from the back of her wheelchair. Observed in her room was a drawer with a lock on it. Resident #44 confirmed she had a key to the locked drawer to secure items as needed. Resident #44 stated she did not secure her cigarettes and lighter in the locked drawer but rather kept her cigarette case containing her cigarettes and lighter, in the back of her wheelchair or in her jacket pocket. During an interview on 2/26/19 at 2:40 PM, Nursing Assistant (NA) #2 stated Resident #44 was an independent smoker so she kept her cigarettes and lighter with her. She stated she did not know where Resident #44 stored her smoking items. NA #2 stated smokers deemed unsafe kept their smoking items locked at the nursing	F 689	All residents have the potential to have been affected by the deficient practice The list of residents identified as smokers has been reviewed and there were no other residents identified as independent smokers. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: In-service training will be provided to all facility staff, to include Part Time and PRN on the smoking policy specific to independent smokers by 03/24/2019. Staff not trained by 3/30/2019 will not be allowed to work until inservice is comleted. On admission, the Social Services Director or the Activities Director will review the smoking policy specific to independent smokers and have them sign the smoking policy sheet. On admission, the Maintenance Director or the Director of Nursing will ensure that the independent smoker is provided with a lock box, and key is and is documented on the smoking policy that these items were provided for the independent smokers. The Social Services Director or the Activities Director will monitor the security measures for those residents identified as	

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F 689	Continued From page 36 station. During an observation on 2/26/19 at 2:50 PM, Resident #26 was observed sitting up in her wheelchair in the doorway of her room. During an interview on 2/27/19 at 9:40 AM, NA #1 stated Resident #44 kept her cigarettes and lighter in a cigarette case in her room, but she was unsure where Resident #44 kept the cigarette case. She stated at present, there were no residents on the 200 hall that were wanderers but confirmed there had been residents on the hall that wandered into other residents' rooms recently. During an observation on 2/27/19 at 5:00 PM, Resident #26 was observed sitting up in her wheelchair in her room waiting on dinner. During another interview and observation on 2/28/19 at 8:38 AM, Resident #44 was lying in bed. She stated she had been out to smoke but not as often. She stated she had not gone out to smoke very often due to the rain and had not felting like smoking. Resident #44 stated her cigarette case containing her cigarettes and lighter were still in the back of her wheelchair positioned on the left side of her bed. During an interview on 2/28/19 at 9:25 AM, Nurse #2 stated Resident #44 kept her cigarettes and lighter on her person or jacket pocket and	F 689	independent smokers daily times two (2) weeks then weekly times two (2) months and reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting with reports being presented by the Social Worker or the Activities Director. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager,Social Worker, Activities Director and the Dietary Manager. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Date of Compliance:04/12/2019	

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F 689	Continued From page 37	F 689		

confirmed there had been wandering residents on the 200 hall but there were none at present. She stated if a resident was deemed a safe smoker, they could keep their cigarette and lighters in their rooms.

During an interview on 2/28/19 at 10:40 AM, the Administrator and Director of Nursing stated it was their expectation that Resident #44 always store her cigarettes and lighter in the locked drawer provided when not in use for the safety of other residents.

2. Resident #9 was admitted to the facility on 9/1/15 with cumulative diagnoses of Hypertension and nicotine dependence.

Resident #9's quarterly Minimum Data Set (MDS) dated 12/4/18 indicated moderate cognitive impairment and exhibited verbal behaviors. He was coded for limited assistance with eating and no impairments to his bilateral upper extremities.

Review of Resident #9's most recent Smoking Assessment dated 12/31/18 read smoking supplies must be locked in his room.

Review of Resident #9's smoking care plan initiated 9/2/15 and last revised 2/22/19 read for staff to provide his smoking items on request. The care plan stated Resident #9 may keep his smoking items locked in his room when not in use.

During an interview on 2/27/19 at 8:20 AM, Nursing Assistant (NA) #1 stated Resident #9 kept his cigarettes and lighter in a bag that he kept around his neck. She stated he was deemed

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F 689	Continued From page 38	F 689		

a safe smoker therefore, he went out and smoked independently.

During an interview and observation on 2/27/19 at 10:50 AM, Resident #9 was sitting in a wheelchair in his room. Observed was a (fanny pack) bag around his neck. He confirmed he kept his cigarettes and lighter in the bag and went outside to smoke independently. Observed in his room was a drawer with a lock on it. Resident #9 stated he did not have anywhere to lock up his cigarettes and lighter because he did not have a key for the drawer with a lock on it.

During an interview on 2/27/19 at 2:27 PM, NA #3 stated all smoking items were to be secured at the nursing station and that no resident could keep cigarettes or lighters in their rooms.

During an interview on 2/27/19 at 3:50 PM, Nurse #3 stated Resident #9 was deemed a safe smoker, so he could keep his cigarettes and lighter in his room, but he was instructed to secure his smoking items when not in use. She stated Resident #9 secured his smoking items in a bag he kept around his neck while awake. Nurse #3 stated she was uncertain where he kept his smoking items when not in use.

During another observation on 2/28/19 at 9:30 AM, Resident #9 was lying in bed with the bag containing his cigarettes and lighter lying on his bedside table. He stated he did not feel like getting up and had not gone outside to smoke.

Multiple observations made on 2/27/19 and 2/28/19 did not reveal Resident #9 outside smoking but rather up in room sitting in his wheelchair or lying in bed. times

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F 689	Continued From page 39 During an interview on 2/28/19 at 9:30 AM, NA #5 stated there were at least two residents on the 300 hall that were known to wander into other resident rooms. She stated all cigarettes and lighter were locked at the nursing station. During an interview on 2/28/19 at 10:40 AM, the Administrator and Director of Nursing stated it was their expectation that Resident #9 always store his cigarettes and lighter in the locked drawer provided when not in use for the safety of other residents.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, Physician, staff and resident interviews and record review, the facility failed to assess, evaluate and determine the cause of increased pain for 1 (Resident #44) of 1 resident reviewed for pain. The findings included: Resident #44 was admitted 8/30/18 with cumulative diagnoses of Chronic Obstructive Pulmonary Disease (COPD), anxiety, chronic pain, Neuropathy (nerve pain), Osteoarthritis, Lupus (an autoimmune disease resulting in inflammation, swelling and pain to tissues) and nicotine dependence.	F 697	F697 Pain Management Based on observations, Physician, staff and resident interviews and record review, the facility failed to assess, evaluate and determine the cause of increased pain for 1 (Resident #44) of 1 resident reviewed for pain. 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:	4/12/19

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F 697	Continued From page 40 Review of Resident #44 hospital admission history and physical indicated prior to her hospitalization, she was prescribed Neurontin (anticonvulsant used to treat nurse pain) three times daily. Review of Resident #44's hospital discharge summary dated 8/30/18 read she was prescribed Oxycodone (narcotic) Immediate Release (IR) 10 milligrams (mg) every 6 hours as needed (prn) for pain. She was also prescribed Neurontin for nerve pain three dimes daily. Review of Resident #44 admission Physician orders dated 8/30/18 read she was prescribed Oxycodone IR 10 mg every 6 hours prn for pain and Neurontin three times daily for nerve pain as indicated on her hospital discharge summary. Review of Resident #44 Physician Admission Progress note dated 8/31/18 read has diagnosis of Osteoarthritis but stated she had not have any problems with joint pains for a while now. She denied back, and neck pain though reported chronic back pain in the past. The physical examination read there was no evidence of joint deformities, redness, warmth, swelling or tenderness and mild generalized shaking. Review of a nursing note dated 9/16/18 at 9:19 AM read there was confusion noted and Resident #44 complained of all over body aches. The nurse reminded Resident #44 that she received her prn pain medication at 7:36 AM. Review of Resident #44's nursing notes from 9/16/18 to 9/29/18 did not include any notes regarding back or joint pain.	F 697	On 2/27/19 the physician ordered x-rays of bilateral knees, feet and lumbosacral spine. On 3/1/19 x-ray results were received with results of a subacute chronic fracture of the right medial tibeal plateau seen. An appointment was scheduled for follow up with an orthopedist and the resident was placed on nonweight bearing status to the right leg until seen by the orthopedist. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to have been affected by the deficient practice. On 3/18 and 19/19, staff nurses assessed all residents for pain and a pain level assessment was implemented on all shifts for all residents. No incidence of unrelieved pain was found. Residents with unrelieved pain will have a Pain User Defined Assessment completed. Incidences of unrelieved pain will be reported by nursing to the medical director for evaluation and follow up. The Director of Nurses or Support Nurse will audit the User Defined Assessments (UDA) for completion of Pain Monday through Friday for appropriate follow up to the physician. On 3/19 and 20/19 the MDS Coordinator audited all resident care plans for the presence of a pain care plan and appropriate pain interventions with all care plans for pain present.	

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F 697	Continued From page 41 Review of Resident #44 September 2018 Medication Administration Record (MAR) indicated she received her prn Oxycodone 36 times for pain rated from 2 to 8 out of 10. The MAR indicated the Oxycodone was effective for pain relief. Review of a Physician progress note dated 10/2/18 read Resident #44 complained of back pain after therapy session and a few days ago, she slid out of her wheelchair. She stated the prn Oxycodone helped but did not completely relieve her pain. She denied joint pain at this time. The physical examination indicated no tenderness or deformity over back or spine and only minimal generalized shaking. There was no evidence of any other assessment or evaluation of her unrelieved pain in back. Orders were written to discontinue her prn Tylenol and begin Tylenol 650 mg scheduled three times daily. Review of Resident #44's nursing notes indicated beginning on 10/20/18 to 11/3/18 she began complaining of leg pain and was receiving the prn Oxycodone every 6 hours. There was no documented evidence of an assessment or evaluation related to her complaint of leg pain. Review of Resident #44 October 2018 Medication Administration Record (MAR) indicated she received her prn Oxycodone 62 times for pain rated from 2 to 8 out of 10. The MAR indicated the Oxycodone was effective for pain relief. Review of Resident #44 November 2018 Medication Administration Record (MAR) indicated she received her prn Oxycodone 84 times for pain rated from 2 to 8 out of 10. The MAR indicated the Oxycodone was effective for	F 697	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/18/19, the Director of Nurses began education of all full time, part time, as needed nurses and certified nursing assistants on pain management to include pain assessment, effectiveness of pain medication, reporting of pain and notification of the physician of unrelieved pain for evaluation to determine the cause of the unrelieved pain. The in-service will be completed by 3/31/19 at which time all nurses must be in-serviced prior to working. The Director of Nurses or Support Nurse will monitor compliance utilizing the Pain Assessment Quality Assurance Tool weekly times two(2) weeks then monthly times three(3) months. The Director of Nursing or Support Nurse will audit four (4) residents experiencing pain to assure compliance. The Director of Nurses or Support Nurse will monitor compliance utilizing the Pain Assessment Quality Assurance Tool weekly times two (2) weeks then monthly times three (3) months. The Director of Nursing or Support Nurse will audit four (4) residents experiencing pain to assure compliance. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Compliance will be monitored and the	

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F 697	Continued From page 42 pain relief except for once on 11/3/18. Review of a Physician progress note dated 12/3/18 read Resident #44 still reported pain in her knees and legs causing difficulty in moving. New orders were written to increase her Oxycodone to 15 mg every 6 hours prn pain. The physical examination read she was able to move all extremities and no pain or discomfit was observed. There was no evidence of any other assessment or evaluation of her unrelieved pain in her knees and legs. Review of Resident #44's nursing notes beginning 12/3/18 through12/16/18 did not include any documentation about leg or knee pain. Review of a Request for Evaluation form to the Physician dated 12/16/18 read Resident #44 complains of pain within 30-45 minutes before her next dose of prn pain medication was ordered. This occurred on all shifts. There was no evidence of a nursing assessment or evaluation to determine reported of unrelieved pain. Review of a Physician progress note dated 12/21/18 read Resident #44 was having more issues with pain management than she did initially on admission. The note reads her Oxycodone dose was increased earlier in December, but nursing staff report she routinely request her prn Oxycodone like "clockwork." Resident #44 described her pain as throbbing, aching, stiffness and soreness in both knees and ankles and worse on the right side. Resident #44 also described a mild sharp stinging needle like pain in the bottom of her feet, but this was better	F 697	ongoing auditing program reviewed at the weekly Quality Assurance Meeting with the Director of Nursing or the Support Nurse presenting the audit results. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, Social Worker, Activities Director and the Dietary Manager. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Date of Compliance: 4/12/19	

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with Neurontin. The physical examination read there was no evidence of joint deformities, redness, warmth, swelling or tenderness but noted only minimal generalized shaking. There was no evidence of any other assessment or evaluation of her unrelieved pain in her knees and legs. New orders were to discontinue the scheduled Tylenol and begin Oxycodone 15 mg four times daily with Oxycodone 15mg prn once for a maximum of 5 pills daily.

Review of a Physician progress note dated 12/28/18 read Resident #44 was experiencing chronic pain due to osteoarthritis and Lupus. She described the pain as throbbing, aching, stiffness and soreness in knees, legs and ankles that worsened with standing or moving about. The physical examination read there was no evidence of joint deformities, redness, warmth, swelling or tenderness but noted only minimal generalized shaking. There was no evidence of any other assessment or evaluation of her unrelieved pain in her knees and legs. New orders were given for Oxycodone 15mg 5 times daily with 1 additional prn dose for a maximum of 6 pills daily.

Review of Resident #44 December 2018 Medication Administration Record (MAR) indicated she received her prn Oxycodone 76 times and her scheduled Oxycodone 4 times daily as ordered beginning on 12/21/18. She rated her pain from 2 to 8 out of 10. The MAR indicated the Oxycodone was effective for pain relief.

Review of Resident #44's quarterly Minimum Data Set (MDS) dated 1/10/19 indicated she was cognitively intact and exhibited no behaviors and coded for supervision with her activities of daily living and coded for 7 of 7 days as receiving

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Opioids. Resident #44 was coded as receiving prn and scheduled pain medication and no non-medication interventions for pain. She was coded with pain frequently, but the pain had not interfered with sleep of daily activities. She rated her pain at a 4 out of 10.

Review of Resident #44 January 2019 Medication Administration Record (MAR) indicated she received her prn Oxycodone 24 times and her scheduled Oxycodone 5 times daily. She rated her pain from 3 to 7 out of 10. The MAR indicated the Oxycodone was effective for pain relief.

Review of a nursing note dated 2/14/19 at 3:16 AM read Resident #44 propelled to the nursing station and was slurring her words and unable to form a full sentence. She received her one-time prn pain pill 2 hours ago and was requesting another dose. When the nurse explained she could not have another pain pill and offered her Tylenol, Resident #44 became agitated and stated, "I don't want that mess."

Review of Resident #44's pain care plan initiated 9/1/18 and last revised on 2/22/19 read she experienced chronic pain. The goal was to have pain not interrupt her normal activities. Interventions included the administration of pain medications as ordered and to monitor, record and report complaints of pain or request for pain treatment.

Review of a nursing note dated 2/23/19 at 4:20 AM read Resident #44 arrived at the nursing station requesting a pain pill. The nurse stated it was too early. Resident #44 became agitated stated "everyone else gives it to me early, why can't I have it now? You better find somewhere

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else to work after I report you because I want a different nurse."

Review of Resident #44 February 2019 Medication Administration Record (MAR) through 2/26/19 indicated she received her prn Oxycodone 19 times and her scheduled Oxycodone 5 times daily. She rated her pain from 1 to 7 out of 10. The MAR indicated the Oxycodone was effective for pain relief.

Review of the electronic and hard copy of the medical record did not include any radiological, imaging testing or lab work to determine the complaints of Resident #44's increased pain.

During an interview and observation on 2/25/19 at 10:32 AM Resident #44 stated she was not experiencing any knee, back or leg pain. There was no observed generalized shaking. She exhibited no grimacing or guarding of her extremities.

During an interview on 2/26/19 at 2:40 PM, Nursing Assistant (NA) #2 stated Resident #44 did not complain of pain when she assisted her. She stated Resident #44 was not as active as she once was and spent a lot of time outside smoking or lying in bed.

During an interview on 2/27 at 8:30 AM, Nurse #1 stated Resident #44 did not verbalize any pain and displayed no outward expressions of pain such as grimacing, but she would rather come to the medication cart an hour before her narcotic was due to remind her to bring it to her room in an hour.

During an interview on 2/27/19 at 9:40 AM, NA #1

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stated Resident #44 did not voice any pain but was not as active and doing as much for herself as she was when she was first admitted.

During an interview on 2/27/19 at 3:45 PM, the Physician stated he was aware of Resident #44's repeated request for pain medication and the pain was from her Lupus and osteoarthritis. He stated since pain was subjective along with her imaging report, he increased her pain medication.

During a second interview on 2/27/19 at 4:10 PM, the Physician confirmed there was no evidence of evaluation such as x-rays or imaging to determine the reason for her pain and he just ordered x-rays of both knees and lumbar back to determine the cause of her pain and increased need of pain medication. The Physician stated he was aware of Resident #44 repeat request for the prn pain medication and the nursing staff requested it be scheduled since she was receiving it so often.

During another interview and observation on 2/28/19 at 8:38 AM, Resident #44 was lying in bed. She stated she had been out to smoke but not as often. She stated she had not gone out to smoke very often due to the rain and had not felting like smoking. She denied leg, knee, ankle and back pain. There was no observed generalized shaking. She exhibited no grimacing or guarding of her extremities.

During an interview on 2/28/19 at 9:25 AM, Nurse #2 stated Resident #44 would ask her for her Oxycodone an hour before it was due stating pain in her knees and low back. Nurse #2 stated the Physician was aware of Resident #44's complaints of pain but had not ordered any

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F 697	Continued From page 47 testing to determine the cause of her pain. She stated Resident #44 was now walking less than she did on admission. During an interview on 2/28/19 at 10:40 AM, the Administrator and Director of nursing stated it was their expectation that the facility assess and evaluate any reports the increased pain or unrelieved pain to determine the underlying cause of pain to effectively treat Resident #44.	F 697		
F 742 SS=G	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident, Psychiatric Nurse Practitioner (PNP), psychotherapist, and staff, the facility failed to promptly obtain psychotherapy services as ordered by the PNP for a resident (Resident #4) with a diagnosis of Post-Traumatic Stress Disorder (PTSD) who expressed passive suicidal ideations for 1 of 2 residents reviewed for behavioral and emotional status. The findings included:	F 742	F742 Treatment/Srvs Mental/Psychosocial Concerns Based on observation, record review, and interviews with resident, Psychiatric Nurse Practitioner (PNP), psychotherapist, and staff, the facility failed to promptly obtain psychotherapy services as ordered by the PNP for a resident (Resident #4) with a diagnosis of Post-Traumatic Stress Disorder (PTSD) who expressed passive suicidal ideations for 1 of 2 residents	4/12/19

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F 742	Continued From page 48 Resident #4 was admitted to the facility on 6/26/18 with diagnoses that included Post-Traumatic Stress Disorder (PTSD), major depressive disorder, and anxiety disorder. A review of nursing notes dated 7/13/18 indicated Resident #4 had frequent episodes of crying and "made statement he didn ' t want to live any more". The physician was notified, and an order was obtained for a psychiatric consultation and for Wellbutrin (antidepressant medication). Resident #4 was placed on suicide precautions with hourly checks conducted by nursing staff. Resident #4 ' s family member was also notified. A physician ' s order dated 7/13/18 indicated Wellbutrin 150 milligrams (mg) once daily for depression. A significant change Minimum Data Set (MDS) assessment dated 7/13/18 indicated Resident #4 ' s cognition was intact. He self-reported feeling down/depressed hopeless on 7 to 11 days, trouble falling asleep/staying asleep/or sleeping or much on 7 to 11 days and feeling tired/having little energy on 12 to 14 days. Resident #4 had other behavioral symptoms on 1 to 3 days and he received antidepressant medication and antianxiety medication on 7 of 7 days. The behavioral symptoms Care Area Assessment (CAA) for Resident #4 ' s 7/13/18 significant change MDS assessment indicated he was alert and able to verbalize his needs. He was previously living at home when he fell and sustained a right tibia and fibula fracture and was hospitalized. Following hospitalization, Resident #4 was discharged to a different nursing facility prior to his transfer to this nursing facility.	F 742	reviewed for behavioral and emotional status. 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #4 was seen by the psychotherapist from 08/27/2018 thru 11/12/2018 however, wished to stop with visits on 11/12/2018. On 03/18/2019 resident again denied request to been seen by psychotherapist. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to have been affected by the deficient practice As of 03/15/2019, the most resent list of residents seen by the Psychiatric Nurse Practitioner was reviewed with the Director of Nursing and the Psychiatric Nurse Practitioner for potental missed orders for psychotherapy. None were identified. On 03/16/2019, all residents Order Summaries were reviewed for missed psychiatric orders. No other resident was identified as needing a psychiatirc evaluation. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 742	Continued From page 49 Resident #4 preferred to stay in his room and showed little interest in activities. He had a significant decline in mood, episodes of crying, and had verbalized the desire to no longer be living. Resident #4 ' s physician and family were aware, a psychiatric consultation was pending, and his treatment was revised. The care plan focus area of Resident #4 ' s risk for suicide and or injuries related to suicidal attempt related to depression with suicidal ideations was initiated on 7/13/18. The following interventions were initiated on 7/13/18: - One-hour checks for 72 hours. - Always take any of the following statements seriously and report to nurse, such as: "I ' d be better off dead, I ' m going to end this, [my] family/friends/everyone would be better off without me". - Report to nurse immediately if Resident #4 verbalized any type of suicidal thoughts. - Encourage Resident #4 to discuss any feelings of loss, frustration, decreased self-worth. - Encourage Resident #4 to get out of room throughout the day to socialize with other residents. - Inspect Resident #4 ' s room every shift and remove any objects that could possibly be used to harm himself. - Provide one on one care as needed. - Remind Resident #4 of his areas of strength and self-worth daily. - Invite Resident #4 and assist him to activities of interest each day. The care plan focus area of Resident #4 ' s episodes of displaying the following behaviors: crying, making verbalizations of depression, and restlessness was initiated on 7/13/18. The	F 742	Effective 03/15/2019 the Director of Nursing and the Social Worker will meet with the Psychiatric Nurse Practitioner following each visit and review those residents with follow-up orders for psychotherapy. Within three days of review the Director of Nursing or the Social Worker will follow-up via telephone or e-mail to ensure the psychotherapist is aware of consult. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Date of Compliance: 04/12/2019	

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following interventions were initiated on 7/13/18:
- Administer medications as ordered, monitor/document side effects and effectiveness.
- Anticipate and meet needs when possible.
- Approach in a calm manner.
- Assess for underlying causes of frustration/behaviors such as: hunger, thirst, discomfort, toileting needs, pain, and intervene when possible.
- Assist Resident #4 to develop more appropriate methods of coping and interacting with others and encourage the expression of feelings.
- Document inappropriate behaviors and the response to interventions.
- Give Resident #4 positive feedback when displaying appropriate behaviors.
- Intervene as necessary to protect the rights and safety of others.
- When possible, discuss Resident #4 ' s behavior with him, and explain why behavior was inappropriate and/or unacceptable.

A Social Worker (SW) late entry note for 7/13/18 (entered on 7/16/18) indicated she was informed that Resident #4 had expressed he no longer wished to live. The SW reported she spoke with Resident #4 on 7/13/18. He was in his room, laying in bed, and appeared calm and relaxed. He stated, "I am tired of facing everyday ...everyday is the same thing ...I just get in these moods ...I would not hurt myself or do something stupid like that .... I have no desire to live". Resident #4 declined a psychiatric consultation reporting that he didn ' t want to talk to anyone. The SW indicated she provided emotional support and reassurance. The Nurse Practitioner (NP) was made aware of SW ' s discussion with Resident #4.

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A nursing note dated 7/24/18 indicated Resident #4 stated he wanted to go home, there was nothing here for him, and nothing to live for here. Resident #4 agreed to a psychiatric consultation scheduled for 7/25/18.

A consent for psychiatric services was signed by Resident #4 on 7/24/18.

A physician ' s order dated 7/25/18 indicated a psychiatric consultation was to be conducted for Resident #4 related to depression.

An NP note dated 7/25/18 indicated Resident #4 had been isolating himself, only remained awake for meals, had no interest in doing anything, and was feeling down and unmotivated all of the time. Resident #4 stated he was depressed because he wanted to go back home. He also expressed feeling down because of a lack of family support. Resident #4 denied hurting himself and/or others but admitted that he didn ' t feel like living anymore. The NP indicated she spoke with the Psychiatric Nurse Practitioner (PNP) on this date (7/25/19) about Resident #4.

A PNP note dated 7/25/18 indicated she saw Resident #4 for an initial psychiatric visit. Resident #4 ' s cognition was intact and he self-reported depression and a passive death wish (PDW). He denied suicidal ideations. Staff reported Resident #4 was irritable and exhibited excessive eating and sleeping. She noted that Resident #4 ' s physician recently ordered Wellbutrin and she had no plans to add any other medications at this time. The PNP indicated a referral was to be made for a psychotherapy evaluation and treatment.

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A PNP note dated 8/22/18 indicated Resident #4 continued with depressed mood, but no statements of PDW or suicidal ideations, and no outward symptoms of anxiety. The PNP again indicated a referral was to be made for a psychotherapy evaluation and treatment.

A psychotherapy note indicated Resident #4 was seen for a mental health assessment/diagnostic interview. The psychotherapist indicated she spoke to facility staff about Resident #4 and was informed he primarily stayed in his room, had not associated or talked with anyone, and appeared to be very depressed. Staff reported concerns over Resident #4 experiencing suicidal ideations. The psychotherapist met with Resident #4 and completed an initial assessment. This assessment identified the diagnoses of PTSD related to a history of childhood physical and emotional abuse as well as depression and anxiety. A safety evaluation revealed Resident #4 currently had wishes to die but had no suicidal intent/plan. He stated he wished he would just close his eyes and not wake up. During the session, Resident #4 was noted to be triggered by a question and began crying uncontrollably. The psychotherapist provided crisis therapy services to assist Resident #4 with his overwhelming emotions. Resident #4 was noted to respond well to the psychotherapists interventions and techniques.

An interview was conducted with the Director of Nursing (DON) on 2/27/19 at 8:15 AM. The initial psychiatric note for Resident #4 dated 7/25/18 and the initial psychotherapy note dated 8/27/18 were reviewed with the DON. She stated she was unsure what the process was for the

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obtainment of psychotherapy services after the PNP made a referral. She explained that the PNP and the psychotherapist worked for the same company. She further explained that once the PNP was involved she made a referral internally through her company to obtain psychotherapy for the resident.

A phone interview was conducted with the PNP on 2/27/19 at 12:40 PM. The initial psychiatric note for Resident #4 dated 7/25/18 and the initial psychotherapy note dated 8/27/18 were reviewed with the PNP. She was asked what the normal process was for a referral to psychotherapy. She stated she worked closely with the psychotherapist and that any resident she provided services to was also seen for psychotherapy unless the resident refused and/or of it the resident ' s cognition prevented productive psychotherapy. The PNP indicated that after her initial visit, the psychotherapist normally saw the resident on her next visit to the facility. She stated she thought the psychotherapist visited the facility once per week. She reported that these psychotherapy sessions allowed her to get more information and insight into the background of the resident which assisted her with decision making. The PNP indicated that Resident #4 had expressed suicidal ideations and a PDW. She revealed that Resident #4 had severe depression and that while she had not thought he had any active suicidal thoughts, that because his depression was so severe that it was vital to take any expressed suicidal ideations seriously. She indicated that her expectation was for psychotherapy to commence for Resident #4 within 2 weeks of her initial visit. She was unable to explain why Resident #4 ' s initial

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psychotherapy session was over a month after her initial visit.

A phone interview was conducted with the psychotherapist on 2/27/19 at 9:10 AM. She was asked what the process was for a referral to psychotherapy. She stated she worked closely with the PNP and that any resident the PNP provided services to was also seen by her for psychotherapy unless the resident refused and/or of it the resident ' s cognition prevented productive psychotherapy. She indicated that after the PNP ' s initial visit, she normally saw the resident for psychotherapy on her next visit to the facility. The psychotherapist stated she visited the facility once per week. The initial psychiatric note for Resident #4 dated 7/25/18 and the initial psychotherapy note dated 8/27/18 were reviewed with the psychotherapist. She was unable to explain why she had not seen Resident #4 for an initial psychotherapy session until over a month after the PNPs initial visit. The psychotherapist revealed that this was out of the normal timeframe as the next date she was at the facility after the PNP ' s 7/25/18 visit was 7/30/18. She stated she reviewed her records and she saw no refusals of psychotherapy for Resident #4 prior to 8/27/18. She reported that Resident #4 was receptive to her on 8/27/18 at their initial visit. She stated he self-reported a history of child abuse, expressed PDW, and was very emotional with periods of crying. The psychotherapist indicated she provided 9 psychotherapy sessions to Resident #4 from 8/27/18 through 11/12/18. She reported Resident #4 had been participating in sessions and had a noted improvement with his mood for several weeks, but then became very depressed again and on 11/12/18 he asked her to leave and requested to be discharged from

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F 742	Continued From page 55 psychotherapy services. An interview was conducted with Resident #4 on 2/28/19 at 9:00 AM. Resident #4 was lying in bed in his room. He was alert and oriented. He confirmed he had received psychotherapy services at the facility for a couple of months. He stated he liked the sessions at first. Resident #4 explained that as the sessions progressed that he had to talk about "stuff I didn ' t want to talk about it ...I just ended up feeling worse afterwards". He stated he asked the psychotherapist not to come back. During an interview with the DON on 2/27/19 at 8:15 AM she indicated it was her expectation for psychotherapy services to be initiated within 1 to 2 weeks after a referral was made by the PNP. An interview was conducted with the Administrator on 2/28/19 at 10:39 AM. She indicated it was her expectation for psychotherapy services to be initiated within 1 to 2 weeks after a referral was made by the PNP.	F 742		
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 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,	F 756		3/20/19

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F 756	Continued From page 56 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, observation, staff, physician and pharmacist interview, the facility failed to provide adequate indication for continued hormone/chemotherapy (Resident #3) for 1 of 5 residents reviewed for unnecessary medication. Findings inlcuded: Resident #3 was admitted to the facility on 11/15/18 with diagnoses of vascular dementia without behaviors and history of breast cancer.	F 756	F756 Drug Regimen Review, Report Irregular, Act On Based on record review, observation, staff, physician and pharmacist interview, the facility failed to provide adequate indication for continued hormone/chemotherapy (Resident #3) for 1 of 5 residents reviewed for unnecessary medication.	

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F 756	Continued From page 57 A review of Resident #3 ' s admission Minimum Data Set dated 11/22/18 revealed the resident had adequate hearing and speech and was understood and usually understands. The resident had a severely impaired cognition. A review of Resident #3 ' s care plan dated 11/16/18 revealed goals and interventions for hormonal treatment for breast cancer. The resident had a physician order for Anastrozole 1 mg dated 11/16/18. A review of the resident ' s medication administration record since admission revealed the resident received the Anastrozole since admission to the facility. The resident had a physician order for Hospice services dated 12/27/18 for advancing dementia. A review of Resident #3 ' s Hospice record revealed the resident had a history of breast cancer diagnosed 1/1/12 which included successful lumpectomy with chemotherapy and radiation and had been in remission for several years. An interview was conducted on 2/27/19 at 3:55 pm with Resident #3 ' s attending physician who was familiar with the resident. The physician stated that he was not aware of how long the resident was taking Anastrozole and agreed that since her lumpectomy was in January, 2012 and the resident was receiving Hospice services for advancing dementia, the therapy was no longer necessary. A resident receiving Anastrozole usually received the medication for 5 years and	F 756	1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: For resident #3 the physician discontinued the order for hormone/chemotherapeutic medication as of 2/28/19. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to have been affected by the deficient practice On 3/26/19 the Pharmacy Consultant reviewed all residents medication orders for the presence of chemotherapeutic/hormone medications for unnecessary medications. No other residents were affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/26/19, the Pharmacy Consultant Director began education of the Pharmacy Consultant, Medical Director /Nurse Practitioner on indications for chemotherapeutic/hormone medications. The in-service will be completed by 3/31/19 at which time the above must be in-serviced prior to working. The Director of Nurses will monitor	

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F 756	Continued From page 58 should be followed by an oncologist and receive an annual bone density test (which had not been done while the resident was in the facility). The resident was admitted from another facility and had been receiving the medication. The attending physician stated that Anastrozole was started after intravenous chemotherapy and the start date was unknown but suspected to be sometime in 2012. When the resident had a bone density test was also unknown. An interview was conducted on 2/27/19 at 4:15 pm with the facility pharmacist who stated she was familiar with the medication Anastrozole which was administered for 5 years and followed by an oncologist because the resident would require an annual bone density and gynecology follow up. The resident ' s medication was reviewed each month (4 times) since admission. The facility pharmacist was not aware why the alternate pharmacist did not bring the Anastrozole to the physician ' s attention as an irregular medication with the first medication review. On 2/28/19 at 11:00 am an interview was conducted with the Administrator who stated she expected the physician to evaluate the resident for unnecessary medication and discontinue as appropriate.	F 756	compliance with monthly drug reviews for the presence of chemotherapy/hormone medications and indications for continued use by the Pharmacy Consultant with review by the Medical Director utilizing the Drug Regimen Review Quality Assurance Tool monthly times three (3) months. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Date of Compliance: 4/12/19	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		3/20/19

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F 757	Continued From page 59 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff, physician and pharmacist interview, the facility failed to provide adequate indication for continued hormone/chemotherapy (Resident #3) for 1 of 5 residents reviewed for unnecessary medication. Findings included: Resident #3 was admitted to the facility on 11/15/18 with diagnoses of vascular dementia without behaviors and history of breast cancer. A review of Resident #3 ' s admission Minimum Data Set dated 11/22/18 revealed the resident had adequate hearing and speech and was understood and usually understands. The resident had a severely impaired cognition. A review of Resident #3 ' s care plan dated	F 757	F757 Drug Regimen is Free from Unnecessary Drugs Based on record review, observation, staff, physician and pharmacist interview, the facility failed to provide adequate indication for continued hormone/chemotherapy (Resident #3) for 1 of 5 residents reviewed for unnecessary medication. 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: For resident#3 the physician discontinued the order for hormone/chemotherapeutic medication as	

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F 757	Continued From page 60 11/16/18 revealed goals and interventions for hormonal treatment for breast cancer. The resident had a physician order for Anastrozole 1 mg dated 11/16/18. A review of the resident ' s medication administration record since admission revealed the resident received the Anastrozole since admission to the facility. The resident had a physician order for Hospice services dated 12/27/18 for advancing dementia. A review of Resident #3 ' s Hospice record revealed the resident had a history of breast cancer diagnosed 1/1/12 which included successful lumpectomy with chemotherapy and radiation and had been in remission for several years. An interview was conducted on 2/27/19 at 3:55 pm with Resident #3 ' s attending physician who was familiar with the resident. The physician stated that he was not aware of how long the resident was taking Anastrozole and agreed that since her lumpectomy was in January, 2012 and the resident was receiving Hospice services for advancing dementia, the therapy was no longer necessary. A resident receiving Anastrozole usually received the medication for 5 years and should be followed by an oncologist and receive an annual bone density test (which had not been done while the resident was in the facility). The resident was admitted from another facility and had been receiving the medication. The attending physician stated that Anastrozole was started after intravenous chemotherapy and the start date was unknown but suspected to be	F 757	of 2/28/19. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to have been affected by the deficient practice On 3/19/19 the Director of Nurses reviewed all resident orders for hormone/chemotherapy orders with no current orders found. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/20/19, the Director of Nurses began education of the Medical Director /Nurse Practitioner/Pharmacy Consultant on the need for recommendations and documentation of indications for the continued need for chemotherapeutic/hormone medications and policy on the monthly pharmacy review. The in-service will be completed by 3/27/19 at which time the above must be in-serviced prior to working. The Pharmacy Consultant will review monthly all residents medication orders for the presence of chemotherapeutic/hormone medications and make appropriate recommendations to the physician. The physician will review monthly pharmacy recommendations for	

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F 757	Continued From page 61 sometime in 2012. When the resident had a bone density test was also unknown. An interview was conducted on 2/27/19 at 4:15 pm with the facility pharmacist who stated she was familiar with the medication Anastrozole which was administered for 5 years and followed by an oncologist because the resident would require an annual bone density and gynecology follow up. The resident ' s medication was reviewed each month (4 times) since admission. The facility pharmacist was not aware why the alternate pharmacist did not bring the Anastrozole to the physician ' s attention as an irregular medication with the first medication review. On 2/28/19 at 11:00 am an interview was conducted with the Administrator who stated she expected the physician to evaluate the resident for unnecessary medication and discontinue as appropriate.	F 757	chemotherapeutic/hormone medications and evaluate the need/indication for continued use of the medication. The Director of Nurses will monitor compliance for the presence of unnecessary chemotherapy/hormone medications utilizing the Unnecessary Chemotherapeutic/Hormone Medication Quality Assurance Tool weekly times two (2)then monthly times three (3) months. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Date of Compliance: 04/20/2019	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		4/12/19

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F 758	Continued From page 62 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §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	F 758		

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F 758	Continued From page 63 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observations, physician, staff and resident interviews and record review, the facility failed to implement nonpharmacological interventions prior to the initiating and increasing the dosage an antianxiety (Xanax) medication for 1 (Resident #44) of 5 residents reviewed for unnecessary psychotropic medications. The findings included: Resident #44 was admitted 8/30/18 with cumulative diagnoses of Chronic Obstructive Pulmonary Disease, anxiety, chronic pain, and nicotine dependence. Review of Resident #44's hospital admission history and physical indicated prior to her hospitalization, she was not taking Xanax for anxiety. Review of Resident #44's hospital discharge summary dated 8/30/18 indicated she was not prescribed Xanax upon her hospital discharge to the facility. Review of Resident #44's admission physician orders dated 8/30/18 indicated she was not prescribed Xanax on admission to the facility.	F 758	F758 Free from Unnec Psychotropic Meds/PRN Use Based on observations, physician, staff and resident interviews and record review, the facility failed to implement non-pharmacological interventions prior to the initiating and increasing the dosage of an antianxiety (Xanax) medication for 1 (Resident #44) of 5 residents reviewed for unnecessary psychotropic medications 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident#44 will have the following non-pharmacological interventions initiated as of 03/20/2019. Interventions include music therapy, reading the Bible and other interventions as requested by the resident. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 758	Continued From page 64 Review of Resident #44's physician admission progress note dated 8/31/18 read she had long-term issues with anxiety and insomnia. She was often shaky and nervous with trouble sleeping. Resident #44 reported she was taking Xanax chronically at home and was on it in the hospital as well, but it was ordered on her facility admission. New orders were written for Xanax 0.25 milligrams (mg) at bedtime and 0.25 mg as needed (prn) twice daily for anxiety. There was no documented evidence of any nonpharmacological approaches attempted prior to the initiation of the medication. Review of Resident #44's nursing notes from 8/31/18 to 9/4/18 included no documented evidence of anxiety. Review of an Acute Visit Physician progress noted dated 9/4/18 read Resident #44 had a long-standing history of anxiety and insomnia. She stated it had been especially bad since her son died about a year ago. She stated she had been "shaky" since admission and found herself snapping at staff without meaning to. Resident #44 stated she was taking Xanax 1 mg 3 times daily every 8 hours at home and was getting Xanax in the hospital. New orders were written for Xanax 0.5mg every 8 hours. There was no documented evidence of any nonpharmacological approaches attempted at this time. Review of a Physician order dated 9/12/18 read Resident #44's Xanax was increased to 1 mg three times daily. There was no documented evidence of any nonpharmacological approaches attempted at this time. Review of Resident #44's September 2018	F 758	All residents have the potential to have been affected by the deficient practice On 3/19/19 the Director of Nurses reviewed antianxiety medication orders for the last 30 days for the use of non-pharmacological interventions prior to the initiation/dose increase of ordered antianxiety medications. Results: Sixteen (16) out of Sixteen (16) residents did not have documented use of nonpharmacological interventions. On 3/19/2019 and 3/20/19 the Director of Nurses and MDS Coordinator reviewed care plans for all residents receiving antianxiety medications for the presence of non-pharmacological interventions. Results: Sixteen (16) out of Sixteen(16)did not have care plans for non-pharmacological interventions. As a result of the review, the Director of Nursing on 03/19/2019, has initiated under all orders for antianxiety medications, non-pharmacological interventions, (ie. offering quiet environment, music therapy, exercise) 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/18/19 the Director of Nurses began inservice education of all nurses, nursing assistants- full time, part time, as needed, the Medical Director, Nurse Practitioner and Activity Director on unnecessary medications and the	

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F 758	Continued From page 65 Medication Administration Record (MAR) indicated she received Xanax 0.5mg every 8 hours till 9/12/18 when her Xanax was increased to 1 mg three times daily. Review of Resident #44's nursing notes indicated on 9/18/18 at 9:49 AM she experienced a lot more shakiness to hands and arms. She experienced one episode of crying while on the phone and appeared confused at times. Review of Resident #44's target behavior monitoring for September 2018 on the Medication Administration Record (MAR) indicated she experienced increased anxiety, shakiness, verbalizing increased anxiety on 8 occasions. Review of an acute visit physician note dated 9/18/18 read she was seen due to shaking. Resident #44 reported a mild tremor and that the increased dose of Xanax was helping with anxiety, sleep and shaking. There was no documented evidence of any nonpharmacological approaches attempted at this time. Review of a regulatory visit physician progress note dated 10/12/18 read Resident #44 felt "stressed, anxious and shaky a lot." She was titrated up to 3 mg of Xanax daily and stated it has helped quite a bit. She requested her Xanax increased to 4 times daily. She denied depression and suicidal ideation. The Physician documented he declined her request to increase the Xanax to 4 mg daily. There was no documented evidence of any nonpharmacological approaches attempted at this time. Review of a Resident #44 nursing notes indicated on 10/29/18 at 6:15 PM, she was experiencing	F 758	utilization of nonpharmacological interventions prior to initiating or increasing dosages of antianxiety medications. Nursing staff and the Activity Director will implement nonpharmacological interventions following the resident□s individualized care plan. Use of nonpharmacological interventions and their effectiveness will be documented in the resident□s electronic medical record and the physician will be notified if the nonpharmaclogical interventions are unsuccessful. The in-service will be completed by 3/31/19 at which time the above must be in-serviced prior to working. The in-service will be completed by 3/29/19 at which time the above must be in-serviced prior to working. The Director of Nurses/Support Nurse or MDS Coordinator will monitor compliance with non-pharmacological intervention use prior to the initiation/dosage increase in antianxiety medications utilizing the Non-pharmacological Intervention Review Quality Assurance Tool weekly times two (2)weeks and monthly times three (3) months. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Reports will be presented to the weekly Quality Assurance committee by the	

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F 758	Continued From page 66 nervousness. There was no other documentation or explanation as to what nervous meant and no documented evidence of any nonpharmacological approaches attempted at this time. Review of a Resident #44's nursing notes indicated on 10/30/18 at 12:41 AM, she was experiencing nervousness. There was no other documentation or explanation as to what nervous meant and no documented evidence of any nonpharmacological approaches attempted at this time. Review of a Resident #44 nursing notes indicated on 10/31/18 at 11:23 PM, she was experiencing nervousness. There was no other documentation or explanation as to what nervous meant and no documented evidence of any nonpharmacological approaches attempted at this time. Review of Resident #44's October 2018 MAR indicated she received Xanax 1 mg every 8 hours. Review of Resident #44's target behavior monitoring for October 2018 on the MAR indicated she experienced increased anxiety, shakiness, verbalizing increased anxiety on 12 occasions. Review of a Resident #44 November 2018 nursing notes did not include any notes regarding anxiety, shaking or nervousness. Review of Resident #44's target behavior monitoring for November 2018 on the MAR indicated she experienced increased anxiety, shakiness, verbalizing increased anxiety on 8	F 758	Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The weekly and monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, Activities Director, Social Worker and the Dietary Manager. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Date of Compliance: 4/12/19	

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occasions.

Review of Resident #44's November 2018 MAR indicated she received Xanax 1 mg every 8 hours.

Review of a Resident #44 December 2018 nursing notes did not include any notes regarding anxiety, shaking or nervousness.

Review of Resident #44's target behavior monitoring for December 2018 on the MAR indicated she experienced increased anxiety, shakiness, verbalizing increased anxiety on 35 occasions.

Review of Resident #44's December 2018 MAR indicated she received Xanax 1 mg every 8 hours.

Review of a Resident #44 January 2019 nursing notes did not include any notes regarding anxiety, shaking or nervousness.

Review of Resident #44's target behavior monitoring for January 2019 on the MAR indicated she experienced increased anxiety, shakiness, verbalizing increased anxiety on 12 occasions.

Review of Resident #44's January 2019 MAR indicated she received Xanax 1 mg every 8 hours.

Review of Resident #44's quarterly Minimum Data Set (MDS) dated 1/10/19 indicated she was cognitively intact, no mood concerns and exhibited no behaviors. She was coded for 7 of 7 days as receiving antianxiety medication.

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Review of a physician order dated 1/28/19 read a new order for Resident #44 to be seen by Psychological Services.

Review of a social services note dated 1/29/19 at 12:11 PM read a psychological consult was ordered for Resident #44 for coping mechanisms for anxiety/depression. Resident #44 declined the psychological consult stating she was not experiencing any depression or anxiety. The note read Resident #44 exhibited a positive effect.

Review of Resident #44's 2/1/19 through 2/25/19 nursing notes did not include any notes regarding anxiety, shaking or nervousness.

Review of Resident #44's target behavior monitoring from 2/1/19 through 2/25/19 on the MAR indicated she experienced increased anxiety, shakiness, verbalizing increased anxiety on 10 occasions.

Review of Resident #44's 2/1/19 through 2/25/19 MAR indicated she received Xanax 1 mg every 8 hours.

Review of Resident #44's anxiety care plan initiated 9/1/18 and last revised on 2/22/19 read she was at risk for adverse side effects from her antianxiety medications. The goal for to show decreased episodes of anxiety through the next review. Interventions included administrating medications as ordered. There was no included nonpharmacological approaches care planned.

During an interview on 2/25/19 at 10:32 AM Resident #44 stated she was not experiencing any anxiety. She did not appear sedated but

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pleasant.

During an interview on 2/26/19 at 12:20 PM, the Health Information Management (HIM) supervisor stated she could find no evidence of any pharmacy recommendations related to Resident #44's Xanax.

During an interview on 2/26/19 at 2:40 PM, Nursing Aide (NA) #2 stated Resident #44 did not exhibit any signs of anxiety. She stated she had not observed any "shaking or crying" by Resident #44 but stated she was not getting up and walking as much but rather propelling more in her wheelchair. NA #2 stated when it was not raining, she liked to go outside, and smoke and she did not smoke when she was first admitted.

During an interview on 2/27 at 8:30 AM, Nurse #1 stated Resident #44 did appear "anxious" at times. If her narcotic was due and it was not ready to administer, Resident #44 could become agitated. Nurse #1 stated she would raise her voice and threaten to get the staff fired. She stated she was uncertain what the "shaking" was attributed to but she had only noted it on a few occasions, and it was not severe. Nurse #1 stated the behavior documentation coded on the daily MAR was if she exhibited any shaking, anxiety such as impatience or she voiced any anxiety on her shift. She stated it was often that she would exhibit impatience with waiting for her pain medication. Nurse #1 stated she felt Resident #44 needed someone to talk to so whenever she found some extra time, she would go and visit with Resident #44.

During an interview on 2/27/19 at 9:40 AM, NA #1 stated Resident #44 did not voice anxiety and

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was cooperative with her care.

During an interview on 2/27/19 at 10:05 AM, the Social Worker (SW) stated she was not aware of any anxiety concerns related to Resident #44 but she was referred to Psychological Services for medication management only.

During an interview on 2/27/19 at 3:45 PM, the Physician stated he was aware of Resident #44 apparently was taking Xanax at a high dose before she was hospitalized. The facility provided no evidence that Resident #44 was receiving Xanax while in the hospital. He stated she requested it be restarted and she exhibited some signs of anxiety during his visits. He confirmed he did not order any Psychological consult until 1/28/19 and he was aware that Resident #44 refused it. The Physician stated he was not certain of the etiology of the "shaking" he described in his notes, but she would appear anxious to him. When asked why he did not increase her Xanax to 4 times daily as she requested on 10/12/18, the Physician stated he did not think she needed it. He went on the say he did feel the Xanax at 3 mg daily was needed due to her long history of taking the medication. The Physician stated Resident #44 had a tolerance of Xanax.

During a telephone interview on 2/27/19 at 4:00 PM, the Pharmacist stated Resident #44's dose of Xanax was unusual but since it was started early September 2018, she would not be due for a gradual dose recommendation until March 2019.

On 2/27/19 at 4:20 PM, the Director of Nursing (DON) provided an undated Pharmacy

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Recommendation (date printed 2/27/19) regarding Resident #44's Xanax and two other psychotropic medications. The recommendation was read to evaluate the current doses and consider an attempt at a gradual dose reduction to ensure the resident was using the lowest possible effective/optimal dose.

During another interview on 2/28/19 at 8:38 AM, Resident #44 was lying in bed. She stated she was very happy with her care at the facility and had decided to stay at the facility rather than returning home. Resident #44 stated she did not attend church activities, but she preferred watching television or going out to smoke. She stated she had stopped smoking while in the hospital and tried the nicotine patches, but she enjoyed smoking and decided to stop using the patches. Resident #44 stated she preferred talking with the staff rather than another resident. She confirmed the social worker spoke to her about seeing a Psychologist, but she refused. She stated she did not think talking to another would help.

During an interview on 2/28/19 at 9:25 AM, Nurse #2 stated Resident #44 would become "a little" agitated before her pain medication was due. She stated when she coded any behaviors for Resident #44 on the MAR, it was usually due to her impatience with waiting for her next dose of her pain medication. She stated the Physician ordered Psychological Services to see Resident #44, but she refused stating she did not believe that psychotherapy was needed.

During an interview on 2/28/19 at 10:40 AM, the Administrator and DON stated it was their expectation that nonpharmacological

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F 758	Continued From page 72 interventions would have been considered and attempted soon after Resident #44's admission to determine the need and amount of Xanax she was currently prescribed.	F 758		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		4/12/19

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F 842	Continued From page 73 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to include a urology consultation report in the medical records for 1 of 5 residents (Residents #47) reviewed for unnecessary medications.	F 842	F842 Resident Records-Identifiable Information Based on record review and staff interview, the facility failed to include a	

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F 842	Continued From page 74 The findings included: Resident #47 was admitted to the facility on 4/25/16 and most recently readmitted on 4/15/18 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 7/10/18 indicated Resident #47' s cognition was severely impaired. A review of Resident #47 ' s hard copy and electronic medical record revealed a urology consultation note dated 9/17/18. There were no urology consultation notes after 9/17/18 in Resident #47 ' s medical record. An interview was conducted with the Director of Nursing (DON) on 2/27/19 at 2:42 PM. The DON stated that Resident #47 was followed by a urologist. She indicated she believed he saw the urologist several times per year. The 9/17/18 urology consultation note for Resident #47 was reviewed with the DON. She reported that she thought Resident #47 had a consultation with the urologist that was not present in the medical record. She indicated she needed to look into this further. A follow up interview was conducted with the DON on 2/27/19 at 5:05 PM. She provided a urology consultation note for Resident #47 that was dated 11/12/18 and faxed to the facility on 2/27/19. She revealed the facility had no documentation related to this 11/12/18 urology consultation for Resident #47 prior to 2/27/19. She stated that the normal process for obtaining documentation from consultations was for a form to be sent with the resident to the provider, the	F 842	urology consultation report in the medical records for 1 of 5 residents (Residents #47) reviewed for unnecessary medications. 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: For resident#47,the Urology consult for the resident was obtained on 03/04/2019 by the Support Nurse and placed in the resident's electronic medical record by the Director of our Health Information Management department director. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to have been affected by the deficient practice A review of scheduled appointments for residents over the past three months was completed by the Director of Nursing and the Transportation Aide on 03/20/2019 to ensure there were no missed consultation reports. None were identified as missing. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: In-service education was provided on 3/20/2019 to all licensed staff to check for consultation reports following residents	

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F 842	Continued From page 75 provider was to document any pertinent information and/or new orders on the form, and then send the form back to the facility with the resident. She revealed there was no monitoring process in place to ensure documentation from the consultations had been obtained. The DON reported she believed it was pertinent to obtain documentation from all consultations as this documentation could affect decisions with the resident ' s plan of care. She stated she was already in the process of developing a new monitoring system to ensure documentation from all consultations were obtained.	F 842	doctor appointments. If none is provided call the physicians office and request the report. Staff not trained by 03/03/2019 will not be allowed to work until education is completed. The Support Nurse or the Registered Nurse Supervisor will review the order listing report daily for resident appointments to ensure consultation reports are received and loaded into the residents electronic medical records by the Healthcare Information Manager. If the consultation report is not received within 48 hours during week and 72 hours on weekends, then notify Director of Nursing to assist in acquiring report. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses or Support Nurse to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, Social Worker, Activities Director and the Dietary Manager. The monthly Quality Assurance Meeting is	

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F 842	Continued From page 76	F 842	attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager,Social Worker, Activities Director and the Dietary Manager. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Date of Compliance: 04/12/2019	
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the physician, Pharmacy Consultant, and staff, the facility failed to follow the Antibiotic Stewardship Program as evidenced by the use of prophylactic (preventative) antibiotics for 1 of 5 residents (Residents #47) reviewed for unnecessary medications. The findings included: A review of the facility ' s Antibiotic Stewardship Program ' s (ASP) policy, last revised May 2018,	F 881	F881 Antibiotic Stewardship Program Based on record review and interviews with the physician, Pharmacy Consultant, and staff, the facility failed to follow the Antibiotic Stewardship Program as evidenced by the use of prophylactic (preventative) antibiotics for 1 of 5 residents (Residents #47) reviewed for unnecessary medications 1. Address how the corrective action will	4/12/19

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indicated it was the facility ' s policy to maintain ASP with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use.

Resident #47 was admitted to the facility on 4/25/16 and most recently readmitted on 4/15/18 with diagnoses that included dementia.

The quarterly Minimum Data Set (MDS) assessment dated 7/10/18 indicated Resident #47 ' s cognition was severely impaired. He was always incontinent of bladder and he received an antibiotic on 7 of 7 days. Resident #47 had no active diagnosis of a urinary tract infection (UTI) or any other infection.

A urology consultation note dated 9/17/18 indicated Resident #47 had recurrent Urinary Tract Infections (UTIs). The urologist prescribed Macrodantin (antibiotic) 50 milligrams (mg) once daily for 6 months.

A nursing note dated 9/17/18 indicated Resident #47 had a urology appointment on this date and returned with a new order for prophylactic (preventative) Macrodantin 50 mg once daily for 6 months related to recurrent UTIs.

A physician ' s order dated 9/18/18 indicated Macrodantin 50 mg once daily for 6 months for Resident #47.

The quarterly MDS assessment dated 10/1/18 indicated Resident #47 ' s cognition was severely impaired. He was always incontinent of bladder and he received an antibiotic on 7 of 7 days. Resident #47 had no active diagnosis of a UTI or

be accomplished for those residents found to have been affected by the deficient practice:

For resident # 47, corrective action was obtained on 3/1/19. The physician discontinued use of the antibiotic, Macrodantin 50mg once daily for 6 months.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents have the potential to have been affected by the deficient practice

On 3/4/19 the Director of Nurses and Support Nurse audited all current residents with antibiotic orders to ensure that all had appropriate stop dates and appropriate indications for use. No other residents were affected.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 3/4/19, the Director of Nurses and the Support Nurse began education of all full time, part time, as needed licensed staff, the Medical Director and Nurse Practitioner on the expectation of following the Antibiotic Stewardship Program, specifically ensuring all antibiotic orders are the result of an active infection and have a stop date. The in-service will be completed by 3/20/19 at which time all

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F 881	Continued From page 78 any other infection. A pharmacy recommendation dated 10/24/18 indicated a recommendation was made related to Resident #47 ' s prophylactic Macrodantin. The recommendation stated, "In light of antibiotic stewardship efforts ...evaluate continued need for antibiotic prophylaxis ...". The recommendation was addressed by the Nurse Practitioner (NP) on 10/30/18 and she indicated a urology consultation was done and that Resident #47 ' s Responsible Party (RP) always insisted that UTIs were treated. A pharmacy recommendation dated 11/27/18 indicated a repeat recommendation was made related to Resident #47 ' s prophylactic Macrodantin. The Pharmacy Consultant asked for the physician to address this recommendation. The recommendation was addressed by the physician on 11/30/18 and he indicated that urology had recommended antibiotic prophylaxis for recurrent UTIs. He wrote that any changes needed to come from urology and be approved by Resident #47 ' s RP. A pharmacy recommendation dated 12/21/18 indicated a repeat recommendation was made related to Resident #47 ' s prophylactic Macrodantin. The Support Nurse wrote on this recommendation that it was previously addressed by the physician on 11/30/18. A pharmacy recommendation dated 1/22/19 indicated a repeat recommendation was made related to Resident #47 ' s prophylactic Macrodantin. The Support Nurse wrote on this recommendation that it was previously addressed by the physician.	F 881	licensed staff must be in-serviced prior to working. The Director of Nurses and Support Nurse will monitor compliance utilizing the Prophylactic Use of Antibiotics Quality Assurance Tool weekly times (2) weeks then monthly times three (3)months. The Director of Nursing will evaluate all residents with antibiotic orders to ensure an appropriate stop date and appropriate documentation from the Primary Medical Provider and consulting specialist, is in place. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting with the Director of Nursing or the Support Nurse presenting the audit review. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, Social Worker, Activities Director and the Dietary Manager. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Date of Compliance: 04/12/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

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F 881	Continued From page 79	F 881		

A review of Resident #47 ' s active care plan indicated the focus area of antibiotic therapy related to recurrent UTIs. This focus area was last revised on 1/27/19. The interventions included, in part, administer medications as ordered and observe for possible side effects every shift.

A review of Resident #47 ' s Medication Administration Records from 9/18/18 through 2/27/19 revealed he had received Macrodantin 50 mg once daily as ordered.

An interview was conducted with the Support Nurse on 2/25/19 at 2:50 PM. She reported that Resident #47 was on Macrodantin as a prophylactic related to a history of recurrent UTIs. She stated that Resident #47 had no acute UTI.

A phone interview was conducted with the Pharmacy Consultant on 2/27/19 at 4:19 PM. She stated that prophylactic antibiotics were not in accordance with the ASP. She confirmed she had made multiple recommendations related to Resident #47 ' s prophylactic Macrodantin.

An interview was conducted with the Director of Nursing (DON) on 2/27/19 at 2:42 PM. The DON indicated that prophylactic antibiotics were not in accordance with the Antibiotic Stewardship Program (ASP). She stated she expected the ASP to be followed. She indicated that Resident #47 ' s RP was very involved with his care and that she had been provided education on antibiotic stewardship, but she was not in agreement with the discontinuation of the prophylactic antibiotic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 881	Continued From page 80 An interview was conducted with Resident #47 ' s physician/facility ' s Medical Director on 2/27/19 at 3:45 PM. He stated he was involved in the ASP at the facility. He indicated that prophylactic antibiotics were not in accordance with the ASP. He reported he had not initiated any orders for prophylactic antibiotics at the facility. The physician ' s order dated 9/18/18 for Macrodantin 50 mg once daily for 6 months for Resident #47 was reviewed with the physician. The physician stated that Resident #47 ' s urologist had recommended this prophylactic antibiotic and that Resident #47 ' s RP also wished for him to have it. He stated that because of Resident #47 ' s history of recurrent UTIs, the urologist ' s recommendation, and the RP ' s wishes, he had deferred this decision to the urologist. An interview was conducted with the Administrator on 2/28/19 at 10:39 AM. She stated she expected the ASP be followed.	F 881		