| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 07/09/19 through 07/12/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #7OLH11. | E 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications (Resident #9) and active diagnosis (Resident #11) for 2 of 13 residents reviewed.<br><br>The findings included:<br><br>1. Resident #9 was admitted to the facility on 4/29/19 a diagnosis of edema.<br><br>A review of the admission MDS dated 5/8/19 revealed Resident #9 had an active diagnosis of edema. The MDS did not reflect Resident #9 ' s use of a diuretic during the look back period.<br><br>A review of the physicians orders for May 2019 revealed Resident #9 had an active order dated 4/29/19 for Lasix (a diuretic) 20 mg on Monday, Wednesday and Friday.<br><br>A review of the Medication Administration Record for May 2019 revealed Resident #9 received Lasix 20 mg on 5/3/19, 5/6/19 and 5/8/19. | F 641 | Corrective action to be accomplished for the resident found to be affected by the deficient practice:<br><br>The MDS for Resident #9 was updated to reflect the diagnosis of edema and coded to reflect treatment with Lasix as a diuretic.<br><br>The MDS for Resident # 11 was updated to include the diagnosis of hemiplegia in Section I.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>MDS and Care plans for all other residents were reviewed for completeness and no other medications or diagnoses were found to be omitted.<br><br>Measures to be put in place or systemic changes made to ensure that the deficient | 8/3/19 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/03/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 641 | Continued From page 1<br><br>An interview with the MDS nurse on 7/12/19 at 2:17 PM revealed Lasix should have been coded on Resident #9 ' s admission MDS but it was overlooked.<br>2. Resident #11 was originally admitted to the facility on 5/7/17 and readmitted on 2/7/18 with diagnoses which included: hemiplegia following a cerebrovascular accident and muscle weakness.<br><br>Review of the quarterly minimum data set (MDS) dated 4/25/19 indicated Resident #11 had short-term and long-term memory problems with severely impaired decision-making skills. The MDS also included the resident's active diagnoses which included: anemia, hypertension, diabetes mellitus, hyperlipidemia, and seizure disorder.<br><br>The MDS did not include hemiplegia as an active diagnosis in Section I.<br><br>During an interview on 7/12/19 at 3:49 p.m., the MDS Coordinator stated that Resident #11's diagnosis of hemiplegia was not included in section I of the MDS due to human error. | F 641 | practice will not occur:<br><br>The MDS assessments will be verbally read and discussed as part of the first care plan meeting in the first 21 days of new admission and quarterly for the current residents to identify any changes in medications or diagnoses.<br><br>How we will monitor our performance to make sure that solutions are sustained:<br><br>An audit of admission MDS assessments and quarterly MDS updates will be completed by the DON or designee to verify any new diagnoses and treatments have been included. New diagnoses will be discussed as well as goals and new interventions as part of the weekly care plan meetings. These audits will be completed for 3 months and extended if needed. The results of the audit will be reported monthly in QAPI and Housewide QI to verify measures are sustained. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive | F 656 | | 8/3/19 |

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| F 656 | Continued From page 2<br>assessment. The comprehensive care plan must describe the following -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews, the facility failed to develop a care plan for 1 of 1 resident (Resident #29) reviewed for range of motion. The resident had right-hand and right elbow contractures. | F 656 | Corrective action to be accomplished for the resident found to be affected by the deficient practice:<br><br>The Care Plan for Resident #29 was updated to reflect the range of motion and | |

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F 656

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Findings included:

Resident #29 was admitted to the facility on 7/19/12 with the diagnoses which included: moderate intellectual disabilities and general idiopathic epilepsy.

The review of the quarterly minimum data set (MDS) dated 6/20/19 indicated Resident #29 had short- and long-term memory problems with severely impaired decision-making skills; and range of motion impairment to one-side of his upper extremities.

The Care Plan dated 6/20/19 did not address Resident #29's range of motion problem with right-hand and elbow contractures.

During an observation on 7/10/19 at 9:14 a.m., Resident #29 was in his wheelchair in the dining room/day room. Both of the resident's hands were fisted. There was a dry, rolled washcloth in the resident's right hand; but there was no splinting device in his left hand. When requested, the resident did not open either hand and would not verbally respond to questions.

During an interview on 7/11/19 at 2:56 p.m., RNA#1 (restorative nursing assistant) revealed Resident #29 was currently receiving restorative exercises for range of motion of his right upper extremity, splinting using a rolled washcloth of his right-hand contracture, and bed mobility.

On 7/11/19 at 3:07 p.m., during an interview, the Rehabilitative Manager stated Resident #29 was not a candidate for skilled rehabilitative services due to his difficulty following

F 656

contracture problems and interventions. The restorative program and interventions continue.

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

An audit of care plans was completed to verify that problems and interventions were documented. No other residents were identified as missing problems and interventions related to mobility and restorative plans of care.

Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur:

The Nursing Rehab/Restorative Plan of Care will be utilized to document problems and interventions for residents identified with mobility needs. A review of the care plans for residents receiving restorative services will be discussed in weekly care plan meetings to verify problems and interventions are documented. The MDS nurse will educate and evaluate the Nursing Rehab / Restorative Plan of Care to ensure documentation is accurately recording the problems and interventions for the residents.

How we will monitor our performance to make sure that solutions are sustained:

An audit of care plans for restorative residents will be completed by the DON or designee to verify problems and

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| F 656 | Continued From page 4<br>instructions/commands related to his moderate intellectual disabilities. She revealed the resident received his yearly evaluation by occupational therapy services on 1/1/19 which revealed the resident had contractures to his right digits, wrist, and elbow (flexion contractures). The occupational therapist recommended Resident #29 receive the restorative nursing program six days each week for six to eight weeks to prevent further contractures of his right digits and also for skin integrity: rolled washcloth to right palm; and passive range of motion to his right wrist, forearm and elbow. The next quarterly rehabilitative screen was performed on 3/18/19 with the recommendation that the resident receive restorative nursing for six days each week for four weeks for range of motion and bed mobility exercises to prevent increase in contractures.<br><br>During an interview on 7/12/19 at 3:53 p.m., the MDS Coordinator acknowledged there was no care plan concerning Resident #29's range of motion and contracture problems. She stated that the care area should have been care planned but was not due to human error. | F 656 | interventions have been included. Residents receiving restorative services will be discussed as part of the weekly care plan meetings. These audits will be completed for 3 months and extended if needed. The results of the audit will be reported monthly in QAPI and Housewide QI to verify measures are sustained. | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives | F 686 | | 8/9/19 |

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| F 686 | Continued From page 5<br>necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to implement physician ordered pressure relieving devices for 3 of 4 residents (Resident #5, Resident #9 and Resident #28) reviewed for pressure ulcers.<br><br>The findings included:<br><br>1. Resident #5 was admitted to the facility on 9/15/16.<br><br>A review of a quarterly Minimum Data Set (MDS) assessment dated 4/17/19 revealed Resident #5 had impaired cognition and required total dependence with bed mobility. Resident #5 was bedbound and did not transfer. Resident #3 had no current pressure ulcers but was at risk of developing pressure ulcers.<br><br>A care plan dated 8/9/18 and updated on 4/19/19 revealed a problem for risk of pressure ulcers. The goal was to prevent pressure ulcer formation over the next 90 days. An intervention listed was to float heels on pillows at all times. The care plan did not include care refusals.<br><br>A review of Resident #5 ' s physician orders revealed an active order to float heels at all times.<br><br>An observation on 7/9/19 at 2:34 PM revealed Resident #5 lying in bed. Resident #5 ' s heels were not floated off the mattress. Instead, they were lying flat on the mattress. | F 686 | Corrective action to be accomplished for the resident found to be affected by the deficient practice:<br><br>Facility failed to ensure physician orders were followed for pressure relieving devices, specifically floating heels, for Resident # 5, Resident # 9 and Resident # 28. The CNA worksheet used to communicate floating heels and other pressure relieving devices was verified to have this order noted for Residents # 5 and Resident # 28. The worksheet was updated by the unit secretary for Resident #9.<br><br>Verbal and written education by the DON was implemented for all Nurses and CNA□s regarding following physician□s orders for pressure relieving devices, specifically floating heels. This education will be completed by August 9, 2019.<br><br>Nurses and CNA□s will be held accountable to have residents□ heels floated as ordered.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>All residents with physician orders for pressure relieving devices, specifically | |

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F 686 Continued From page 6

An observation on 7/11/19 at 9:54 AM of Resident #5 revealed her heels were not floated off the mattress.
Observations throughout the remainder of the survey revealed Resident #5 did not have her heels floated.

On 7/11/19 at 2:18 PM, an interview was conducted with Nurse Aide (NA) #1. NA#1 stated resident information is on a paper they get when they come on shift. NA#1 stated it included whether the resident had to have heels floated. When NA #1 was shown Resident #5 ' s heels were not floated, she stated Resident #5 didn ' t like the pillow folded, she liked it flat.

On 7/11/19 at 2:36 PM, and interview was conducted with Nurse #2. She stated she spot checked residents to make sure they had things in place like floating heels. Nurse #2 stated the NA ' s know they should float Resident #5 ' s heels, but isn ' t sure they always do it. She stated this resident did not refuse to have her heels floated.

On 7/12/19 at 3:00 PM, an interview was conducted with the Director of Nursing. She stated nursing assistants should be making sure the residents had pressure reducing devices in place and nurses should be checking on rounds.

2. Resident #9 was admitted to the facility on 4/29/19. Her diagnoses included dementia with behavioral disturbance and hyperlipidemia.

A review of Resident # 9 ' s admission MDS assessment dated 5/8/19 revealed Resident #9 was totally dependent with 2 people for bed

F 686

floating heels, have this order communicated to the CNA□s and Nurses through the daily worksheet which lists patient problems and ordered interventions. The nursing secretary compared August 1, 2019 monthly orders against the worksheet and updated interventions for all other residents.

Verbal and written education by the DON was implemented for all Nurses and CNA□s regarding following physician□s orders for pressure relieving devices, specifically floating heels. This education will be completed by August 9, 2019.

Nurses and CNA□s will be held accountable to have residents□ heels floated as ordered.

Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur:

Any changes to physician orders will be updated on the CNA worksheet when the orders are copied. The unit secretary will double check the orders have been updated on the CNA worksheet weekly.

An audit of the monthly orders will be reconciled with the CNA worksheet by the DON or designee and updated if needed. This audit process was started with the August, 2019 monthly orders.

Verbal and written education by the DON was implemented for all Nurses and CNA□s regarding following physician□s

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mobility and transfers. The MDS also indicated Resident #9 was a risk for developing pressure ulcers.

A review of the care plan dated 5/9/19 revealed a problem for risk of developing pressure ulcers due to generalized weakness. The goal was to prevent pressure ulcer formation for the next 90 days. An intervention was to float heels in bed.

A review of the physician orders for July 2019 revealed an order to float heels in bed ordered on 4/29/19.
An observation on 7/9/19 at 4:00 PM revealed Resident #9 lying in bed. Resident #9 did not have her heels floated off the mattress, they were lying flat on the mattress.

An observation on 7/10/19 at 8:45 AM revealed Resident #9 lying in bed. Resident #9 did not have her heels floated off the mattress, they were lying flat on the mattress.

At various times throughout the remainder of the survey, Resident #9 was observed to not have her heels floated.

On 7/10/19 at 3:19 PM, and interview was conducted with NA #2. NA #2 stated the nursing assistant paper lists the residents and their needs. She stated pressure reducing devices were not listed for Resident #9, but she was aware they needed to float her heels. When NA #2 was shown Resident #9 ' s heels were not floated off the mattress, NA #2 stated they usually have them up and she checks them on rounds.

On 7/11/19 at 2:36 PM, an interview was conducted with Nurse #2. She stated she spot

F 686

orders for pressure relieving devices, specifically floating heels. This education will be completed by August 9, 2019.

Daily rounds will be made by the charge nurse, DON, and/or MDS to ensure physician ordered pressure relieving devices for risk of pressure ulcers, specifically floating heels is being consistently completed for all residents. Nurses will provide feedback and demonstration to the CNA□s at the time of rounds if pressure relieving devices for risk of pressure ulcers are not being properly used. These audits began August 1, 2019.

How we will monitor our performance to make sure that solutions are sustained:

The Charge nurse, DON, and or the MDS nurse will make daily rounds beginning August 1, 2019 and will audit implementation of physician ordered pressure relieving devices for risk of pressure ulcers on residents with orders and/or care plan interventions that state such. Audit will be performed for 3 months and extended if needed.

An audit of the monthly orders will be reconciled with the CNA worksheet by the DON or designee and updated if needed. This audit process was started with the August, 2019 monthly orders and will continue for 3 months and extended if needed.

The results of these audits will be

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| F 686 | Continued From page 8<br>checked residents to make sure they had things in place like floating heels. Nurse #2 stated the NA ' s know they should float Resident #9 ' s heels, but isn ' t sure they always do it. She stated this resident did not refuse to have her heels floated and did not remove the pillow herself.<br><br>On 7/12/19 at 3:00 PM, an interview was conducted with the Director of Nursing. She stated nursing assistants should be making sure the residents had pressure reducing devices in place and nurses should be checking on rounds.<br><br>3. Resident #28 was admitted to the facility on 4/18/17. Her diagnoses included diabetes mellitus type 2 and a history of stage 4 pressure ulcer.<br><br>A review of Resident #28 ' s annual MDS assessment dated 6/12/19 revealed Resident #28 was at risk for pressure ulcers and used a pressure relieving device to her bed.<br><br>A review of the care plan revealed Resident #28 had a healed stage 3 pressure ulcer. The goal was for Resident #28 to have no pressure ulcer formation for the next 90 days. Interventions included to float heels in bed.<br><br>A review of the physician orders for July 2019 revealed an order to float heels in bed dated 6/11/19.<br>An observation on 7/9/19 at 1:32 PM revealed Resident #28 ' s feet were resting on pillows and her heels were not floated.<br><br>An observation on 7/10/19 at 8:44 AM revealed Resident #28 ' s feet were resting on pillows and her heels were not floated. | F 686 | reported monthly in QAPI and Housewide QI to verify measures are sustained.<br><br>Corrective Action Completion Date: August 9, 2019. | |

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| F 686 | Continued From page 9<br>Observations were made throughout the remainder of the survey of Resident #28 ' s heels not floated off the mattress.<br><br>On 7/10/19 at 3:19 PM, an interview was conducted with NA #2. NA #2 stated the nursing assistant paper lists the residents and their needs. She stated pressure reducing devices was listed for Resident #28. When NA #2 was shown Resident #28 ' s heels were not floated off the mattress, NA #2 stated they usually have them up and she checks them on rounds. She stated Resident #28 must have scooted down.<br><br>On 7/11/19 at 2:36 PM, an interview was conducted with Nurse #2. She stated she spot checked residents to make sure they had things in place like floating heels. Nurse #2 stated the NA ' s know they should float Resident #28 ' s heels, but isn ' t sure they always do it. She stated this resident did not refuse to have her heels floated and did not scoot down in bed.<br><br>On 7/12/19 at 3:00 PM, an interview was conducted with the Director of Nursing. She stated nursing assistants should be making sure the residents had pressure reducing devices in place and nurses should be checking on rounds. | F 686 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered | F 695 | | 8/9/19 |

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| F 695 | Continued From page 10<br>care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to change oxygen tubing weekly per physician ' s orders for 1 of 1 residents (Resident #20) reviewed for respiratory care.<br><br>The findings included:<br><br>Resident #20 was admitted to the facility on 5/29/19 with diagnoses of, in part, atrial fibrillation and congestive heart failure.<br><br>A review of physician ' s orders for July 2019 revealed an order for oxygen at 2 liters per minute via nasal cannula to keep oxygen saturations above 90%.<br><br>An observation on 7/9/19 at 1:40 PM revealed Resident #20 out of bed in the day room. Resident #20 was observed to be using oxygen at 2 liters per minute via nasal cannula. The cannula tubing was observed to be dated 6/24/19.<br><br>An observation on 7/10/19 at 3:54 PM revealed Resident #20 lying in bed in her room. Resident #20 was observed to be using oxygen at 2 liters per minute via nasal cannula. The cannula tubing was observed to be dated 6/24/19.<br><br>An interview with Nurse #2 was conducted on 7/11/19 at approximately 4:30 PM. She stated there are orders to change the oxygen tubing weekly and the night nurses are responsible for doing it. She stated Resident #20 did not have an order to change her tubing weekly, but should. | F 695 | Corrective action to be accomplished for the resident found to be affected by the deficient practice:<br><br>The oxygen tubing for Resident #20 was changed and dated on July 12, 2019.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>A review of all charts for residents receiving oxygen was completed and all residents have orders to change oxygen tubing weekly.<br><br>Oxygen tubing was checked on all residents with oxygen orders to assure that the tubing was changed weekly and dated to reflect the change by the DON or designee. This was completed on August 2, 2019<br><br>Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur:<br><br>Current facility policy was reviewed on July 29, 2019 and no changes were identified.<br><br>Oxygen tubing will be checked on all residents with oxygen orders to assure that the tubing is changed weekly as indicated on the treatment sheet and | |

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| | 345166 | A. BUILDING ______ B. WING ______ | 07/12/2019 |

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| F 695 | Continued From page 11<br>Nurse #1 wrote an order for oxygen tubing for Resident #20 to be changed weekly.<br><br>An observation on 7/12/19 at 2:55 PM revealed Resident #20 ' s oxygen tubing was still dated 6/24/19.<br><br>An interview with the Director of Nursing was conducted on 7/12/19 at 3:00 PM. The Director of Nursing stated oxygen tubing should be changed and dated weekly and Nurse #2 should have changed the tubing yesterday when the order was written. | F 695 | dated to reflect the change. This will be completed by the DON or designee.<br><br>Verbal and written education has been provided by the DON and will be completed with all staff regarding respiratory care policies and procedures that includes weekly oxygen tubing changes and dating of tubing to reflect the change was completed. This education will be completed by August 9, 2019.<br><br>How we will monitor our performance to make sure that solutions are sustained:<br><br>Chart audits of all residents with oxygen orders will be done weekly with verification of tubing change and date tag. This audit will be completed for 3 months by Director of Nursing or designee to ensure policy adherence. Results will be reported monthly at the QAPI meeting and to Housewide QI.<br><br>Corrective Action Completion Date: August 9, 2019. | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On<br>CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any | F 756 | | 8/3/19 |

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| F 756 | Continued From page 12<br>irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(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.<br>(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.<br>(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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and pharmacist interview, the pharmacist failed to complete a monthly medication review for April 2019 for 1 of 5 residents (Resident #31) reviewed for unnecessary medications.<br><br>The findings included:<br><br>Resident #31 was readmitted to the facility on | F 756 | Corrective action to be accomplished for the resident found to be affected by the deficient practice:<br><br>The monthly medication review by the pharmacist for April on Resident #31 had been omitted by human error and discovered by the pharmacist when the May review was completed. The monthly | |

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| F 756 | Continued From page 13<br>3/12/19. Diagnoses included, in part, dementia with behavioral disturbance and delusional disorder.<br><br>A record review revealed a monthly medication review had not been completed for April 2019 for Resident #31.<br><br>An interview was conducted with the pharmacist on 7/12/19 at 10:10 AM. She stated she completes the monthly medication reviews on the residents and they are documented in the chart. She was unable to locate the monthly medication review for April 2019 for Resident #31 in the chart and stated she didn ' t have her records with her to see if it had been done. The pharmacist had not presented the monthly medication review for April 2019 for Resident #31 to the surveyor by the time the survey ended. | F 756 | medication reviews for subsequent months of May, June and July, 2019 have been completed.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>An audit of all resident charts was completed on August 1, 2019 and all other residents had monthly medication reviews by the pharmacist for the last four months or monthly since admission. This audit was current through the month of July, 2019.<br><br>Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur:<br><br>An audit to verify that monthly medication reviews by the pharmacist have been completed will be conducted on the last day of each month will be completed by the DON or designee. The pharmacist will be notified by the DON of any resident record identified as not having a monthly medication review by the last day of the calendar month. The pharmacist will then complete the review no later than the 3rd day of the next month.<br><br>How we will monitor our performance to make sure that solutions are sustained:<br><br>Chart audits of all residents will be conducted to verify monthly reviews have been completed by the Director of Nursing or designee on the last day of the | |

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| F 756 | Continued From page 14 | F 756 | calendar month and if not complete for that month, will notify the pharmacist to complete within 3 days. Audit results and actions taken will be reported monthly at the QAPI meeting and to Housewide QI.<br><br>Corrective Action Completion Date: August 3, 2019. | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§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:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§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;<br><br>§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;<br><br>§483.45(e)(3) Residents do not receive | F 758 | | 8/3/19 |

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| F 758 | Continued From page 15<br>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<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff and pharmacist interviews, the pharmacist facility failed to identify the continued use of an as needed antianxiety medication that was not time limited in duration for 1 of 5 residents (Resident #31) reviewed for unnecessary medications.<br><br>The findings included:<br><br>Resident #31 was readmitted to the facility on 3/12/19 with diagnoses, in part, of dementia with behavioral disturbance and delusional disorder.<br><br>A review of Resident #31 ' s physician orders for March 2019 revealed an order for Klonopin (an antianxiety medication) 0.5 milligrams by mouth every 6 hours as needed for anxiety. | F 758 | Corrective action to be accomplished for the resident found to be affected by the deficient practice:<br><br>The pharmacist contacted the physician with the recommendation to discontinue the prn order for Klonopin for Resident #31 and the order to discontinue was received on August 3, 2019.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>An audit of all resident orders for prn Psychotropic medications was completed. Two residents had new orders for psychotropic medications which had a 14 | |

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A record review revealed a monthly medication review conducted by the pharmacist on 3/29/19. There were no documented recommendations to the physician regarding the as needed antianxiety use.

A review of Resident #31 ' s physician orders for April 2019 revealed an order for Klonopin 0.5 milligrams by mouth every 6 hours as needed for anxiety.

A record review revealed a monthly medication review had not been completed by the pharmacist for April 2019.

A review of Resident #31 ' s physician orders for May 2019 revealed and order for Klonopin 0.5 milligrams by mouth every 6 hours as needed for anxiety.

A record review revealed a monthly medication review conducted by the pharmacist on 5/29/19. There were no documented recommendations to the physician regarding the as needed antianxiety use.

A review of Resident #31 ' s physician orders for June 2019 revealed and order for Klonopin 0.5 milligrams by mouth every 6 hours as needed for anxiety.

A record review revealed a monthly medication review conducted by the pharmacist on 6/29/19. There were no documented recommendations to the physician regarding the as needed antianxiety use.

A review of Resident #31 ' s physician orders for July 2019 revealed and order for Klonopin 0.5

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day stop date ordered. One resident had a new order for prn Lorazepam on 7/25/2019 and another resident had a new order for prn Lorazepam on 7/23/19 without stop dates and a subsequent order was received for a 14 day stop date on these two residents. One resident had a prn psychotropic medication ordered on 5/20/2019 and an order was received to discontinue. A new resident was admitted on 7/12/19 with a prn psychotropic and a new 14 day order was received until the physician evaluated and discontinued the prn order.

Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur:

The administrator met with the pharmacist and verified that the prn psychotropic medication regulations have been in place and discussed at monthly medical staff meetings on a regular basis. The pharmacist acknowledged she had completed monthly reviews but had not consistently followed through to enforce this regulation. The pharmacist has documentation of details of monthly medication reviews to include the number of prn medications and psychotropic medications as well as other pertinent review data. The pharmacist will complete written recommendations to the ordering providers regarding data from monthly medication reviews for residents, to include recommendations regarding prn psychotropic use for the individual resident.

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milligrams by mouth every 6 hours as needed for anxiety.

An interview was conducted with Nurse #1 on 7/12/19 at 8:58 AM. Nurse #1 stated Resident #31 had been sent to the hospital for her behaviors a few months ago, but since returning she had been much better. Nurse #1 stated Resident had not used the as needed Klonopin at all in June or July 2019.

An interview was conducted with the pharmacist on 7/12/19. The pharmacist stated she did monthly medication reviews on the residents. She stated she used a form to communicate recommendtions with the physician but it was not kept on the chart. She stated she was unaware of the regulation to limit the duration of as needed antianxiety medications. She stated there are standing orders that are in place for 10 days for medications such as Tylenol. When shown the regulation by the surveyor, the pharmacist stated she was glad she was made aware of it.

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The DON or designee will assist with communication of pharmacist recommendations to ordering providers and that physician orders reflect medication changes or if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

The administrator has communicated these expectations to the pharmacist, attending physicians and prescribing practitioners and DON via Memo on August 3, 2019.

How we will monitor our performance to make sure that solutions are sustained:

Weekly Chart audits of all residents will be conducted to verify orders for new PRN psychotropics have a 14 day limit or the attending physician or prescribing practitioner should document their rationale in the resident's medical record as to why they believe that it is appropriate for the PRN order to be extended beyond 14 days and indicate the duration for the PRN order. The audit will be completed by the Director of Nursing or designee for six months. Audit results will be reported monthly at the medical staff meeting, QAPI meeting and to Housewide QI.

Corrective Action Completion Date:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 758 | Continued From page 18 | F 758 | August 5, 2019. | |