

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

PRINTED: 04/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/05/2020
NAME OF PROVIDER OR SUPPLIER WOODLAND HILL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments	E 000			
F 000	An unannounced Recertification survey was conducted on 3/2/2020 through 3/5/2020. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #BWUL11.	F 000			
F 623 SS=C	INITIAL COMMENTS A recertification with complaint investigation survey was conducted 3/2/2020 through 3/5/2020. 0 of the 5 allegations were substantiated. Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (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.	F 623		4/15/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/23/2020

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 623	<p>Continued From page 1</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(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</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(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;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(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</p>	F 623			

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F 623	<p>Continued From page 2</p> <p>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</p> <p>(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.</p> <p>§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.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, family, and staff, the facility failed to notify the resident and/or Responsible Party in writing of the reason for hospital discharge for 4 of 4 sampled residents reviewed for hospitalization (Residents #10, #15, #55, and #71).</p>	F 623	<p>F623 Facility failed to document reason for transfer or discharge on the Nursing Home notice of discharge/transfer form.</p> <p>Element one: Corrective action for patients affected</p>		

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F 623	<p>Continued From page 3</p> <p>The findings included:</p> <p>1. Resident #55 was admitted to the facility on 7/20/19 with diagnoses that included epilepsy and schizophrenia.</p> <p>Resident #55 ' s medical record indicated his Responsible Party (RP) was a family member. The medical record additionally indicated Resident #55 was admitted to the hospital and discharged from the facility on 1/18/20. On 1/23/20 Resident #55 was readmitted to the facility. There was no documentation that written notice that included the reason for the hospital discharge was provided to Resident #55 and/or to his RP for this 1/18/20 hospital discharge.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 1/30/20 indicated Resident #55 ' s cognition was intact.</p> <p>On 3/4/20 at 2:25 PM, Nurse #2 was interviewed. Nurse #2 stated that the RP was notified by phone when a resident was discharged to the hospital. She indicated that a Hospital Transfer Form was sent with emergency personnel for the hospital staff and this form included the reason the resident was sent to the hospital. She reported that this form was not given to the resident and/or RP. Nurse #2 stated that she was familiar with Resident #55 and she confirmed a family member was his RP.</p> <p>On 3/4/20 at 2:43 PM during a phone interview with Resident #55 ' s RP she indicated she had not recalled receiving any written information from the facility staff that included the reason for the hospital discharge related to the resident ' s</p>	F 623	<p>Resident and/or Family of resident number 10, 15, 55 and 71 were issued a notification of transfer/ discharge form with the reason for discharge indicated on the form. This was complete on March 23, 2020 by the Administrator.</p> <p>Element two: Potential patients affected: An audit was complete for all residents discharged in the last year and found to be missing the reason for transfer. A Nursing Home notice of discharge/transfer form was mailed to those residents discharged with the reason for discharge stated. All resident discharged or transferred will receive the Nursing Home notice of discharge/transfer form with the reason for discharge written on the form. The Medical Records Coordinator will complete the form, write the reason for discharge, and the form will be brought to the Administrator to sign. Once Administrator signs the Medical Records Coordinator will mail the forms. The Administrator will ensure the reason is stated on the form prior to signing the form beginning March 12, 2020.</p>		

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F 623	<p>Continued From page 4 1/18/20 hospitalization.</p> <p>On 3/4/20 at 3:00 PM the Admissions Director was interviewed. She stated that she provided a follow up call to the resident ' s RP the next weekday after a hospitalization occurred. She reported that she had not provided the resident and/or RP with written notice that included the reason for the hospital discharge.</p> <p>An interview was conducted with the Administrator on 3/4/20 at 1:15 PM. The Administrator stated when a resident was transferred to the hospital that a Hospital Transfer Form was sent with emergency personnel for the hospital staff and this form included the reason the resident was sent to the hospital. She reported that this form was not provided to the resident and/or RP. She indicated that if a resident had an RP that a form was mailed to them that stated the date of the hospital transfer, but this form did not include the reason why the resident was transferred to the hospital. The Administrator revealed that she knew there was a regulation that required the resident and/or RP to be provided with written notice of hospital transfers/discharges, but she had not known that this written notice needed to include the reason for the hospital transfer/discharge. The Administrator indicated the form needed to be revised to include the reason for hospital transfer/discharge to meet the requirements of the regulation.</p> <p>2. Resident #15 was admitted to the facility on 1/30/19. The resident was discharged to a hospital on 12/13/19 with reentry to the facility on 12/18/19. His diagnoses included an acute infection with sepsis.</p>	F 623	<p>Element three: Procedures put in place/systemic changes/education The Nursing Home reason of discharge/transfer form will indicate the reason patients are discharged or transferred out of the facility. The form is mailed to the patient or responsible party. A copy is sent to the Ombudsman. The Medical Records Coordinator was provided education on this new procedure on or before March 2, 2020 by The Administrator. The nursing staff was inserviced regarding the need to indicate a reason for discharge/ transfer on the form when residents are transferred or discharged from the facility by Nurse Practice Educator on/or before March 28, 2020.</p> <p>Element four: Audits and QA The Medical Records Coordinator will keep a copy of the Nursing Home notice of discharge/transfer form with the reason for discharge written on the form. The Medical Records Coordinator will bring the copies of the Nursing Home notice of discharge/transfer form to the Administrator with a list of patients discharged from the facility. The Administrator will audit to ensure the notices were sent on each transfer/discharge and that a reason for discharge was noted on the form. The Administrator will audit the process daily times 2 weeks, weekly times 3weeks,</p>		

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F 623	<p>Continued From page 5</p> <p>Resident #15 ' s medical record indicated his Responsible Party (RP) was a family member. The medical record did not include documentation to indicate a written notice with the reason for his hospital discharge on 12/13/19 was provided to either Resident #15 or to his RP.</p> <p>Resident #15 ' s medical record included an annual Minimum Data Set (MDS) assessment dated 12/31/19. This assessment reported the resident had severely impaired cognitive skills for daily decision making.</p> <p>On 3/4/20 at 2:25 PM, Nurse #2 was interviewed. Nurse #2 stated that the RP was notified by phone when a resident was discharged to the hospital. She indicated that a Hospital Transfer Form was sent with emergency personnel for the hospital staff and this form included the reason the resident was sent to the hospital. She reported this form was not given to the resident and/or RP.</p> <p>An interview was conducted on 3/4/20 at 1:15 PM with the facility ' s Administrator. The Administrator stated when a resident was transferred to the hospital, a Hospital Transfer Form was sent with emergency personnel for the hospital staff. The Hospital Transfer Form included the reason the resident was sent to the hospital. However, the Administrator reported this form was not provided to the resident or RP. She indicated that if a resident had an RP, a form was mailed to them that stated the date of the hospital transfer but this form did not include the reason why the resident was transferred to the hospital. The Administrator revealed she knew a regulation required the resident and/or RP to be provided with written notice of hospital</p>	F 623	<p>monthly times 3 months and quarterly times 3 quarters. Results of audits will be reviewed monthly in Quality Assurance and Performance Improvement meetings.</p>		

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F 623	<p>Continued From page 6</p> <p>transfers/discharges, but she did not know the written notice needed to include the reason for the hospital transfer/discharge. The Administrator indicated the form needed to be revised to include the reason for hospital transfer/discharge.</p> <p>A telephone interview was conducted on 3/5/20 at 9:25 AM with Resident #15 ' s RP. Upon inquiry, the RP reported she did not believe she received written notification with the reason for the resident ' s transfer to the hospital. However, the RP also stated she was out of the country at the time of his hospitalization.</p> <p>A follow-up interview was conducted on 3/5/20 at 12:25 PM with the facility ' s Administrator. During the interview, the Administrator reported written notification of transfer/discharge was being sent out to all residents and/or their RP, including those residents transferred to the hospital. However, she acknowledged the reason for the hospital transfer was not included on the form sent out for residents discharged to the hospital.</p> <p>3. Resident #71 was admitted to the facility on 4/1/19. The resident was discharged to the hospital on 1/28/20 with reentry to the facility on 2/5/20. Her diagnoses included exacerbation of chronic obstructive pulmonary disease (COPD) and pneumonia.</p> <p>Resident #71 ' s medical record revealed she was her own Responsible Party (RP). There was no documentation to indicate a written notice with the reason for the hospital discharge (dated 1/28/20) was provided to Resident #71.</p>	F 623			

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F 623	<p>Continued From page 7</p> <p>Resident #71 ' s medical record included an annual Minimum Data Set (MDS) assessment dated 2/13/20. This assessment reported the resident had intact cognitive skills for daily decision making.</p> <p>On 3/4/20 at 2:25 PM, Nurse #2 was interviewed. Nurse #2 stated that the RP was notified by phone when a resident was discharged to the hospital. She indicated that a Hospital Transfer Form was sent with emergency personnel for the hospital staff and this form included the reason the resident was sent to the hospital. She reported this form was not given to the resident and/or RP.</p> <p>An interview was conducted on 3/4/20 at 1:15 PM with the facility ' s Administrator. The Administrator stated when a resident was transferred to the hospital, a Hospital Transfer Form was sent with emergency personnel for the hospital staff. The Hospital Transfer Form included the reason the resident was sent to the hospital. However, the Administrator reported this form was not provided to the resident or RP. She indicated that if a resident had an RP, a form was mailed to them that stated the date of the hospital transfer but this form did not include the reason why the resident was transferred to the hospital. The Administrator revealed she knew a regulation required the resident and/or RP to be provided with written notice of hospital transfers/discharges, but she did not know the written notice needed to include the reason for the hospital transfer/discharge. The Administrator indicated the form needed to be revised to include the reason for hospital transfer/discharge.</p>	F 623			

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F 623	<p>Continued From page 8</p> <p>An interview was conducted on 3/5/20 at 10:00 AM with Resident #71. Upon inquiry, the resident reported she did not receive written notification of the reason for her transfer to the hospital from 1/28/20. Resident #71 confirmed she was her own Responsible Party.</p> <p>A follow-up interview was conducted on 3/5/20 at 12:25 PM with the facility ' s Administrator. During the interview, the Administrator reported written notification of transfer/discharge was being sent out to all residents and/or their RP, including those residents transferred to the hospital. However, she acknowledged the reason for the hospital transfer was not included on the form sent out for residents discharged to the hospital.</p> <p>4) Resident #10 was originally admitted to the facility on 9/17/19 with diagnoses that included cerebrovascular accident (CVA-stroke), seizure disorder and diabetes.</p> <p>Resident #10's medical record revealed she was transferred to the hospital on 11/10/19 and readmitted back to the facility on 11/11/19. There was no documentation of a written notice of transfer was provided to the resident and/or responsible party.</p> <p>During an interview with the Social Worker on 3/4/2020 at 2:00pm, she stated she didn't provide any written information to the resident and/or responsible party when a resident was transferred to the hospital.</p>	F 623			

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F 623	Continued From page 9 On 3/4/2020 at 3:00pm the Admissions Coordinator stated she didn't provide the resident and/or responsible party with any written notice of the reason for a hospital transfer. The Administrator was interviewed on 3/4/2020 at 3:05pm and indicated she was not aware of the requirement to send written notification to the resident and/or responsible party of the reason for a hospital transfer. The Administrator revealed the facility had not provided any written information to the resident and/or responsible party when a resident was transferred from the facility to the hospital. On 3/5/2020 at 1:14pm, the Administrator and Director of Nursing stated it was their expectation for the resident and/or responsible party to be notified in writing for the reason of the hospital transfer, per the regulation.	F 623			
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		4/15/20	

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F 657	<p>Continued From page 10</p> <p>An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, the facility failed to incorporate Nursing Assistants into the care planning process for 2 of 2 residents (Residents #33 and #70) reviewed for the care plan process.</p> <p>The findings included:</p> <p>1. Resident #33 was admitted to the facility on 9/25/17 with diagnosis that included chronic obstructive pulmonary disease and heart disease.</p> <p>The annual Minimum Data Set (MDS) assessment dated 1/8/20 indicated Resident #33 's cognition was moderately impaired.</p> <p>The medical record revealed no care plan meetings were conducted for Resident #33 from 1/26/19 through 3/3/20.</p> <p>An interview was conducted with the Social Worker (SW) on 3/4/20 at 11:05 AM. The SW stated that care plan meetings were utilized to incorporate the resident and/or Responsible Party (RP) in the development and quarterly review of care plans for all residents. She indicated that the care plan meeting attendees were the resident and/or RP, herself, the MDS</p>	F 657	<p>F 657 Failure to incorporate nursing assistants into the care planning process</p> <p>Element one: Corrective action for those affected:</p> <p>Resident number 33 and 70 care plan meeting was held on or before April 15, 2020 by the interdisciplinary team to review the residents care plan together. A nursing assistant was present during these meetings. Resident's number 33 and 70 chose not to attend the care plan meeting held on March 27, 2020. A nursing assistant attended these care plan meetings.</p> <p>Element two: Potential residents affected:</p> <p>The facility process was changed and care plan meetings are held for every resident whether the responsible party or resident attends or chooses not to attend. The meetings are scheduled and letters are mailed to the responsible party or given to the resident with the date/time of the care plan meeting by the Director of Social Services. The care plan meeting</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/05/2020
NAME OF PROVIDER OR SUPPLIER WOODLAND HILL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 VISION DRIVE ASHEBORO, NC 27203		
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F 657	<p>Continued From page 11</p> <p>Coordinator, a Nursing Assistant (NA), and the department heads that were relevant to the resident ' s care plan such as dietary or therapy. The SW revealed that care plan meetings were only conducted if the resident and/or RP wanted to attend the meeting. She explained that when a meeting was not conducted that the department heads relevant to the resident ' s care plan were required to independently review the care plan on the electronic medical record when the quarterly and/or annual MDS assessments were due and they were required to electronically sign the document to indicate the review was completed. The SW reported that she had not known how Nursing Assistants were involved in the care plan review process if a meeting was not conducted.</p> <p>This interview with the SW continued. She stated that she was familiar with Resident #33. She reported that this resident and/or RP had not wished to attend a care plan meeting over the past year. She revealed that a care plan meeting had not been conducted for Resident #33 since 2018.</p> <p>An interview was conducted with the MDS Coordinator on 3/4/20 at 11:12 AM. She confirmed the SW interview that indicated a care plan meeting was not conducted if the resident and/or RP was not going to attend. She further confirmed that all department heads relevant to the resident ' s care plan were required to electronically sign the care plan quarterly to indicate it was reviewed. The MDS Coordinator revealed that NAs were not incorporated into the care plan review process if a meeting was not conducted. She stated that NAs had no access to the electronic medical record that contained the residents ' care plans.</p>	F 657	<p>will be held regardless of whether a responsible party or resident decides to attend or not to attend. Those who participated in the meetings will be documented in the medical record along with the date and time of the care plan meeting and will include the nursing assistant in attendance. This process will be in place on or before April 15, 2020.</p> <p>Element Three: Procedures put in place/systemic changes/education Care plan meetings are scheduled by the Director of Social Services per the Minimum Data Set schedule and include the interdisciplinary team. An invitation to attend the meeting is mailed to the responsible party and given to the resident. The meeting will be held and the care plan will be discussed in the care plan meeting regardless of whether the responsible party or resident attends. The interdisciplinary team were provided education on meetings being scheduled and meetings occurring for every patient due a care plan review and that a nursing assistant must attend. Education was provided by the Administrator on/or before April 15, 2020. Notation will be made on the care plan schedule list of who chose not to attend by the Director of Social Services or the Unit Manager at each meeting. The Unit Manager will ensure the nursing assistant attends care plan meetings for each meeting.</p> <p>Element four: audits and quality assurance and performance improvement The Director of Nursing, Nurse Practice Educator, Unit Manager, Nursing</p>		

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F 657	<p>Continued From page 12</p> <p>An interview was conducted with NA #6 on 3/4/20 at 11:10 AM. She stated that she had worked at the facility for over 20 years. She reported that she never reviewed the care plans for residents as the NAs had no access to the electronic medical record that contained the care plans.</p> <p>During an interview with the Administrator on 3/5/20 at 1:15 PM she stated that she was aware of the regulation that required NAs to be incorporated into the care planning process. She revealed she was not aware that care plan meetings were not being conducted if the resident and/or RP were not planning to attend the meeting. She stated that she expected all required staff to be incorporated into the care planning process.</p> <p>2. Resident #70 was admitted to the facility on 6/29/18 with diagnosis that included dementia.</p> <p>The annual Minimum Data Set (MDS) assessment dated 2/12/20 indicated Resident #70 ' s cognition was intact.</p> <p>The medical record revealed no care plan meetings were conducted for Resident #70 from 1/26/19 through 3/3/20.</p> <p>An interview was conducted with the Social Worker (SW) on 3/4/20 at 11:05 AM. The SW stated that care plan meetings were utilized to incorporate the resident and/or Responsible Party (RP) in the development and quarterly review of care plans for all residents. She indicated that the care plan meeting attendees were the resident and/or RP, herself, the MDS Coordinator, a Nursing Assistant (NA), and the department heads that were relevant to the resident ' s care plan such as dietary or therapy.</p>	F 657	<p>Supervisor, or Minimum Data Set nurse will audit the care plan list and ensure the meeting occurred and the nursing assistant attended the meeting. Audits will be conducted weekly times 3 weeks, monthly times 3 months and quarterly times 3 quarters. Results of the audits will be reviewed in the monthly quality assurance performance improvement meeting.</p>		

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F 657	<p>Continued From page 13</p> <p>The SW revealed that care plan meetings were only conducted if the resident and/or RP wanted to attend the meeting. She explained that when a meeting was not conducted that the department heads relevant to the resident ' s care plan were required to independently review the care plan on the electronic medical record when the quarterly and/or annual MDS assessments were due and they were required to electronically sign the document to indicate the review was completed. The SW reported that she had not known how Nursing Assistants were involved in the care plan review process if a meeting was not conducted.</p> <p>This interview with the SW continued. She stated that she was familiar with Resident #70. She reported that this resident and/or RP had not wished to attend a care plan meeting over the past year. She revealed that a care plan meeting had not been conducted for Resident #70 since 2018.</p> <p>An interview was conducted with the MDS Coordinator on 3/4/20 at 11:12 AM. She confirmed the SW interview that indicated a care plan meeting was not conducted if the resident and/or RP was not going to attend. She further confirmed that all department heads relevant to the resident ' s care plan were required to electronically sign the care plan quarterly to indicate it was reviewed. The MDS Coordinator revealed that NAs were not incorporated into the care plan review process if a meeting was not conducted. She stated that NAs had no access to the electronic medical record that contained the residents ' care plans.</p> <p>An interview was conducted with NA #6 on 3/4/20 at 11:10 AM. She stated that she had worked at the facility for over 20 years. She reported that</p>	F 657			

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F 657	Continued From page 14 she never reviewed the care plans for residents as the NAs had no access to the electronic medical record that contained the care plans. During an interview with the Administrator on 3/5/20 at 1:15 PM she stated that she was aware of the regulation that required NAs to be incorporated into the care planning process. She revealed she was not aware that care plan meetings were not being conducted if the resident and/or RP were not planning to attend the meeting. She stated that she expected all required staff to be incorporated into the care planning process.	F 657			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, observation, staff interviews and Nurse Practitioner interview, the facility failed to transcribe physician orders accurately for 2 of 18 sampled residents whose physician's orders were reviewed (Residents #389 and #55). The findings included: 1) Resident #389 was admitted to the facility on 2/21/2020 with diagnoses that included diabetes. The hospital discharge summary dated 2/21/2020 revealed an order for Basaglar insulin 25 units	F 658	F658 Facility failed to transcribe physician orders accurately Element one: changes for residents affected Resident number 389 The physician order was corrected to state Insulin subcutaneously and resident number 55 order for isolation that was no longer indicated was discontinued on March 4, 2020 by the Unit Manager. Element two: Potential residents affected An audit was completed for 100% of resident orders to assure the physician	4/15/20	

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F 658	<p>Continued From page 15 subcutaneously twice a day.</p> <p>The active physician orders revealed an order dated 2/21/2020 for Basaglar insulin 25 units by mouth twice a day for diabetes.</p> <p>The February 2020 and March 2020 Medication Administration Records (MAR) indicated to give 25 units of Basaglar insulin by mouth two times a day.</p> <p>On 3/4/2020 at 10:05am an interview occurred with Nurse #3 who was working on the medication cart for Resident #389's hall. She stated she was familiar with the resident and had provided his Basaglar insulin subcutaneously. Nurse #3 acknowledged the MAR read for the medication to be provided by mouth which was inaccurate.</p> <p>At 1:54pm on 3/4/2020 a phone interview was held with Nurse #4 who had transcribed the order for Basaglar insulin on 2/21/2020. She stated it was error and should have read to administer the medication subcutaneously.</p> <p>An interview was held with Nurse Practitioner #1 on 3/5/2020 at 9:50am. She reviewed the physician orders and the February 2020 and March 2020 MAR's and acknowledged the Basaglar insulin should have read to administer the medication subcutaneously. She further stated she expected medication routes to be transcribed correctly for insulin.</p> <p>The Director of Nursing was interviewed on 3/5/2020 at 1:14pm and stated she expected all medication administration routes to be transcribed correctly when the order was received</p>	F 658	<p>order was written with the appropriate route of administration and that the orders are followed through with stop dates and the orders end as stated by the physician order by the Director of Nursing, Nurse Practice Educator, Unit Manager, Nursing Supervisor and/or the Minimum Data Set nurse on or before March 24, 2020. The audit noted one G-tube order that stated PO as the route and this was corrected. The Director of Nursing, Nurse Practice Educator, Unit Manager, Supervisor, and/or Minimum Data Set nurse will print the orders daily, from the computer system, and review them to assure the route of administration is accurate, stop dates are stated and orders end as written by the physician. This process will be in place on or before March 28, 2020.</p> <p>Element three: Procedures put in place/systemic changes/education Physician orders will be reviewed daily by the Director of Nursing, Nurse Practice Educator, Unit Manager, Nursing Supervisor, and/or the Minimum Data Set nurse to ensure administration routes are stated correctly, stop dates are assigned and orders end as per the physician order. Education was provided to the Unit Manager, Nurse Practice Educator, Nursing Supervisors and the Minimum Data Set nurse on this new system by the Director of Nursing on 3/20/20. The Nurse Practice Educator or Director of Nursing provided education to the nurses on the system of ensuring the physician orders obtain the correct administration route, stop dates and that stop dates are</p>		

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F 658	<p>Continued From page 16 and/or reviewed.</p> <p>2. Resident #55 was admitted to the facility on 7/20/19 and most recently readmitted on 1/23/20 with diagnoses that included Extended Spectrum Beta-Lactamase (ESBL).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 12/31/19 indicated Resident #55 ' s cognition was intact.</p> <p>A physician ' s order dated 1/24/20 indicated Invanz (antibiotic) solution reconstituted 1 gram (gm) intravenously one time a day for 7 days. The stop date of this order was 1/31/20.</p> <p>A nursing note dated 2/3/20 indicated Resident #55 had recently completed an antibiotic and was removed from contact precautions.</p> <p>On 3/4/20 a review of the active orders for Resident #55 indicated a physician ' s order for contact precautions was initiated on 1/24/20 and continued to be an active order. This order was entered into the electronic medical record by Nurse #5.</p> <p>An observation was conducted of Resident #55 on 3/4/20 at 1:50 PM. The resident was in bed in his room and contact precautions were not in place.</p> <p>An interview was conducted with Nurse #2 on 3/4/20 at 1:55 PM. She stated that Resident #55 ' s contact precautions were only in place until his antibiotic was completed on 1/31/20. Nurse #2 reviewed Resident #55 ' s active orders and</p>	F 658	<p>stated and orders end as written by the physician. Education for all nurses will be complete by the Nurse Practice Educator on or before March 28, 2020. Nursing staff will not be allowed to work until education is provided.</p> <p>Element four: Audits and quality assurance and performance improvement The Director of Nursing, Nurse Practice Educator, Unit Manager, and/or Minimum Data Set nurse will complete audits daily that physician orders are printed, reviewed for correct administration routes, stop dates are in place and follow through of physician orders has occurred. The Director of Nursing will ensure this process is followed daily. The weekend Supervisor will print and review orders assuring medication routes are stated correctly, stop dates are assigned and orders end as per the physician order. Daily audits will be presented in monthly quality assurance performance improvement meetings monthly times 3 months.</p>		

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F 658	Continued From page 17 confirmed the contact precautions order was still active. She stated that the nurse who entered the order should have included a stop date that coincided with the antibiotic stop date. Nurse #2 went on to explain that this contact precautions order was placed under the category of "other" which meant that it was not showing up on the Medication Administration Record (MAR). She further explained that this was probably why no one had noticed that the order for contact precautions continued to be active. An interview was conducted with Nurse #5 on 3/4/20 at 4:05 PM. The active order for contact precautions for Resident #55 was reviewed with Nurse #5. Nurse #5 confirmed she entered this order into the electronic record and should have transcribed the order with a stop date that coincided with the stop date of the antibiotic. She revealed that this was a transcription error. During an interview with Nurse Practitioner #1 on 3/5/20 at 9:50 AM she stated that Resident #55 ' s stop date for contact precautions should have coincided with the stop date for his antibiotic. She reported that she expected orders to be transcribed correctly. An interview was conducted with the Administrator and Director of Nursing on 3/4/20 at 1:15 PM. The both indicated they expected physician ' s order to be transcribed with a stop date as ordered by the physician.	F 658			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		4/15/20	

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F 690	<p>Continued From page 18</p> <p>resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to secure the indwelling urinary catheter for 1 of 3 residents reviewed for urinary catheter use. (Resident #10)</p>	F 690	<p>F690 Facility failed to secure a urinary catheter to the patient's leg Element one: changes for residents affected A urinary catheter leg strap was applied to</p>		

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F 690	<p>Continued From page 19</p> <p>The findings included:</p> <p>Resident #10 was originally admitted to the facility on 9/17/19 with diagnoses that included retention of urine and a history of hydronephrosis (swelling of the kidney due to a build-up of urine).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 12/10/19 indicated Resident #10 had moderately impaired cognition. She required extensive assistance from staff for toileting and had an indwelling urinary catheter.</p> <p>Review of Resident #10's care plan dated 12/18/19 revealed a problem area for an indwelling urinary catheter due to urinary retention.</p> <p>On 3/3/2020 at 2:30pm Nurse Aide #1 (NA) was observed providing catheter care to Resident #10. A catheter securement device was not present. NA #1 stated residents with indwelling urinary catheters should have a securement device but could not explain why Resident #10 did not have one. She further stated she would let the nurse know so a securement device could be applied.</p> <p>On 3/4/2020 at 8:55am Resident #10 was observed having urinary catheter care by Nurse Aide #2. A catheter securement device was not present. NA #2 stated residents with urinary catheters should have a securement device and the NA's should let the nurses know when one wasn't present. She could not explain why Resident #10 did not have a securement device.</p> <p>Nurse #1 was interviewed on 3/4/2020 at 10:15am and explained residents with indwelling</p>	F 690	<p>patient number 10 leg on March 4, 2020 by the Nurse Manager.</p> <p>Element two: Potential residents affected Residents with a urinary catheter leg strap were assessed by the Unit Manager on March 4, 2020 and each patient who had a indwelling catheter had a leg strap noted in place.</p> <p>Element three: Procedures put in place/systemic changes/education Education was provided to the nursing staff on need for urinary catheter leg straps to be in place by Nurse Practice Educator on/or before March 28, 2020. Nursing staff not inserviced will be removed from the schedule on March 28, 2020. Patients who have urinary catheters will be indicated on the MAR and nurse will check for placement and document leg strap is in place or apply leg strap is in place and document. This system will be in place on or before March 28, 2020.</p> <p>Element four: Audits and quality assurance and performance improvement The Director of Nursing, Nurse Practice Educator, Unit Manager, Nursing Supervisor and/or Minimum Data Set nurse will audit patients with indwelling urinary catheters to ensure leg straps are secured to the patient's leg. Audits will be completed daily times 2 weeks, weekly times 3 weeks, monthly times 3 months and quarterly times 3 quarters. Results of audits will be reviewed in monthly quality assurance and performance improvement meetings.</p>		

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F 690	Continued From page 20 urinary catheters should have a securement device to prevent pulling on the catheter and accidental dislodgement. She further stated the nurse aides should have reported if there was not a catheter securement device present and had been unaware Resident #10's catheter tubing was not secured to her leg. An interview occurred with the Unit Manger #1 on 3/4/2020 at 4:15pm and stated all residents with indwelling urinary catheters are expected to have a securement device and Resident #10 had one placed earlier today. The Director of Nursing was interviewed on 3/5/2020 at 1:14pm and stated it was her expectation for indwelling urinary catheter tubing's to be secured or properly anchored to the resident's thigh to prevent accidental pulling.	F 690			
F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with resident, staff, Psychiatric Mental Health Nurse Practitioner, and Nurse Practitioner, the facility failed to provide the care planned intervention of a psychiatric consultation for a resident with a diagnosis of dementia who exhibited a pattern of paranoia, delusions, physical behavioral symptoms, and verbal behavioral symptoms for 1 of 4 residents	F 744	F744 Facility failed to provide care planned psychiatric care Element one: changes for residents affected Resident number 70 had an order reinstated on or before March 28, 2020 by the Unit Manager Element two: Potential residents affected	4/15/20	

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F 744	<p>Continued From page 21 (Resident #70) reviewed for dementia care.</p> <p>The findings included:</p> <p>Resident #70 was admitted to the facility on 6/29/18 with diagnoses that included dementia.</p> <p>On 3/4/19 Resident #70 had a care plan developed with the focus area of impaired/decline in cognitive function or impaired thought processes related to dementia. The interventions included, in part, evaluate need for psychiatric/behavioral health consultation.</p> <p>A physician ' s order for behavior monitoring for Resident #70 dated 3/4/19 indicated the nurse was to document each shift if the resident was behavior free and if behaviors were present the nurse was to document the behavior in a nursing note.</p> <p>A physician ' s order for Resident #70 dated 3/25/19 indicated 2 nurses were to verify and chart medication administration.</p> <p>On 3/25/19 Resident #70 ' s care plan related to impaired/decline in cognitive function was updated with the intervention of 2 nurses to verify medication administration for resident ' s reassurance.</p> <p>On 3/27/19 Resident #70 had a care plan developed with the focus area of the occurrence of refusing care related to cognitive loss/dementia. The interventions included, in part, evaluate need for psychiatric/behavioral health consultation and postpone care/activity if resident becomes combative or resistive.</p> <p>The quarterly Minimum Data Set (MDS)</p>	F 744	<p>Residents with behaviors were assessed on or before April 15, 2020 by the Director of Social Services and psych services are in place for these residents. Education was provided by the Administrator to the Director of Social Services to have a list of residents with psych services indicated and to reconcile the list with the physician orders. Education was provided on 3/24/20.</p> <p>Element three: Procedures put in place/systemic changes/education The Director of Social Services will print the physician's orders to ensure residents with behaviors are assessed for psych services. Any resident with behaviors without psych service orders will be offered psych services.</p> <p>Element four: Audits and quality assurance and performance improvement The Director of Social Services will audit the physician orders for patients with behaviors having psych services. Those found not to have orders for psych services will be offered these services. The audits will be completed daily times 2 weeks, weekly times 3 months and monthly thereafter. Results of these audits will be reviewed in monthly quality assurance and performance improvement meetings.</p>		

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F 744	<p>Continued From page 22</p> <p>assessment dated 4/1/19 indicated Resident #70 ' s cognition was moderately impaired. The resident reported no mood issues. She was assessed with delusions during the MDS reviewed period. Resident #70 had verbal behaviors and rejection of care on 1 to 3 days during the 7-day review period. Her active diagnoses included dementia, anxiety, and depression. Resident #70 received antidepressant medication on 6 of 7 days and antianxiety medication on 3 of 7 days.</p> <p>A physician ' s order for Resident #70 dated 4/6/19 indicated Buspar (antianxiety medication) 5 milligrams (mg) two times daily for anxiety and agitation.</p> <p>On 4/15/19 Resident #70 had a care plan developed with the focus area of exhibiting symptoms of delirium related to perceptual disturbances such as delusions. Resident #70 was noted to believe someone had stolen her cushions, believe her teeth were not hers, and believe she had not been given the correct medication. The goal of this focus area was for Resident #70 to remain free of signs/symptoms of delirium with no unexplained or rapid changes in cognition, mental status, mood, behavior, motor function, sleep patterns and/or communication ability. The interventions included, in part, evaluate need for psychiatric/behavioral health consultation, cue and supervise as needed, redirect in a calm/quiet/comforting manner, and reassure as necessary.</p> <p>A Psychiatric Mental Health Nurse Practitioner (PMHNP) note dated 4/16/19 indicated Resident #70 was seen for an initial psychiatric evaluation. She was noted with a history of depression,</p>	F 744			

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F 744	<p>Continued From page 23</p> <p>anxiety, and dementia. The Social Worker (SW) reported to the PMHNP that Resident #70 had been experiencing increased delusional thoughts that included accusing people of stealing her things, refusing medication because she believed they were poison, and thinking that someone had been coming into her room and unplugging her phone/tv/refrigerator. The PMHNP noted that paranoia/delusions were present during evaluation. The diagnoses identified by the PMHNP were major depressive disorder, moderate, stable; anxiety disorder, moderate, stable; and dementia with behaviors, moderate, worsening. The plan was to reassess in 4 weeks to determine the need for initiation of medication such as low dose Abilify (antipsychotic medication) or Risperdal (antipsychotic medication) for Resident #70 ' s paranoia/delusions.</p> <p>A PMHNP note dated 5/16/19 indicated Resident #70 was seen for a follow up visit. She was noted to experience paranoia/delusions during the visit stating that someone had taken her teeth from her. Resident #70 ' s teeth were observed by the PMHNP to be in the resident ' s mouth. Staff reported to PMHNP that resident believed staff were poisoning her, stealing her teeth, and giving her medications to cause arthritis. Resident #70 was noted with worsening dementia with behaviors, major depressive disorder, and anxiety disorder. The plan was to add Risperdal 0.25 mg at night, continue Buspar 5 mg twice daily, and continue Zoloft (antidepressant medication) 50 mg daily. Resident #70 was to have a follow up visit in 4 to 8 weeks for assessment.</p> <p>A physician ' s order for Resident #70 dated 5/16/19 indicated Risperdal 0.25 mg once daily at</p>	F 744			

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F 744	<p>Continued From page 24 bedtime for delusions.</p> <p>A Status Change Notification note completed by the Customer Service Advocate (CSA) from the psychiatric provider dated 5/16/19 indicated that Resident #70 was discontinued from all psychiatric services as she was discharged from the facility.</p> <p>The medical record indicated Resident #70 was not discharged from the facility on 5/16/19. The record also indicated that 5/16/19 was the last time Resident #70 was seen by a psychiatric provider.</p> <p>A nursing note dated 5/19/19 indicated Resident #70 was argumentative stating that she had not received her morning medication and she was unable to be re-directed or convinced otherwise.</p> <p>A note completed by the Administrator dated 5/21/19 indicated that Resident #70 continued to exhibit paranoia/delusions revolving around believing items of hers were stolen or broken when the items were observed in proper working condition in the resident 's room.</p> <p>Nursing notes dated 5/25/19 and 6/24/19 indicated Resident #70 believed she had not been given her medications and when she was assured that she received them she became verbally aggressive with staff. Two nursing staff continued to be present for medication administration.</p> <p>A nursing quarterly review note dated 6/25/19 indicated Resident #70 was alert with behaviors. She was noted with physical behaviors and verbal behaviors directed toward others up to 5 days a</p>	F 744			

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F 744	<p>Continued From page 25</p> <p>week. She was also noted with agitation, restlessness, and frustration.</p> <p>The annual MDS assessment dated 6/26/19 indicated Resident #70 ' s cognition was intact. The resident reported trouble falling asleep/staying asleep/sleeping too much and feeling tired/having little energy on 2-6 days out of the 7-day MDS review period. She was coded with no delusions and no rejection of care. Resident #70 had verbal behaviors on 1 to 3 days during the 7-day review period and the behaviors were noted to significantly impact others by disrupting care or the living environment. Resident #70 received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days.</p> <p>A nursing note dated 7/1/19 indicated Resident #70 believed she had not been given her medications and when she was assured that she received them she became verbally aggressive with staff.</p> <p>Notes completed by the Administrator dated 7/2/19 and 7/5/19 indicated Resident #70 continued to have paranoia/delusions that related to her medications being taken and/or changed by the Administrator herself. She was noted to be verbally aggressive and physically aggressive with the Administrator and was unable to be redirected or reassured.</p> <p>A nursing note dated 7/11/19 indicated Resident #70 repeatedly asked for her medications that had already been provided. She was verbally aggressive and physically aggressive with staff.</p> <p>A nursing note dated 7/13/19 indicated Resident</p>	F 744			

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F 744	<p>Continued From page 26</p> <p>#70 continued to periodically have behaviors related to her medication. She accused staff of not giving her the correct medication.</p> <p>A nursing note dated 7/14/19 indicated Resident #70 was argumentative with staff stating that she had not received her medications after they had been administered.</p> <p>A note completed by the Director of Nursing (DON) dated 7/17/19 indicated Resident #70 continued to have behaviors and was refusing medications at times.</p> <p>A nursing note dated 7/22/19 indicated Resident #70 believed she had been not been administered the correct medication. Two nursing staff were present during medication administration.</p> <p>A nursing notes dated 7/23/19 indicated Resident #70 requested medications that had already been given. The resident became verbally and physical aggressive with staff when she was assured her medications had already been given.</p> <p>The quarterly MDS assessment dated 7/24/19 indicated Resident #70 's cognition was moderately impaired. The resident reported no mood issues. She was assessed with no delusions. Resident #70 was noted to have verbal behaviors daily and rejection of care 1 -3 days out of the 7-day MDS review period. She received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days.</p> <p>Nursing notes dated 7/24/19, 7/30/19, and 8/1/19 indicated Resident #70 requested medications</p>	F 744			

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F 744	<p>Continued From page 27</p> <p>that had already been given. The resident became verbally and/or physical aggressive with staff when she was assured her medications had already been given.</p> <p>On 8/6/19 the physician ' s order from 3/4/19 for Resident #70 ' s behavior monitoring was revised to include the specific target behaviors of refusing medication, calling staff names, accusing staff of taking/moving her things, and accusing staff and providers that medication was poison.</p> <p>On 8/7/19 Resident #70 had a care plan developed with the focus area of exhibiting physical/verbal behaviors related to cognitive loss/dementia and ineffective coping skills. Resident #70 was noted to curse and kick at staff when agitated. The goal of this focus area was for Resident #70 substitute acceptable ways of expressing frustration/impatience/anger and to demonstrate the ability to seek out staff/caregiver support when feeling frustrated or provoked. The interventions included, in part, allow resident to verbalize her frustration and postpone care/activity if resident became combative or resistive.</p> <p>A nursing note dated 8/8/19 indicated Resident #70 was verbally aggressive with staff.</p> <p>Nursing notes dated 9/6/19, 9/10/19, 9/12/19, and 9/30/19 indicated Resident #70 requested medications that had already been given. The resident became verbally and/or physical aggressive with staff when she was assured her medications had already been given.</p> <p>A nursing note dated 10/2/19 indicated Resident #70 was reviewed in the At-Risk Meeting and was</p>	F 744			

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F 744	<p>Continued From page 28</p> <p>noted with continued behaviors of accusing staff of stealing things from her room and not giving her medications. Resident #70 was indicated to be followed by psychiatric services.</p> <p>Nursing notes dated 10/8/19, 10/18/19, 10/20/19, and 10/21/19, indicated Resident #70 requested medications that had already been given. The resident became verbally and/or physical aggressive with staff when she was told her medications had already been given.</p> <p>The quarterly MDS assessment dated 10/23/19 indicated Resident #70 's cognition was moderately impaired. The resident reported feeling tired/having little energy on 2-6 days out of 7. She was assessed with no delusions and no rejection of care. Resident #70 was noted to have verbal behaviors 1 -3 days out of the 7-day MDS review period. She received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days.</p> <p>A nursing note dated 11/2/19 indicated Resident #70 requested medications that had already been given. The resident became verbally aggressive with staff when she was told her medications had already been given.</p> <p>The quarterly MDS assessment dated 11/12/19 indicated Resident #70 's cognition was moderately impaired. The resident reported no mood issues. She was assessed with no delusions, no behaviors, and no rejection of care. Resident #70 received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days.</p> <p>Nursing notes dated 11/20/19, 11/22/19, 11/23/19,</p>	F 744			

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F 744	<p>Continued From page 29</p> <p>and 12/17/19 indicated Resident #70 requested medications that had already been given. The resident became verbally aggressive with staff when she was told her medications had already been given.</p> <p>A nursing note dated 1/15/20 indicated Resident #70 believed someone was trying to poison her.</p> <p>A nursing note dated 1/26/20 indicated Resident #70 stated that she either got the wrong pills or didn ' t get the pills at all. She was noted to be verbally aggressive with staff and redirection was minimally successful.</p> <p>A nursing note dated 1/30/20 indicated Resident #70 had physical behaviors toward her Nursing Assistant (NA).</p> <p>The annual MDS assessment dated 2/12/20 indicated Resident #70 ' s cognition was intact. The resident reported trouble falling asleep/staying asleep/sleeping too much and feeling tired/having little energy on 2-6 days out of the 7-day MDS review period. She was coded with no delusions and no rejection of care. Resident #70 had verbal behaviors on 1 to 3 days during the 7-day review period and the behaviors were noted to significantly impact others by disrupting care or the living environment. Resident #70 received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days.</p> <p>Nursing notes dated 2/12/20, 2/13/20, and 2/16/20 indicated Resident #70 requested medications that had already been given. The resident became verbally and/or physical aggressive with staff when she was told her</p>	F 744			

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F 744	<p>Continued From page 30</p> <p>medications had already been given.</p> <p>A Bi-annual comprehensive assessment dated 2/17/20 completed by Nurse Practitioner (NP) #2 indicated Resident #70 had worsening cognition, depression, anxiety, disorientation, and paranoia. She was assessed with vascular dementia with behaviors that included agitation and combativeness. Resident #70 also was assessed with psychoactive substance dependence, continued psychotic behaviors, and major depressive disorder with severe psychotic symptoms complicated by anxiety and paranoia. NP #2 indicated that psychiatry and psychotherapy collaboration was to continue.</p> <p>A nursing note dated 3/1/20 indicated Resident #70 was asking questions about her medications and when she was given answers she became verbally aggressive with staff.</p> <p>The NA care guide was reviewed on 3/2/20 and indicated Resident #70 had physical and verbal behaviors and would benefit from reminders to accommodate cognitive limitations.</p> <p>Resident #70 ' s March 2020 physician ' s order summary included an active order initiated on 3/25/19 for psychiatric consultation for behaviors.</p> <p>An interview was conducted with Resident #70 on 3/2/20 at 10:30 AM. The resident was observed to be calm and pleasant and she was alert and oriented to person and place with noted confusion to time and situation. Resident #70 inaccurately reported that she had never seen any psychiatric provider, nor had she seen any other type of doctor since she had been at the facility. She was unable to state how long she had resided at</p>	F 744			

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F 744	<p>Continued From page 31 the facility.</p> <p>An interview was conducted with NA #3 on 3/4/20 at 9:45 AM. She stated that she regularly worked with Resident #70. She reported that the resident frequently had verbal behaviors and physical behaviors directed toward staff. She indicated that she always attempted to calm Resident #70 with reassuring words. She stated that if this intervention was ineffective she reported to the nurse and postponed care until the resident calmed down.</p> <p>An interview was conducted with Nurse #2 on 3/3/20 at 11:10 AM. She stated that she regularly worked with Resident #70. She confirmed NA #3 's interview that Resident #70 frequently had verbal behaviors and physical behaviors directed toward staff. She explained that Resident #70 had delusions and paranoia which tended to revolve around medication and this was what normally led to the behaviors. She further explained that Resident #70 either believed she had not been given her medication or that the medication she was given was not hers. Nurse #2 reported that the delusions/paranoia tended to cycle with multiple occurrences for several days in a row with a period in between where the resident had no issues. She indicated that there had been no increase in frequency of the cycle nor an increase in the level/extent of the delusions/paranoia and/or behaviors over the past several months. Nurse #2 reported that 2 nurses were always present to administer medications to provide resident reassurance and attempt to alleviate any of her concerns. She stated that the staff tried not to argue with the resident as her beliefs about her medication were generally fixed and were unable to be changed in</p>	F 744			

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F 744	<p>Continued From page 32</p> <p>that moment. Nurse #2 reported that Resident #70 was on Risperdal to target the delusions and paranoia. She indicated she believed Resident #70 was followed by the facility 's psychiatric provider.</p> <p>During an interview with the Administrator on 3/3/20 at 1:10 PM she stated that she reviewed the Status Change Notification note dated 5/16/19 that indicated Resident #70 was discharged from psychiatric services due to facility discharge. She revealed that Resident #70 had not been discharged from the facility and that she was unsure why this happened. The Administrator stated that she had not realized until today (3/3/20) that Resident #70 had not been seen by psychiatric services since 5/16/19.</p> <p>This interview with the Administrator continued. She stated she was very familiar with Resident #70. She indicated that she herself seemed to be a trigger to the resident as the resident frequently had delusions and paranoia that involved her. She explained that Resident #70 had accused her of stealing her teeth, stealing her dentures, breaking her phone, and changing her medications. The Administrator indicated that she made a concerted effort to avoid the resident to refrain from causing her unnecessary distress.</p> <p>An interview was conducted with the SW on 3/3/20 at 3:10 PM. She stated that the normal facility process was for all residents on psychotropic medications to be followed by the psychiatric provider unless the resident and/or Responsible Party (RP) declined services. She reported that the psychiatric provider came to the facility twice per month. The SW revealed that she had not known Resident #70 was discharged</p>	F 744			

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NAME OF PROVIDER OR SUPPLIER WOODLAND HILL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 VISION DRIVE ASHEBORO, NC 27203		
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F 744	<p>Continued From page 33</p> <p>from psychiatric services in May 2019 until the Administrator told her this afternoon (3/3/20). She reported she spoke with office staff from the psychiatric provider and they confirmed Resident #70 had not been seen since 5/16/19. She indicated they were unable to say for certain why this occurred, but they believed there was a mix up with residents and the wrong resident was discharged from their services. The SW stated that Resident #70 would be seen by the psychiatric provider on their next visit to the facility.</p> <p>This interview with the SW continued. She stated that Resident #70 had verbal and physical behaviors directed toward staff. She indicated that the behaviors generally revolved around medications or believing someone had taken items of hers such as her cushions, dentures and/or teeth. She reported that Resident #70 was appropriate for psychiatric services and she should have been regularly seen by the provider.</p> <p>A phone interview was conducted with the CSA from the psychiatric provider on 3/4/20 at 8:45 AM. The Status Change Notification note dated 5/16/19 that indicated Resident #70 was discharged from psychiatric services due to facility discharge was reviewed with the CSA. The CSA stated that she was unable to say for certain why Resident #70 was discharged from services, but she assumed it may have been human error. She explained that it could have been this resident was mixed up with another resident. She confirmed that Resident #70 had not been seen by the psychiatric provider since 5/16/19, but she was placed on the list to be seen on the providers next visit to the facility.</p>	F 744			

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F 744	<p>Continued From page 34</p> <p>A phone interview was conducted with the PMHNP on 3/4/20 at 9:25 AM. She confirmed that she had not seen Resident #70 since 5/16/19. She stated that she had not realized the resident was not her caseload until her office staff notified her on 3/3/20. She reported that she reviewed her note from her 5/16/19 visit with Resident #70 and indicated that she had planned for a follow up assessment in 4-8 weeks to assess the resident after the initiation of Risperdal.</p> <p>An interview was conducted with NP #2 on 3/4/20 at 11:18 AM. She reported that Resident #70 had paranoia and delusions which tended to lead to behavioral issues. She explained that Resident #70 ' s paranoia and delusions included believing someone had stolen her medication or had given her the wrong medication. She further explained that these beliefs caused behaviors that included agitation, combativeness, and profanity. NP #2 reported that she previously wrote an order for psychiatric consultation for Resident #70. She stated that she thought Resident #70 was regularly being seen by psychiatric services until facility staff informed her on 3/3/20 that she had been mistakenly discharged from their services in May 2019. NP #2 indicated that Resident #70 was appropriate for psychiatric services due to her diagnoses of dementia with behavioral symptoms, anxiety, and major depressive disorder, as well as her delusions, paranoia, verbal and physical behavioral symptoms, and psychotropic medication use.</p> <p>A phone interview was attempted with Resident #70 ' s physician on 3/4/20 at 11:45 AM. The physician was unable to be reached.</p>	F 744			

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F 744	Continued From page 35 During an interview with the Administrator and DON on 3/5/20 at 1:15 PM they both confirmed they thought Resident #70 was being routinely seen by the psychiatric provider until the 5/16/19 discharge note was reviewed on 3/3/20. They stated that Resident #70 ' s diagnoses as well as her paranoia, delusions, and behavioral symptoms made psychiatric services a necessary intervention.	F 744			
F 755 SS=D	Pharmacy Srvc/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		4/15/20	

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F 755	<p>Continued From page 36 reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to maintain an accurate accounting of a controlled medication for 1 of 2 residents reviewed for pain (Resident #6).</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on 5/23/14 with diagnoses that included rheumatoid arthritis and osteoarthritis.</p> <p>Resident #6 ' s June 2019 physician ' s order summary indicated an order for oxycodone (opioid medication) 7.5 milligrams (mg) 4 times daily.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 6/4/19 indicated Resident #6 ' s cognition was intact. She was administered opioid medication on 7 of 7 days.</p> <p>A nursing note dated 6/13/19 at 4:29 PM completed by Nurse #6 indicated 1 missing dose of Oxycodone 7.5 mg was identified for Resident #6.</p> <p>A review of the controlled medication record for Resident #6 indicated oxycodone 7.5 mg was signed out 5 times rather than the 4 times the medication was ordered for on 6/13/19. The additional 7.5 mg of Oxycodone was signed out by Nurse #6 and an illegible time was handwritten</p>	F 755	<p>F755 Facility failed to maintain an accurate accounting of controlled medication Element one: changes for residents affected Resident number 8 narcotic declining inventory sheet correction was made by Nurse/Unit Manager on or before March 5, 2020.</p> <p>Element two: Potential residents affected 100% audit of facilities 4 narcotic declining inventory sheets were assessed by the Director of Nursing or Unit Manager on March 24, 2020. No discrepancies were noted per the facility narcotic policy.</p> <p>Element three: Procedures put in place/systemic changes/education Oncoming and offgoing hall nurse <input type="checkbox"/>s count the narcotics together at each end of shift. The facility will implement a system of a management nurse observing random narcotic count processes. The observation will be conducted by the Director of Nursing, Nurse Practice Educator, Unit Manager, Nursing Supervisor, and/or the Minimum Data Set nurse. Education was provided by the Director of Nursing for the Nurse Practice Educator, Unit Manager, Nursing Supervisor and the Minimum Data Set</p>		

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F 755	<p>Continued From page 37 on the form.</p> <p>A phone interview was conducted with Nurse #6 on 3/5/20 at 4:35 PM. Nurse #6 stated that she no longer worked at the facility. The 6/13/19 nursing note that indicated a missing dose of 7.5 mg of Oxycodone was identified for Resident #6 as well as the controlled medication record that indicated Oxycodone 7.5 mg was signed out by Nurse #6 on 1 additional time than ordered by the physician were reviewed with Nurse #6. Nurse #6 stated that she was unable to recall anything about this incident that occurred on 6/13/19. She reported that she had not recalled anything about this incident. She further reported that she had not recalled any incident in which a 7.5 mg dose of Oxycodone went missing nor any incident when Resident #6 was mistakenly administered 1 more dose than ordered.</p> <p>An interview was conducted with the Director of Nursing (DON) on 3/5/20 at 10:20 AM. The June 2019 controlled medication record and the 6/13/19 nursing note completed by Nurse #6 were reviewed with the DON. The DON stated that she had not recalled anything about this missing dose of oxycodone for Resident #6. She indicated that according to the Nurse #6 's note, she wrote that the medication was missing, but signed the controlled medication record as if the medication was administered 1 additional time than it was ordered for. She reported that Nurse #6 no longer worked at the facility. The DON was unable to provide any additional explanation.</p> <p>During a follow up interview with the DON on 3/5/20 at 1:15 PM she indicated that she expected staff to implement their system to ensure all controlled medications were accounted</p>	F 755	<p>Nurse on or before March 28, 2020. Education for the nursing staff on this process was provided on or before March 28, 2020 by Nurse Practice Educator or the Nursing Supervisor. Nursing staff that have not received training will not be allowed to work until training is complete. The Narcotic Declining Inventory sheets will be audited to assure counts are correct during the random observations by the Director of Nursing, Nurse Practice Educator, Unit Manager, Nursing Supervisor and or the Minimum Data Set Nurse.</p> <p>Element four: Audits and quality assurance and performance improvement The Director of Nursing, Nurse Practice Educator, Unit Manager, Nursing Supervisor, and/or the Minimum Data Set nurse will conduct observational audits 7 days a week on 25% of medication carts for 2 weeks, weekly times 2 weeks, monthly times 3 months and quarterly times 3 quarters. Director of Nursing will assure audits are done. Results of audits will be reviewed in monthly quality assurance performance improvement meetings.</p>		

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F 755	Continued From page 38 for. The DON reported that she was supposed to be informed of any discrepancies with controlled medications and that she had not been informed of this incident.	F 755			
F 756 SS=E	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, 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	F 756		4/15/20	

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F 756	<p>Continued From page 39</p> <p>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:</p> <p>Based on record reviews, and staff, consultant pharmacist, Nurse Practitioner, Psychiatric Mental Health Nurse Practitioner, and physician interviews, the consultant pharmacist failed to identify and report medication irregularities (Residents #71, #76, #24 and #389), failed to complete a monthly medication regimen review (Resident #71), the facility failed to act upon pharmacy recommendations in a timely manner (Residents #71, #14, and #70), and also failed to retain pharmacy consultation reports (Resident #71). This was for 6 of 6 residents reviewed for unnecessary medications.</p> <p>The findings included:</p> <p>1-a) Resident #71 was admitted to the facility on 4/1/19. Her cumulative diagnoses include chronic obstructive pulmonary disease (COPD) with acute exacerbation, cavitory lesion of the lung (cavities characterized by thick-walled, abnormal gas-filled spaces within the lung), and necrotizing pneumonia. Necrotizing pneumonia is a rare complication of pneumonia in which tissue death (necrosis) begins to occur in the lung.</p> <p>Resident #71 ' s medical record revealed she was discharged to the hospital on 5/8/19 with a diagnosis of sepsis secondary to pneumonia. Her hospital discharge summary reported the resident underwent a bronchoscopy and</p>	F 756	<p>F756 Pharmacist failed to identify and report medication irregularities, perform a monthly medication review, and facility failed to act of pharmacy recommendations</p> <p>Element one: changes for residents affected Resident number 71, 76, 24, and 389 medical charts were reviewed by the pharmacist to address any irregularities on or before April 15, 2020 by the pharmacist. The next pharmacy medical record review will be conducted on or before April 15, 2020 by the pharmacist. The Director of Nursing and Unit Managers received the recommendations on or before April 15, 2020 and completed the follow through and areas being addressed on or before April 15, 2020. Resident number 71 had a monthly medication regimen review on or before April 15, 2020 by the pharmacist and recommendations were followed through on or before April 15, 2020 by the Director of Nursing, Nurse Practice Educator, Unit Manager, Nursing Supervisor and/or the Minimum Data Set nurse. Resident number 71, 14 and 70 had pharmacy medical record review and pharmacy recommendations were</p>		

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F 756	<p>Continued From page 40</p> <p>specimens were obtained, which included Hemophilus influenza (a type of bacteria) and presumptive fungus/mold. She was started on antibiotics and 200 milligrams (mg) voriconazole (an oral antifungal medication) to be given twice daily for 3 months.</p> <p>The resident was discharged from the hospital back to the facility on 5/15/19. A review of the admission orders to the facility included 200 mg voriconazole to be given by mouth twice daily for 92 days. On 5/17/19, the consulting pulmonologist recommended changing voriconazole to itraconazole 200 mg daily (another antifungal medication). He also indicated an infectious disease consultation would need to be arranged for Resident #71.</p> <p>The resident ' s Medication Administration Records (MARs) for May, June, July, and August 2019 documented itraconazole was initiated on 5/18/19 as one-100 mg capsule provided twice daily and was continued through 8/20/19.</p> <p>Resident #71 was seen for a consultation with her infectious disease (ID) physician on 8/15/19. He noted the resident had bronchopulmonary aspergillosis (an infection, usually of the lungs, caused by the fungus Aspergillus) and recommended to stop the itraconazole and initiate the use of voriconazole to provide better activity for Aspergillus. Resident #71 ' s paper chart included a hard copy of the prescription written by her ID physician on 8/15/19 for 200 mg voriconazole to be given as one tablet (200 mg dose) by mouth two times daily. The prescription was written for 60 tablets (30 days of treatment) with two additional refills. The written prescription included a notation indicating the start date for</p>	F 756	<p>addressed on or before April 15, 2020 by the Director of Nursing, Nurse Practice Educator, Unit Manager, Nursing Supervisor and/or the Minimum Data Set nurse.</p> <p>Resident number 71 monthly medication review completed on or before April 15, 2020 by the pharmacist and follow through complete and was placed on the medical record by the Unit Manager. Subsequent medication reviews will be placed in the medical record once complete by the Unit Manager and/or the Medical Records Coordinator.</p> <p>Element two: Potential residents affected The Director of Nursing, Nurse Practice Educator, Unit Managers, Nursing Supervisors and Minimum Data Set nurse completed a 100% audit of all medical records, on or before April 15, 2020, for patients inhouse to ensure pharmacy visits were recorded, a pharmacy recommendation form was in place, irregularities were noted and follow through was complete. This audit will be complete on or before April 15, 2020. Physician orders will be reviewed every day by the Director of Nursing, Nurse Practice Coordinator, Unit Manager, Minimum Data Set Nurse, Supervisor and/or weekend Supervisor for lab orders to assure they have been drawn, followed through and in the medical record. A Pharmacist will provide oversight of current Pharmacist by reviewing 10% of the medication reviews and recommendations.</p>		

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F 756	<p>Continued From page 41</p> <p>voriconazole was 8/15/19 and the end date was 11/13/19.</p> <p>Resident #71 ' s physician orders and August 2019 MARs were reviewed. The first order entered into the facility ' s electronic medical record on 8/16/19 initiated 200 mg voriconazole for the resident to be given twice daily; no end date was specified for on this order entry. However, the order was revised on 8/16/19 to indicate voriconazole would be provided for 60 days (versus 3 months as the ID physician recommended).</p> <p>The August 2019 MAR documented voriconazole was initiated for Resident #71 on 8/16/19. Based on documentation from the resident ' s September and October MARs, the resident received voriconazole up until the morning of 10/15/19 (60 days after it had been initiated).</p> <p>A Medication Regimen Review was conducted by the facility ' s Consultant Pharmacist on 10/26/19. Documentation on that date referred to his report for comments and recommendation(s) noted. A review of the Pharmacy Consultation Report (also dated 10/26/19) revealed no reference to the discontinuation of voriconazole was made by the pharmacist in the report. No irregularity related to the discontinuation of voriconazole was documented by the pharmacist.</p> <p>On 11/12/19, the ID physician ' s office was notified Resident #71 was no longer receiving voriconazole. A recommendation was made by the ID physician to resume administration of 200 mg voriconazole twice daily and an order was written by the facility ' s NP for re-initiation of the medication. Documentation on Resident #71 ' s</p>	F 756	<p>Element three: Procedures put in place/systemic changes/education</p> <p>The facility pharmacist medication review will be completed monthly as per regulations. The Administrator will assure the pharmacy visit occurs monthly. The Pharmacist will notify the Administrator or Director of Nursing of the days he is scheduled to conduct his medical review. The Administrator or Director of Nursing will ensure the recommendations of that scheduled visit is received the day of the visit. The results of the review will be emailed to the Director of Nursing and addition copies will now be emailed to the Administrator and Unit Managers. A copy will be printed by the Unit Managers and Unit Managers will report to the Director of Nursing any recommendations not addressed each Wednesday of each week. The Director of Nursing will contact any provider that has not addressed the recommendations in 10 days of date of email. The Director of Nursing provided education to the Unit Managers, Pharmacist, Nurse Practitioners, Medical Records Coordinator, Nurse Practitioners and physicians regarding this process on or before April 10, 2020. A new process will be initiated of completing an audit of 10% of records the pharmacist reviews to assure medication irregularities are addressed. This audit will be complete by another Pharmacist within 10 days of the Pharmacy visit.</p> <p>Element four: Audits and quality assurance and performance improvement</p> <p>The current Pharmacist reviews will be</p>		

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F 756	<p>Continued From page 42</p> <p>October and November 2019 MARs indicated the resident did not receive voriconazole from 10/15/19 to 11/14/19.</p> <p>An interview was conducted on 3/4/20 at 10:15 AM with Unit Manager #2. During the interview, Resident #71 ' s consultation visits with the ID physician and implementation of his recommendations were discussed. The unit manager recalled when the resident returned from her consult appointment in August, she had a prescription for the voriconazole and she thought the prescription had a 60-day stop date on it. When asked how it was recognized the voriconazole was discontinued after 60 days of administration, Unit Manager #2 thought one of the nurses alerted her to it. Upon inquiry as to whether or not the pharmacy consultant alerted the facility voriconazole had been discontinued, the Unit Manager stated, "Not that I remember."</p> <p>A telephone interview was conducted on 3/4/20 at 2:31 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported he was unable to recall any details in regards to the 30-day lapse of voriconazole treatment for Resident #71.</p> <p>An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, concern was shared regarding the lapse of voriconazole administered to Resident #71 for approximately 1 month from mid-October to mid-November. When shown the script sent back with the resident from the ID consult on 8/15/19, the DON stated this should have at least raised questions about the 60-day duration input into the computer orders for voriconazole. The prescription from the ID</p>	F 756	<p>audited by another Pharmacist for 10% of medication reviews conducted by the Pharmacist to ensure medication irregularities are addressed. These audits will be complete monthly times 3 months and quarterly times 3 months and reported monthly in Quality Assurance and Performance Improvement meetings. The Director of Nursing will be provided each Wednesday with progress toward completion of the Pharmacist recommendations and need for her to assist by Unit Managers. The Director of Nursing will make notes of any concerns during her Wednesday audits and contact the provider for completion. The Director of Nursing will report results of Audits in monthly quality assurance and performance improvement meetings.</p>		

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F 756	<p>Continued From page 43</p> <p>physician explicitly indicated the medication had a start date of 8/15/19 and an end date of 11/13/19.</p> <p>1-b) Resident #71 was admitted to the facility on 4/1/19. Her cumulative diagnoses include chronic obstructive pulmonary disease (COPD) with acute exacerbation, cavitory lesion of the lung (cavities characterized by thick-walled, abnormal gas-filled spaces within the lung), and necrotizing pneumonia. Necrotizing pneumonia is a rare complication of pneumonia in which tissue death (necrosis) begins to occur in the lung.</p> <p>The Consultant Pharmacist ' s monthly Medication Regimen Reviews (MRRs) documented in Resident #71 ' s electronic medical record were reviewed and noted to include the following:</p> <p>--4/4/19 A medication regimen review was performed - see report for comments / recommendation(s) noted.</p> <p>--4/29/19 No irregularities found.</p> <p>--5/30/19 No irregularities found.</p> <p>--6/30/19 No irregularities found.</p> <p>--7/16/19 No irregularities found.</p> <p>--8/22/19 No irregularities found.</p> <p>--9/25/19 A medication regimen review was performed - see report for comments / recommendation(s) noted.</p> <p>--10/26/19 A medication regimen review was performed - see report for comments / recommendation(s) noted.</p> <p>--11/22/19 A medication regimen review appeared to have been initiated in the resident ' s electronic medication record. However, one of two radial buttons were required to be checked to indicate whether or not irregularities were found and recommendations were made as a result of the review. It could not be determined whether or not</p>	F 756			

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F 756	<p>Continued From page 44</p> <p>the MRR was completed.</p> <p>--12/31/19 A medication regimen review was performed - see report for comments / recommendation(s) noted.</p> <p>--2/8/20 (late entry) No irregularities found.</p> <p>--2//27/20 No irregularities found.</p> <p>A telephone interview was conducted on 3/4/20 at 2:31 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported he did not have access to the resident ' s medical records or his monthly notes at the time of the interview. He was unable to recall any details in regards to Resident #71 ' s medication regimen reviews but stated he was not aware the documentation for the 11/22/19 MRR was incomplete.</p> <p>An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, concern regarding the Consultant Pharmacist ' s MRR from 11/22/19 was discussed. The DON reported she would expect the monthly MRRs to be completed and available for review.</p> <p>1-c) Resident #71 was admitted to the facility on 4/1/19. Her cumulative diagnoses include chronic obstructive pulmonary disease (COPD) with acute exacerbation, cavitory lesion of the lung (cavities characterized by thick-walled, abnormal gas-filled spaces within the lung), and necrotizing pneumonia. Necrotizing pneumonia is a rare complication of pneumonia in which tissue death (necrosis) begins to occur in the lung.</p> <p>On 10/24/19, an order for 7.5 milligrams (mg) temazepam (an antianxiety/hypnotic medication) was received for Resident #71 with instructions to</p>	F 756			

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F 756	<p>Continued From page 45</p> <p>give as one capsule by mouth every 24 hours as needed (PRN) for insomnia. There was no documentation in the medical record to indicate an end date was specified for the PRN medication; and, there was no documentation for the rationale of using temazepam PRN for an extended duration of time. The resident ' s MAR revealed she received 5 doses of PRN temazepam between 10/24/19 - 10/31/19.</p> <p>A Medication Regimen Review (MRR) was conducted by the facility ' s Consultant Pharmacist on 10/26/19. Documentation on that date referred to his report for comments and recommendation(s) noted. A review of the Pharmacy Consultation Report (also dated 10/26/19) included the following comment: "(Resident #71) has a PRN order for an anxiolytic without a stop date: Restoril (brand name for temazepam) 7.5 mg." A recommendation was made to, "Please discontinue PRN Restoril. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period."</p> <p>Resident #71 ' s MARs revealed she received PRN temazepam 19 times in November 2019, 19 times in December 2019, and 12 times in January 2020.</p> <p>On 1/14/20, the resident ' s nurse practitioner (NP #1) responded to the Consultant Pharmacist ' s recommendations made on 10/26/19. NP #1 was identified by nursing staff from her handwriting and signature on the 10/26/19 consult form. NP #1 checked a response to indicate, "I decline the recommendation above and do not wish to</p>	F 756			

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F 756	<p>Continued From page 46</p> <p>implement any changes due to the reasons below." She handwrote, "Change Restoril 7.5 mg po (by mouth) q (every) HS (hour of sleep) to scheduled." The notation was dated 1/14/20.</p> <p>A telephone interview was conducted on 3/4/20 at 2:31 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported he did not have access to the resident ' s medical records or his monthly notes at the time of the interview. Upon further inquiry, the pharmacist reported he emailed his recommendations to the facility ' s Director of Nursing (DON) either before leaving the facility or sometimes within a few days after his consultation visits. The pharmacist also reported if he made a recommendation about a PRN psychotropic medication, he would generally regenerate the recommendation or ask the facility about it if he had not received a response back from the provider by his next monthly visit.</p> <p>Multiple unsuccessful telephone attempts were made to contact the resident ' s physician (who was also the facility ' s Medical Director) for an interview.</p> <p>An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported the facility recently changed the process for physician/Nurse Practitioner (NP) review when they identified a delay in the responses to the pharmacy recommendations. However, she also reported this process was still being reviewed and needing to be adjusted. The DON stated the process for pharmacy consults to be reviewed by the provider with recommendations implemented (as deemed appropriate by the provider) should be completed within 30 days of the Consultant Pharmacist ' s</p>	F 756			

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F 756	<p>Continued From page 47 report.</p> <p>A telephone interview was conducted on 3/5/20 at 1:25 PM with NP #1. Upon inquiry, the nurse practitioner reported she came to the facility twice a week. While at the facility, she checked her folder for any Pharmacist Consultant Reports, reviewed them, and signed the reports as they became available to her. NP #1 was hesitant to say how much time would be reasonable for the Pharmacist Consultant Reports to be made available for review and the recommendations implemented as deemed appropriate by the provider. When asked, however, the NP agreed 2 and ½ months was a long delay between when the Pharmacist Consultant Report was submitted and when it was reviewed by the provider.</p> <p>1-d) Resident #71 was admitted to the facility on 4/1/19. Her cumulative diagnoses include chronic obstructive pulmonary disease (COPD) with acute exacerbation, cavitory lesion of the lung (cavities characterized by thick-walled, abnormal gas-filled spaces within the lung), and necrotizing pneumonia. Necrotizing pneumonia is a rare complication of pneumonia in which tissue death (necrosis) begins to occur in the lung.</p> <p>The Consultant Pharmacist ' s monthly Medication Regimen Reviews (MRRs) documented in Resident #71 ' s electronic medical record were reviewed and noted to include the following: --4/4/19 A medication regimen review was performed - see report for comments / recommendation(s) noted. --4/29/19 No irregularities found. --5/30/19 No irregularities found. --6/30/19 No irregularities found.</p>	F 756			

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F 756	<p>Continued From page 48</p> <p>--7/16/19 No irregularities found.</p> <p>--8/22/19 No irregularities found.</p> <p>--9/25/19 A medication regimen review was performed - see report for comments / recommendation(s) noted.</p> <p>--10/26/19 A medication regimen review was performed - see report for comments / recommendation(s) noted.</p> <p>--11/22/19 An incomplete medication regimen review was initiated in the resident ' s electronic medication record.</p> <p>--12/31/19 A medication regimen review was performed - see report for comments / recommendation(s) noted.</p> <p>--2/8/20 (late entry) No irregularities found.</p> <p>--2/27/20 No irregularities found.</p> <p>The facility provided copies of the Consultant Pharmacist ' s recommendations made on 9/25/19 and 10/26/19 as a result of the monthly reviews conducted for Resident #71. A request was made at that time to also review the Consultant Pharmacist ' s recommendations made on 4/4/19 and 12/31/19.</p> <p>A telephone interview was conducted on 3/4/20 at 2:31 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported he did not have access to the resident ' s medical records or his monthly notes at the time of the interview. He was unable to provide any additional information regarding Resident #71 ' s MRRs or recommendations made on 4/4/19 or 12/31/19. Upon further inquiry, the pharmacist reported he emailed his recommendations to the facility ' s Director of Nursing (DON) either before leaving the facility or sometimes within a few days after his consultation visits.</p>	F 756			

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F 756	<p>Continued From page 49</p> <p>On 3/4/20 at 2:46 PM, the facility ' s Administrator reported they "could not find" the two missing recommendations (dated 4/4/19 and 12/31/19) from the Consultant Pharmacist.</p> <p>An interview was conducted on 3/4/20 at 4:15 PM with the Medical Records clerk. Upon inquiry, she reported no additional Pharmacy Consultation Reports had been found.</p> <p>An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she would expect the monthly MRRs to be completed and available for review.</p> <p>2) Resident #389 was admitted to the facility on 2/21/2020 with diagnoses that included diabetes.</p> <p>The active physician orders revealed an order dated 2/21/2020 for Basaglar insulin 25 units by mouth twice a day for diabetes.</p> <p>Review of the baseline care plan dated 2/24/2020 revealed a problem area for a diagnosis of diabetes.</p> <p>The February 2020 and March 2020 Medication Administration Records (MAR) indicated to give 25 units of Basaglar insulin by mouth two times a day.</p> <p>Resident #389's medical record revealed a monthly medication review was completed by the consultant pharmacist on 2/26/2020 and no irregularities were found.</p>	F 756			

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F 756	<p>Continued From page 50</p> <p>On 3/4/2020 at 10:05am an interview occurred with Nurse #3 who was working on the medication cart for Resident #389's hall. She stated she was familiar with the resident and had provided his Basaglar insulin subcutaneously. Nurse #3 acknowledged the MAR read for the medication to be provided by mouth which was inaccurate.</p> <p>On 3/4/2020 at 3:05pm, a phone interview was conducted with the facility's consultant pharmacist. The pharmacist stated the error in the administration route of the resident's Basaglar Insulin should have been identified as an irregularity on the resident's monthly medication review completed on 2/26/20 and was most likely an oversight.</p> <p>The Administrator and Director of Nursing were interviewed on 3/5/2020 at 1:14pm and stated they expected the facility's consultant pharmacist to alert staff to errors in administration routes during his monthly medication reviews.</p> <p>3. Resident #76 was admitted to the facility on 9/11/2018 with diagnoses that included major depressive disorder and anxiety disorder.</p> <p>Resident #76 had a physician's order for 25 milligrams (mgs) of Quetiapine Fumarate (Seroquel) by mouth every morning and a hemoglobin A1C level to be drawn every three months with a start date of 2/8/2019.</p> <p>Resident #76's February 2020 Medication Administration Record (MAR) revealed the resident received 25mg of Quetiapine Fumarate by mouth every morning at 9:00am. The MAR</p>	F 756			

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F 756	<p>Continued From page 51</p> <p>also indicated the resident was to have a hemoglobin A1C level drawn every three months on the 8th of February, May, August, and November. The resident's MAR for February 8th 2020 was blank, indicating the labs were not drawn.</p> <p>During a record review, laboratory results could not be found for hemoglobin A1C level during the month of February 2020. The most recent hemoglobin A1C level for Resident #76 was drawn on 11/8/2019.</p> <p>Record review indicated the consult pharmacist completed a monthly review of Resident #76's medications on 2/26/2020 and noted no irregularities and no new recommendations.</p> <p>On 03/04/2020 at 10:27am an interview was conducted with the Director of Nursing (DON) regarding results of the hemoglobin A1C that was ordered to be drawn in February 2020. She stated she could not find any results that would indicate the lab was drawn and was not sure why it was not drawn.</p> <p>On 03/05/2020 at 9:59am during an interview with the facility's Nurse Practitioner, (NP) she stated Quetiapine Fumarate or Seroquel is known to cause hyperglycemia in patients, both those with diabetes and those without diabetes so recommendations suggest checking hemoglobin A1C levels to monitor for this. She did not feel that missing the labs had endangered the resident as he had no signs or symptoms of hyperglycemia reported while in the facility. She further stated she had given the nurses an order to draw the missed lab that day.</p>	F 756			

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F 756	<p>Continued From page 52</p> <p>During an interview with the consultant pharmacist on 03/04/2020 at 3:03pm he stated he did not recommend checking hemoglobin A1C levels with the use of Quetiapine Fumarate, that was not a typical order. The consultant pharmacist stated he did not review the physician orders for Resident #76 when conducting the medication review in February 2020.</p> <p>4. Resident #24 was admitted to the facility on 11/6/2016 with diagnoses that included dementia, major depressive disorder, and diabetes type 2.</p> <p>Record review revealed a physician's order dated 4/6/2019 that read, draw hemoglobin A1C next lab day and every 3 months while receiving Seroquel, every 3 months on the 6th of the month.</p> <p>The resident's January 2020 Medication Administration Record (MAR) indicated the resident received Seroquel at 12.5 milligrams (mg) by mouth in the morning and 25mg by mouth in the evening for psychosis. The MAR also indicated a hemoglobin A1C should be drawn every three months on the 6th of the month. The January 2020 MAR revealed the initials of Nurse # 7, indicating the hemoglobin A1C lab was drawn.</p> <p>Laboratory results for Resident #24 did not reveal results for a hemoglobin A1C in January 2020.</p> <p>The consultant pharmacist conducted a monthly review of Resident #24's medications on 1/31/2020 and indicated no irregularities and no new recommendations. The consultant pharmacist completed a monthly review of the</p>	F 756			

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F 756	<p>Continued From page 53</p> <p>resident's medications on 2/27/2020 with the only recommendations being a gradual dose reduction of Xanax.</p> <p>On 03/04/2020 at 10:27am an interview was conducted with the Director of Nursing (DON) regarding results of the hemoglobin A1C that should have been drawn in January 2020. She stated she could not find any results that would indicate the lab was drawn.</p> <p>03/05/20 12:35 PM a phone interview was conducted with Physician #2. He stated the resident had diabetes type 2 and was on Seroquel. The recommendations are to monitor hemoglobin A1C in these patients due to the side effect of hyperglycemia. He further stated he did not feel the resident suffered any harm from not having the lab completed as ordered.</p> <p>During an interview with the consultant pharmacist on 03/04/2020 at 3:03pm he stated he did not recommend checking hemoglobin A1C levels with the use of Quetiapine Fumarate or Seroquel, that was not a typical order. The consultant pharmacist stated he did not review the physician orders for Resident #24 when conducting the medication review in January 2020 or February 2020.</p> <p>5. Resident #14 was admitted to the facility on 2/22/2017 with diagnoses that included anxiety disorder, major depressive disorder, and cerebral infarct (stroke).</p> <p>Resident #14s May 2019 Medication Administration Record (MAR) indicated on 5/27/2019 there was a written order for Haldol 0.5mg by mouth every 4 hours as needed for</p>	F 756			

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F 756	<p>Continued From page 54</p> <p>agitation and restlessness and a written order for Ativan 0.5mg by mouth every 8 hours as needed for agitation and restlessness.</p> <p>The monthly medication review by the pharmacist completed on 5/30/2019 recommended discontinuing the order for as needed Haldol or adding a stop date that did not exceed 14 days.</p> <p>The monthly medication review completed by the consult pharmacist on 6/30/2019 also recommended discontinuing the order for as needed Haldol and Ativan or adding a stop date that did not exceed 14 days.</p> <p>The monthly medication review for Resident #14 completed by the consultant pharmacist on 7/16/2019 indicated no irregularities and no new recommendations.</p> <p>The August 2019 medication review on 8/16/2019 recommended an Abnormal Involuntary Movement Scale (AIMS) be completed with the use of Haldol.</p> <p>The September 2019 medication review dated 9/25/2019 for Resident #14 completed by the consultant pharmacist read, "repeated recommendation" to discontinue as needed orders for Ativan and Haldol or place a stop date that did not exceed 14 days. This order was acknowledged/signed by the NP on 9/25/2019.</p> <p>Resident #14's monthly MARs from June 2019 through September 25, 2019 indicated the as needed orders for both the Ativan and Haldol without stop dates remained on the resident's medication administration record. The MARs indicted the resident was not administered any of</p>	F 756			

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F 756	<p>Continued From page 55</p> <p>the as needed orders of the Ativan or Haldol.</p> <p>On 3/4/2020 at 12:23pm an interview was conducted with Nurse Practitioner (NP) #2 who signed the and acknowledged the September 25th pharmacy recommendation. She stated she acted on the recommendation as soon as she was made aware. She stated she did not receive the 5/30/2019 or the 6/30/2019 pharmacy recommendations to stop the as needed orders for Ativan and Haldol until 9/25/2019. She explained that the recommendation were being put into a folder in the physician's box and were not getting to her or the physician. She stated she was made aware of the issue in September 2019 and it had been corrected. She further stated she was aware when Ativan or Haldol were written as needed, they would require a stop date of no more than 14 days.</p> <p>A phone interview with Physician #2 was conducted on 03/05/20 12:35pm in which he stated the facility had been told to fax pharmacy recommendations to him if the NP was not in the building to address them on the day the recommendation was received by the facility. He stated he was not aware of the delay in acknowledging and acting on the pharmacy recommendations from May 2019 and June 2019 and is not sure why that would have occurred.</p> <p>On 03/04/2020 at 3:03pm at phone interview was conducted with the consult pharmacist in which he stated if the as needed orders for Ativan and Haldol remained on the resident's MAR in July and August, and he did not make a repeat recommendation to discontinue them or make them 14 days in duration, then it was most likely an oversight.</p>	F 756			

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F 756	<p>Continued From page 56</p> <p>6. Resident #70 was admitted to the facility on 6/29/18 with diagnosis that included dementia.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 10/23/19 indicated Resident #70 ' s cognition was moderately impaired. She was assessed with verbal behaviors on 1 to 3 days and her active diagnoses included dementia, anxiety, and depression. Resident #70 received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days.</p> <p>A pharmacy recommendation dated 10/26/19 indicated Resident #70 had received Risperdal (antipsychotic medication) 0.25 milligrams (mg) at bed time since 5/16/19 and a Gradual Dose Reduction (GDR) was recommended to change Risperdal to 0.125 mg at bed time. Nurse Practitioner (NP) #2 signed the recommendation as declined on 1/3/20.</p> <p>A pharmacy recommendation dated 1/31/20 indicated Resident #70 had received Buspar (antianxiety medication) 5 mg twice daily since 4/6/19 and a GDR was recommended to change Buspar to 7.5 mg once daily. The Psychiatric Mental Health Nurse Practitioner (PMHNP) signed her acceptance of this recommendation on 2/6/20. A review of the physician ' s orders indicated that Resident #70 ' s Buspar remained at 5 mg twice daily until 3/2/20 when it was reduced to 7.5 mg once daily.</p> <p>A phone interview was conducted with the Pharmacy Consultant on 3/4/20 at 3:00 PM. He reported that he expected his recommendations to be reviewed, responded to, and acted upon (if applicable) by the time of his next monthly Medication Regimen Review (MRR).</p>	F 756			

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F 756	Continued From page 57 An interview was conducted with the Director of Nursing (DON) on 3/4/20 at 11:30 AM. She stated that she received the pharmacy recommendations by fax from the Pharmacy Consultant. She indicated that they recently changed the normal process for physician/Nurse Practitioner (NP) review when they identified a delay in the responses to the pharmacy recommendations. She explained that prior to the change, the previous process was for the recommendations to be placed in the physicians ' folders that were kept at each nurse ' s station. The DON stated that the physicians (2 primary physicians who came to the facility) were not in the facility weekly as their NPs (2 NPs came to the facility) were in the facility multiple times per week. She further stated that when the physicians were in the facility they were not always reviewing the recommendations that were in their folders. She revealed that this was why some of the recommendations were not responded to for 2 or more months. She stated that sometime after the beginning of 2020 the process was changed so that all pharmacy recommendations not related to psychotropic medications were given to the Unit Managers (UMs) to put directly into the NPs ' folders rather than the physicians ' folders. She reported that all pharmacy recommendations for psychotropic medications were given to the Social Worker (SW) to provide to the PMHNP for her review, the PMHNP then gave them back to the SW, and the SW gave the recommendations to the UMs to place in the appropriate NP folder for final review prior to implementing any changes. The DON revealed that although the process had been changed, it had not completely resolved the problem as there were still recommendations that	F 756			

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F 756	<p>Continued From page 58</p> <p>were taking over a month to be reviewed, responded to, and/or acted upon.</p> <p>A phone interview was attempted with Resident #70 ' s physician on 3/4/20 at 11:45 AM. The physician was unable to be reached.</p> <p>A phone interview was conducted with the PMHNP on 3/4/20 at 9:25 AM. The pharmacy recommendation dated 1/31/20 related to Resident #70 ' s Buspar signed by the PMHNP on 2/6/20 and the Buspar GDR implemented on 3/2/20 in accordance with the recommendation were reviewed with the PMNHP. She stated that she normally reviewed pharmacy recommendations while she was at the facility, but on 2/6/20, there was a problem with the electronic medical records system due to a storm, so she took the recommendations with her and she brought them back on her next visit to the facility on 2/20/20 and gave them to the SW. The PMHNP was unable to say why the recommendation was not implemented until 3/2/20.</p> <p>An interview was conducted with the SW on 3/4/20 at 9:49 AM. The pharmacy recommendation dated 1/31/20 related to Resident #70 ' s Buspar signed by the PMHNP on 2/6/20 and the Buspar GDR implemented in accordance with the recommendation on 3/2/20 were reviewed with the SW. The SW reported that she recalled the PMHNP had to take the recommendations out of the facility for review as there was a problem with the electronic medical records system on 2/6/20. She stated that the PMHNP returned the recommendations to her on 2/20/20. She was unable to recall for certain when she gave the recommendations to the UMs,</p>	F 756			

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F 756	<p>Continued From page 59</p> <p>but she believed it would have been 2/25/20 at the latest. The SW was unable say why the recommendation was not implemented until 3/2/20.</p> <p>An interview was conducted with UM #2 on 3/3/20 at 3:30 PM. The pharmacy recommendation dated 1/31/20 related to Resident #70 ' s Buspar signed by the PMHNP on 2/6/20 and the GDR implemented on 3/2/20 in accordance with the recommendation were reviewed with UM #2. UM #2 stated that she first saw the recommendation on 2/28/20 and she put it in NP #2 ' s folder that afternoon. She explained that NP #2 requested a final review of all pharmacy recommendations prior to the implementation of any changes. She indicated that since the form was not in NP #2 ' s folder until the afternoon of 2/28/20, it was not seen by NP #2 until the following weekday, 3/2/20.</p> <p>An interview was conducted with NP #2 on 3/4/20 at 11:18 AM. She stated that she was at the facility 3 times a week and she reviewed, responded to, and acted upon (if applicable) pharmacy recommendations that were placed in her folder every time she was in the facility. The pharmacy recommendation dated 10/26/19 related to Resident #70 ' s Risperdal that was signed by NP #2 on 1/3/20 was reviewed. She reported that when she signed this recommendation on 1/3/20 she had just received it in her folder. The pharmacy recommendation dated 1/31/20 related to Resident #70 ' s Buspar signed by the PMHNP on 2/6/20 and the 3/2/20 Buspar GDR implemented in accordance with the recommendation were reviewed with NP #2. NP #2 indicated that she received this recommendation for review on 3/2/20. She</p>	F 756			

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F 756	Continued From page 60 explained that the PMHNP was given this recommendation for initial review and she completed a final review prior to implementation of any changes. She stated that once she reviewed the recommendation on 3/2/20 she agreed with the change and she gave the order to GDR Buspar. This interview with NP #2 continued. She stated that her expectation was for the pharmacy consultant to provide the facility with the recommendations on the date he completed the MRR and for the facility staff to put the recommendations in her folder as soon as they were provided with them. She further stated if the PMHNP was reviewing a recommendation for psychotropic medication, then the reviewed recommendation should be placed in her folder as soon as the PMHNP 's review was completed. NP #2 stated that there was no reason why it should take over a month for her to be given the pharmacy recommendations. During an interview with the Administrator and DON on 3/5/20 at 1:15 PM they both acknowledged that there was no system in place to ensure a timely review of pharmacy recommendations were completed by the medical provider. They indicated they had been working on revamping this process, but revealed it was still a work in progress.	F 756			
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		4/15/20	

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F 758	<p>Continued From page 61</p> <p>but are not limited to, drugs in the following categories:</p> <p>(i) Anti-psychotic;</p> <p>(ii) Anti-depressant;</p> <p>(iii) Anti-anxiety; and</p> <p>(iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§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;</p> <p>§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;</p> <p>§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</p> <p>§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.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic</p>	F 758			

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F 758	<p>Continued From page 62</p> <p>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:</p> <p>Based on record reviews, staff interviews and physician and nurse practitioner interviews, the facility failed to monitor labs for psychotropic medications as ordered (Residents #76 and #24) and orders written for as needed use of psychotropic medications were time limited (Residents #14 and #71) for 4 of 6 sampled residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>1) Resident #76 was admitted to the facility on 9/11/2018 with diagnoses that included major depressive disorder and anxiety disorder.</p> <p>Resident #76 had a physician's order for 25 milligrams (mgs) of Quetiapine Fumarate (Seroquel) by mouth every morning and a hemoglobin A1C level to be drawn every three months with a start date of 2/8/2019.</p> <p>Resident #76's February 2020 Medication Administration Record (MAR) revealed the resident received 25mg of Quetiapine Fumarate by mouth every morning at 9:00am. The MAR also indicated the resident was to have a hemoglobin A1C level drawn every three months on the 8th of February, May, August, and November. The resident's MAR for February 8th 2020 was blank, indicating the labs were not drawn.</p> <p>The resident's most recent quarterly Minimum</p>	F 758	<p>F758 Facility failed to monitor labs for psychotropic medications as ordered and as needed medications were not time limited</p> <p>Element one: changes for residents affected</p> <p>Resident number 76 and 24 ordered labs for hemoglobin A1C level was drawn on or before March 28, 2020 by the Laboratory witnessed by the Unit Manager. The Nurse Practitioner was notified of the lab results, addressed and the results were placed in the medical record. Resident number 14 and 71 as needed medications were addressed by the Nurse Practitioner and the 14 day limit was added to the orders on or before March 28, 2020.</p> <p>Element two: Potential residents affected</p> <p>The Unit Manager reviewed 100% of residents with lab orders for completion as ordered and 14 day limits set on/or April 15, 2020. The Unit Manager will review Physician orders in morning meetings for the presence of labs ordered and that lab test have been logged into the lab log and that the lab test is drawn and completed. Any psychotropic medication that is on an as needed medication has a time limit written for them on or before April 15, 2020 by the Nurse Practitioner or the Medical Doctor. Education was provided to the Unit Manager by the Director of</p>		

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F 758	<p>Continued From page 63</p> <p>Data Set (MDS) dated 2/18/2020 indicated the resident was coded as receiving antipsychotics, antidepressants, and anti-anxiety medications 7 out of 7 days during the assessment period.</p> <p>During a record review, laboratory results could not be found for hemoglobin A1C level during the month of February 2020. The most recent hemoglobin A1C level for Resident #76 was drawn 11/8/2019.</p> <p>On 03/04/2020 at 10:27am an interview was conducted with the Director of Nursing (DON) regarding results of the hemoglobin A1C that was ordered to be drawn in February 2020. She stated she could not find any results that would indicate the lab was drawn and was not sure why it was not drawn.</p> <p>An interview was conducted with the unit manager on 03/05/2020 at 10:27am. She stated the nurse who worked on the first shift on 3/5/2020 should have seen the order for the hemoglobin A1C on the resident's MAR for 02/08/, filled out a requisition form, and had it ready for the lab technician when she/he came to the facility to draw the labs. If the lab technician did not come during first shift, then the first shift nurse should have passed on the information and the requisition form to the oncoming nurse. She stated the nurse working February 8th works weekends only and may not have known the process for completing labs.</p> <p>Attempts to contact the nurse, who worked on the first shift of 02/08/20, during the survey were not successful.</p> <p>On 03/05/2020 at 9:59am during an interview with</p>	F 758	<p>Nursing on or before April 15, 2020.</p> <p>Element three: Procedures put in place/systemic changes/education The Unit Manager will review psychotropic medications orders in morning meetings beginning on or before March 28, 2020. Psychotropic medication orders will be reviewed for the presence of the 14 day stop date. The Unit Manager will review all lab orders in morning meeting to assure they are logged on the lab log and that they are completed. Any psychoactive medications that are as needed will be reviewed to ensure the 14 day stop date has been added to the order by the Unit Manager. Any psychotropic medications that do not have 14 day stop dates will be brought to the attention of the Nurse Practitioner or the Medical Doctor so they can address them. This will occur daily in morning meeting. The Nurse Practice Educator or Director of Nursing will provide education to the Unit Managers on the lab log system and the 14 day stop date rule on or by March 28, 2020. The Nurse Practice Coordinator will educate the unit nurses on the 14 day stop day on as needed psychoactive medications on or before March 28, 2020.</p> <p>Element four: Audits and quality assurance and performance improvement The Director of Nursing, Nurse Practice Educator, Unit Manager, Nursing Supervisor and/or Minimum Data Set nurse will audit the lab logs for labs ordered and 14 day as needed</p>		

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F 758	<p>Continued From page 64</p> <p>the facility's Nurse Practitioner, (NP) she stated Quetiapine Fumarate or Seroquel is known to cause hyperglycemia in patients, both those with diabetes and those without diabetes so recommendations suggest checking hemoglobin A1C levels to monitor for this. She did not feel that missing the labs had endangered the resident as he had no signs or symptoms of hyperglycemia reported while in the facility. She further stated she had given the nurses an order to draw the missed lab that day.</p> <p>On 03/05/2020 at 12:25pm an interview was conducted with the facility's administrator and the DON in which they stated they expected physician ordered labs to be drawn per physician's orders.</p> <p>2) Resident #24 was admitted to the facility on 11/6/2016 with diagnoses that included dementia, major depressive disorder, and diabetes type 2.</p> <p>The resident's most recent quarterly Minimum Data Set (MDS), dated 1/2/2020 revealed the resident was coded as having had antipsychotic, antianxiety, and antidepressant medications 7 out of 7 days during the assessment period. Resident #24 was also coded as having received insulin 6 out of 7 days during the assessment period.</p> <p>Record review revealed a physician's order dated 4/6/2019 that read, draw hemoglobin A1C next lab day and every 3 months while receiving Seroquel, every 3 months on the 6th of the month.</p> <p>The resident's January 2020 Medication Administration Record (MAR) indicated the resident received Seroquel at 12.5 milligrams</p>	F 758	<p>medication stop dates daily times 2 weeks, weekly times 2 weeks, monthly times 3 months and quarterly times 3 quarters. The results of the audits will be reviewed in the monthly quality assurance and performance improvement meetings.</p>		

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F 758	<p>Continued From page 65</p> <p>(mg) by mouth in the morning and 25mg by mouth in the evening for psychosis. The MAR also indicated a hemoglobin A1C should be drawn every three months on the 6th of the month. The January 2020 MAR revealed the initials of Nurse # 7, indicating the hemoglobin A1C lab was drawn.</p> <p>Laboratory results for Resident #24 did not reveal results for a hemoglobin A1C in January 2020.</p> <p>On 03/04/2020 at 10:27am an interview was conducted with the Director of Nursing (DON) regarding results of the hemoglobin A1C that should have been drawn in January 2020. She stated she could not find any results that would indicate the lab was drawn and she was uncertain why Nurse #7 would have signed off the MAR without completing the labs.</p> <p>An interview was conducted with the unit manager on 03/05/2020 at 10:27am she stated the nurse who worked on the first shift on 3/5/2020 should have seen the order for the hemoglobin A1C on the resident's MAR for 02/08/20, filled out a requisition form, and had it ready for the lab technician when she/he came to the facility to draw the labs. If the lab technician did not come during first shift, then the first shift nurse should have passed on the information and the requisition form to the oncoming nurse. She stated the nurse working February 8th works weekends only and may not have known the process for completing labs.</p> <p>Attempts to contact Nurse #7 during the survey were unsuccessful.</p> <p>03/05/20 12:35 PM a phone interview was</p>	F 758			

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F 758	<p>Continued From page 66</p> <p>conducted with Physician #2. He stated the resident had diabetes type 2 and was on Seroquel. The recommendations are to monitor hemoglobin A1C in these patients due to the side effect of hyperglycemia. He further stated he did not feel the resident suffered any harm from not having the lab completed as ordered.</p> <p>On 03/05/2020 at 12:25pm an interview was conducted with the facility's administrator and the DON in which they stated they expected physician ordered labs to be drawn per physician's orders.</p> <p>3) Resident #14 was admitted to the facility on 2/22/2017 with diagnoses that included anxiety disorder, major depressive disorder, and cerebral infarct (stroke).</p> <p>Resident #14's May 2019 Medication Administration Record (MAR) indicated on 5/27/2019 there was a written order for Haldol 0.5mg by mouth every 4 hours as needed for agitation and restlessness and a written order for Ativan 0.5mg by mouth every 8 hours as needed for agitation and restlessness.</p> <p>The monthly medication review by the pharmacist completed on 5/30/2019 recommended discontinuing the order for as needed Haldol or adding a stop date that did not exceed 14 days.</p> <p>The monthly medication review completed by the consult pharmacist on 6/30/2019 also recommended discontinuing the order for as needed Haldol and Ativan or adding a stop date that did not exceed 14 days.</p> <p>The September 2019 medication review dated</p>	F 758			

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F 758	<p>Continued From page 67</p> <p>9/25/2019 for Resident #14 completed by the consultant pharmacist read, "repeated recommendation" to discontinue as needed orders for Ativan and Haldol or place a stop date that did not exceed 14 days. This order was acknowledged/signed by the NP on 9/25/2019.</p> <p>Resident #14's monthly MARs from June 2019 through September 25, 2019 indicated the as needed orders for both the Ativan and Haldol without stop dates remained on the resident's medication administration record. The MARs indicted the resident was not administered any of the as needed orders of the Ativan or Haldol.</p> <p>On 3/4/2020 at 12:23pm an interview was conducted with Nurse Practitioner (NP) #2 who signed the and acknowledged the September 25th pharmacy recommendation. She stated she acted on the recommendation as soon as she was made aware. She stated she did not receive the 5/30/2019 or the 6/30/2019 pharmacy recommendations to stop the as needed orders for Ativan and Haldol until 9/25/2019. She explained that the recommendation were being put into a folder in the physician's box and were not getting to her or the physician. She stated she was made aware of the issue in September and it had been corrected. She further stated she was aware when Ativan or Haldol were written as needed, they would require a stop date of no more than 14 days.</p> <p>A phone interview with Physician #2 was conducted on 03/05/20 12:35pm in which he stated the facility has been told to fax pharmacy recommendations to him if the NP is not in the building to address them on the day the recommendation was received by the facility. He</p>	F 758			

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F 758	<p>Continued From page 68</p> <p>stated he was not aware of the delay in acknowledging and acting on the pharmacy recommendations from May and June and is not sure why that would have occurred.</p> <p>4-a). Resident #71 was admitted to the facility on 4/1/19. Her cumulative diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder, anxiety disorder, and insomnia.</p> <p>The resident ' s medical record included a physician ' s order initiated on 7/16/19 for 7.5 milligrams (mg) temazepam (a hypnotic used to treat insomnia) to be given as 1 capsule by mouth every 24 hours as needed (PRN) for insomnia. There was no documentation in the medical record to indicate an end date was specified for the PRN medication; and, there was no documentation for the rationale of using temazepam PRN for an extended duration of time.</p> <p>Resident #71's Medication Administration Records (MARs) revealed the resident did not receive PRN temazepam in either July or August of 2019. She did receive PRN temazepam 14 times in September 2019.</p> <p>A Pharmacist Consultation Report dated 9/25/19 indicated Resident #71 had a PRN order for a sedative/hypnotic (7.5 mg temazepam) which had been in place for greater than 14 days without a stop date. The provider responded to the recommendation on 10/3/19 and discontinued this medication. Based on the resident ' s MAR, she received PRN temazepam 2 times between</p>	F 758			

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F 758	<p>Continued From page 69 10/1/19 and 10/3/19.</p> <p>On 10/8/19, 7.5 mg temazepam was ordered by the provider to be given as one capsule by mouth every 24 hours as needed for insomnia for a period of 14 days. Resident #71 ' s MAR indicated she received 8 doses of PRN temazepam between 10/8/19 and 10/22/19.</p> <p>On 10/24/19, PRN temazepam was re-ordered for Resident #71 with instructions to give as one capsule (7.5 mg) by mouth every 24 hours as needed for insomnia. There was no documentation in the medical record to indicate an end date was specified for the PRN medication; and, there was no documentation for the rationale of using temazepam PRN for an extended duration of time. The resident ' s MAR revealed she received 5 doses of PRN temazepam between 10/24/19 - 10/31/19.</p> <p>Resident #71 ' s medical record included a quarterly Minimum Data Set (MDS) assessment dated 11/19/19. This assessment revealed the resident had intact cognitive skills for daily decision making. No rejection of care nor behaviors were reported. The MDS indicated Resident #71 received a hypnotic medication on 3 out of 7 days during the look back period.</p> <p>Resident #71 ' s MARs revealed she received PRN temazepam 19 times in November 2019, 19 times in December 2019, and 12 times in January 2020.</p> <p>The PRN order for temazepam initiated on 10/24/19 continued until 1/14/20. At that time, temazepam was ordered to be given on a scheduled (versus as needed) basis in response</p>	F 758			

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F 758	<p>Continued From page 70</p> <p>to a Pharmacy Consultation Report dated 10/26/19. The consultation report recommended PRN temazepam be discontinued.</p> <p>A telephone interview was conducted on 3/4/20 at 2:31 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported he did not have access to the residents ' medical records or his notes at that time. The pharmacist reported if he made a recommendation about a PRN psychotropic medication, he would generally regenerate the recommendation or ask the facility about it if he had not received a response back from the provider by his next monthly visit.</p> <p>Multiple unsuccessful attempts were made to contact the facility ' s Medical Director by telephone for an interview.</p> <p>An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported nursing staff tried to watch for PRN psychotropics used beyond 14 days. Although this was an issue previously identified by the facility, the DON reported a plan of correction had not been developed to ensure orders for PRN psychotropics included an acceptable end date.</p> <p>4-b) Resident #71 was admitted to the facility on 4/1/19. Her cumulative diagnoses included chronic obstructive lung disease (COPD), major depressive disorder, anxiety disorder, and insomnia.</p> <p>Resident #71 ' s medical record included a quarterly Minimum Data Set (MDS) assessment dated 11/19/19. This assessment revealed the resident had intact cognitive skills for daily</p>	F 758			

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F 758	<p>Continued From page 71</p> <p>decision making. No rejection of care nor behaviors were reported.</p> <p>The resident ' s medical record included a physician ' s order with a start date of 12/12/19 for 0.5 milligrams (mg) lorazepam (an antianxiety medication) to be given as 1 tablet by mouth every 8 hours as needed (PRN) for anxiety/sleep distress. There was no documentation in the medical to indicate an end date for the medication; and, there was no documentation for the rationale of using lorazepam for an extended duration of time.</p> <p>Resident #71's Medication Administration Records (MARs) revealed the resident received PRN lorazepam 3 times in December 2019 and 1 time in January 2020.</p> <p>The PRN order for lorazepam initiated on 12/12/19 was continued until the resident was discharged to a hospital on 1/28/20.</p> <p>A telephone interview was conducted on 3/4/20 at 2:31 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported he did not have access to the residents ' medical records or his notes at that time. The pharmacist was unable to recall details of his medication regimen reviews for Resident #71. However, he reported if a recommendation was made about a PRN psychotropic medication, he would generally regenerate the recommendation or ask the facility about it if he had not received a response back from the provider by his next monthly visit.</p> <p>Multiple unsuccessful attempts were made to contact the facility ' s Medical Director by telephone for an interview.</p>	F 758			

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F 758	Continued From page 72	F 758			
F 760 SS=E	<p>Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)</p> <p>The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on facility, hospital, and consulting Infectious Disease (ID) record reviews, and staff, nurse practitioner and ID clinical supervisor interviews, the facility failed to continue voriconazole (an antifungal medication) as recommended by the consulting ID physician, resulting in an unintended 30-day lapse of treatment for 1 of 2 residents reviewed for respiratory infections (Resident #71).</p> <p>The findings included:</p> <p>Resident #71 was admitted to the facility on 4/1/19. Her cumulative diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation, cavitory lesion of the lung (cavities characterized by thick-walled, abnormal gas-filled spaces within the lung), and necrotizing pneumonia. Necrotizing pneumonia is a rare complication of pneumonia in which</p>	F 760	<p>F760 Facility failed to continue an antifungal medication Element one: changes for residents affected Resident number 71 antifungal medication was reinstated as ordered by the infectious disease doctor on or before March 28, 2020.</p> <p>Element two: Potential residents affected 100% review of current residents who have had an out of facility consult within the last 6 months will be conducted to assure documentation was received and followed through by the nursing staff. The audit will be completed by the Director of Nursing, Nurse Practice Coordinator, Unit Manager, Nursing Supervisor, and/or the Minimum Data Set nurse. Review will be complete on or before April 15, 2020.</p>	4/15/20	

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F 760	<p>Continued From page 73</p> <p>tissue death (necrosis) begins to occur in the lung.</p> <p>The resident ' s admission Minimum Data Set (MDS) dated 4/8/19 revealed she had intact cognitive skills for daily decision making and was independent with her Activities of Daily Living. Section N of the MDS indicated Resident #71 received an antibiotic on 7 out of 7 days during the look back period. She was reported to receive oxygen therapy while a resident at the facility.</p> <p>Resident #71 ' s care plan included the following areas of focus, in part: --Resident exhibits or is at risk for respiratory complications related to COPD, other cavitary lesion (Date Initiated: 4/1/19); --Resident exhibits or is at risk for complications of infection related to COPD, cavitary lesion in lung, and necrotizing pneumonia (Date Initiated: 4/1/19; Revised on: 4/2/19).</p> <p>Resident #71 ' s medical record revealed she was discharged to the hospital on 5/8/19 with a diagnosis of sepsis secondary to pneumonia. Her hospital discharge summary reported the resident underwent a bronchoscopy and specimens were obtained, which included Hemophilus influenza (a type of bacteria) and presumptive fungus/mold. She was started on antibiotics and 200 milligrams (mg) voriconazole (an oral antifungal medication) to be given twice daily for 3 months. Discharge plans included follow-up with a pulmonologist within 1-2 weeks.</p> <p>The resident was discharged from the hospital back to the facility on 5/15/19. A review of the re-admission orders to the facility included 200</p>	F 760	<p>Element three: Procedures put in place/systemic changes/education Nursing staff are to ensure patients who return have documentation from the physician visit for out of facility visits. The Unit Manager, Nursing Supervisor or Director of Nursing will contact physician for residents who have out of facility specialty consults and return without documentation of their visit by April 15, 2020. Copies of documentation for those visits will be obtained and followed through if still indicated. If Unit Manager is unable to secure records the Medical Records Coordinator will contact the consulting physician to secure these records. Education will be provided by the Nurse Practice Educator or Nursing Supervisor on this new process and with the nursing staff and Medical Records Coordinator on or before April 15, 2020.</p> <p>Element four: Audits and quality assurance and performance improvement Director of Nursing, Nurse Practice Educator, Unit Manager, Nursing Supervisor or Minimum Data Set nurse will audit medical records of all residents who have an out of facility consult daily times one week, weekly audits of 50% of out of facility consult documentation times 2 weeks, 50% of out of facility consult documentation monthly times 2 months and 50% of out of facility consult documentation quarterly times 2 quarters. Audit results will be reviewed in monthly quality assurance and performance improvement meetings.</p>		

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F 760	<p>Continued From page 74</p> <p>mg voriconazole to be given by mouth twice daily for 92 days. On 5/17/19, the consulting pulmonologist recommended changing voriconazole to itraconazole 200 mg daily (another antifungal medication) due to its availability and lower cost. He also indicated an infectious disease consultation would need to be arranged for Resident #71.</p> <p>The resident ' s Medication Administration Records (MARs) for May, June, July, and August 2019 documented itraconazole was initiated on 5/18/19 as one-100 mg capsule provided twice daily. The medication was continued through 8/20/19.</p> <p>Resident #71 was seen for a consultation with her infectious disease (ID) physician on 8/15/19. He noted the resident had bronchopulmonary aspergillosis (an infection, usually of the lungs, caused by the fungus Aspergillus) and recommended to stop the itraconazole and initiate the use of voriconazole to provide better activity for Aspergillus. A review of the Resident #71 ' s paper chart at the facility revealed it included a hard copy of the prescription written by the ID physician on 8/15/19 for 200 mg voriconazole to be given as one tablet (200 mg dose) by mouth two times daily. The prescription was written for 60 tablets (providing 30 days of treatment) with two additional refills. A notation on the prescription indicated the start date was 8/15/19 and the end date was 11/13/19.</p> <p>Resident #71 ' s physician orders at the facility and her August 2019 MARs were reviewed. The first order entered into the facility ' s electronic medical record on 8/16/19 initiated 200 mg voriconazole for the resident to be given twice</p>	F 760			

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F 760	<p>Continued From page 75</p> <p>daily; no end date was specified for on this order entry. However, the order was revised on 8/16/19 to indicate voriconazole would be provided for 60 days (versus 3 months as the ID physician recommended).</p> <p>Resident #71 ' s August 2019 MAR documented the administration of voriconazole was initiated for Resident #71 on 8/16/19.</p> <p>The resident was seen for follow-up by the ID physician on 9/12/19. He recommended continuation of the voriconazole as previously prescribed.</p> <p>Based on documentation from the resident ' s September and October 2019 MARs, the resident received voriconazole through the month of September. However, the medication was discontinued after the morning dose on 10/15/19 (60 days after it had been initiated). She did not receive voriconazole during the remainder of October.</p> <p>On 11/11/19, the resident was started on an antibiotic for a diagnosis of pneumonia. A review of Resident #71 ' s November 2019 MAR indicated she had not received the voriconazole during this month to date.</p> <p>Resident #71 ' s paper chart at the facility included call documentation dated 11/12/19 at 10:51 AM from the ID physician ' s office records. A notation made by the ID physician ' s office read, in part: "I talked to the unit manager at (name of facility) and the VFend (brand name for voriconazole) had dropped off their orders and her last dose was 10/16 ...She said if we faxed orders over for the VFend they can</p>	F 760			

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F 760	<p>Continued From page 76</p> <p>restart...Patient is stable and labs are stable per (name of Unit Manager at the facility)...." The ID physician requested an order be sent to the facility to resume voriconazole as 200 mg twice daily.</p> <p>An Interdisciplinary Team (IDT) Progress note dated 11/12/19 at 11:11 AM documented a nurse spoke with the ID physician ' s office to report a new antibiotic had been initiated for Resident #71. The ID office was also informed the resident ' s antifungal medication had been discontinued and a new prescription was needing to be faxed to the facility. The note indicated a request was made for all paperwork from the ID office (including orders, labs, and visit notes) be faxed to the facility because a family member typically transported the resident to their office for her appointments and rarely turned in a paperwork to staff after the resident ' s appointments.</p> <p>On 11/13/19, 200 mg voriconazole was ordered to be re-initiated by the nurse practitioner (NP) who cared for the resident at the facility. The new order indicated the start date for voriconazole was 11/14/19; the end date was noted to be indefinite. Documentation on Resident #71 ' s October and November 2019 MARs indicated she did not receive voriconazole from 10/15/19 up until 11/14/19 (a treatment lapse of 30 days).</p> <p>Resident #71 was seen for a follow-up visit on 12/12/19 with the ID physician. A progress note from this visit documented the ID physician had been unaware the resident ' s voriconazole was discontinued at the facility until he received a phone call note on 11/11/19. At the time of this visit, the ID physician planned to continue the voriconazole treatment for at least 3 additional</p>	F 760			

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F 760	<p>Continued From page 77 months.</p> <p>On 1/28/20, Resident #71 was transferred to a hospital with acutely progressive confusion and fever. She was diagnosed with sepsis and a urinary tract infection, a respiratory infection, and acute encephalopathy (a broad term for any brain disease that alters brain function or structure). On 2/3/20, the resident was seen by her ID physician in the hospital. A note authored by the physician read, in part: "...I started voriconazole mid August 2019, however for some reason the facility she is at discontinued therapy just a few weeks after, and this was then restarted 11/13..."</p> <p>Resident #71 was discharged from the hospital and re-entered the facility on 2/5/20.</p> <p>An interview was conducted on 3/3/20 at 12:40 PM with NP #1. During the interview, the NP reported Resident #71 ' s medications were managed by the consulting pulmonologist and ID physicians. When asked, the NP recalled the facility was in communication with the resident ' s ID physician when some of her lab work was elevated towards the end of January 2020. He recommended the voriconazole be held (which it was) for a couple of days just prior to the resident ' s hospitalization on 1/28/20. Upon further inquiry, the NP did not recall any other lapse in voriconazole therapy for this resident.</p> <p>An interview was conducted on 3/4/20 at 10:15 AM with Unit Manager #2. During the interview, Resident #71 ' s consultation visits with the ID physician and implementation of his recommendations were discussed. Unit Manager #2 reported a family member typically accompanied the resident to her appointments</p>	F 760			

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F 760	<p>Continued From page 78</p> <p>with the ID physician. The unit manager recalled when the resident returned from her consult appointment in August, she had a prescription for the voriconazole and thought the prescription had a 60-day stop date on it. Unit Manager #2 reported when a family member took a resident to an outside physician ' s office, the facility would typically send a copy of her MAR and labs with the resident. However, she also stated it had been difficult to obtain consultation notes and recommendations back from Resident #71 ' s ID physician ' s office so the facility would be informed of them. When asked how it was recognized the voriconazole was discontinued on 10/15/19 after 60 days of administration, Unit Manager #2 thought one of the nurses had alerted her to it. However, she did not recall at that time who the nurse was.</p> <p>A follow-up interview was conducted on 3/4/20 at 3:05 PM with Unit Manager #2. During the interview, the Unit Manager reported she contacted the ID physician ' s office earlier on this date (3/4/20). The ID office stated medical records at the facility needed to request the ID consultation reports so they would be sent to the facility. A second follow-up interview was conducted with Unit Manager #2 on 3/5/20 at 8:23 AM. Upon inquiry, the Unit Manager reported a Physician Progress Note or Order sheet was sent with the resident to outside appointments, in addition to her MARs and lab reports previously reported. During the interview, the Unit Manager was asked why there was a discrepancy between the two orders for voriconazole input on 8/16/19, (one with no stop date and the other with a stop date of 60 days). The unit manager reported she was not sure. She stated there was some confusion at first as to who was going to handle</p>	F 760			

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F 760	<p>Continued From page 79</p> <p>the management of Resident #71 ' s medication orders and whether it would be the primary provider at the facility, the ID physician, or the pulmonary consultant. It was uncertain as to where the 60-day end date for the voriconazole had originated from.</p> <p>Multiple attempts were made to contact the ID physician during the 4-day on-site survey. Several messages were left requesting a return phone call from the physician. However, the ID physician did not return the call.</p> <p>The Clinical Supervisor from the ID physician ' s office returned a phone call on 3/5/20 at 10:30 AM and a telephone interview was conducted with her. Upon inquiry, the supervisor confirmed Resident #71 was seen at the ID office on 8/15/19, 9/12/19, 12/12/19, and while she was in the hospital during her most recent admission. When asked how recommendations from the ID physician consultations were be relayed to the facility, the supervisor reported the physician typically wrote orders on an order sheet to send back to the facility.</p> <p>Multiple unsuccessful attempts were made to contact the facility ' s Medical Director by telephone for an interview.</p> <p>An interview was conducted on 3/5/20 at 11:15 AM with the facility ' s Director of Nursing (DON). During the interview, concern was shared regarding the lapse of voriconazole administered to Resident #71 for approximately 1 month from mid-October to mid-November. Upon reviewing the voriconazole prescription sent back with the resident from the ID consult on 8/15/19, the DON stated this should have at least raised questions</p>	F 760			

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F 760	Continued From page 80 about the 60-day end date put into the computer orders for the voriconazole. The prescription explicitly indicated the medication had a start date of 8/15/19 and an end date of 11/13/19. The DON was then asked who was responsible to obtain the ID physician ' s recommendations made for Resident #71 and to implement any recommendations approved by the resident ' s physician or NP at the facility. The DON responded by stating she recognized it was the facility's responsibility. The DON also stated she would expect the patient to come back with recommendations from the outside consult and for the facility to follow-up on obtaining the reports and/or recommendations if these were not returned to the facility with the resident.	F 760			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		4/15/20	

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F 761	<p>Continued From page 81</p> <p>the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and staff interviews, the facility: 1) Failed to discard expired medications stored on 2 of 2 medication carts observed (300 Hall med cart and 400 Hall med cart); and, 2) Failed to store medications as specified by the manufacturer on 2 of 2 medication carts observed (300 Hall med cart and 400 Hall med cart).</p> <p>The findings included:</p> <p>1-a) Accompanied by Nurse #9, an observation of the 300 Hall medication cart was conducted on 3/3/20 at 3:12 PM. The observation revealed a bubble pack card containing 50 milligram (mg) tramadol (an opioid medication) with 23 tablets remaining for Resident #38 was stored on the cart. The bubble pack card was labeled by the pharmacy with an expiration date of 12/31/19.</p> <p>An interview was conducted on 3/3/20 at 3:20 PM with Nurse #9. During the interview, the nurse confirmed the identified medication was expired. When asked what the facility 's process was for identifying and removing an expired controlled substance medication from the med cart, Nurse #9 reported the medication would be removed from the med cart while witnessed by another licensed nurse. The medication would be put in a plastic bag and locked up until it could be returned to the pharmacy.</p>	F 761	<p>F761 Facility failed to discard expired medication, failed to store a medication per manufacturer's recommendation</p> <p>Element one: changes for residents affected</p> <p>Expired medication was discarded when staff was notified and medication that was stored inaccurately was discarded by the Unit Manager on March 4, 2020.</p> <p>Element two: Potential residents affected 100% of medication carts were audited for medications expired and that medications were stored per manufacturer's recommendation by the Nursing Supervisor on or before March 28, 2020.</p> <p>Element three: Procedures put in place/systemic changes/education</p> <p>Medication carts will be checked nightly for expired medications and medication storage per manufacturer's recommendations by the nurse assigned to the unit. A medication cart checklist/spreadsheet was developed. The medication cart spreadsheet will be signed by the third shift nurse indicating she checked the cart and the medications are not expired and the medications are stored per manufacturer's recommendation. The Unit Manager and</p>		

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F 761	<p>Continued From page 82</p> <p>An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During the interview, the DON reported she had been made aware some medications on the medication carts were identified on 3/3/20 as being expired. A follow-up interview was conducted on 3/4/20 at 9:58 AM with the DON. Upon request, the DON described the facility ' s process to ensure expired medications were removed from the med carts. She reported the 2nd shift supervisor was responsible for checking the meds on the med carts and in the med store rooms once a month. When an expired controlled substance medication was identified, it would be pulled from the med out and signed out on the controlled substance inventory book (along with a second signature). The medication would then be put in bag, sealed, scanned (to let the pharmacy know the expired med was needing to be returned), and then the medication would be locked in the med cart until it was picked up by pharmacy.</p> <p>1-b) Accompanied by Nurse #8, an observation of the 400 Hall medication cart was conducted on 3/3/20 at 2:45 PM. The observation revealed a bubble pack card containing 0.5 milligrams (mg) lorazepam (an antianxiety medication) containing 21 tablets for Resident #71 was stored on the cart. The bubble pack card was labeled by the pharmacy with an expiration date of 12/31/19.</p> <p>An interview was conducted on 3/3/20 at 3:09 PM with Nurse #8. During the interview, the nurse confirmed the identified medication was expired. When asked what the facility ' s process was for identifying and removing an expired controlled substance medication from the med cart, the</p>	F 761	<p>Nursing Supervisor will review the log daily and ensure the cart has been checked and is compliant. Nursing staff was provided education on this new procedure on or before March 28, 2020 by Nurse Practice Educator.</p> <p>Element four: Audits and quality assurance and performance improvement The Director of Nursing, Nurse Practice Educator, Unit Manager, Nursing Supervisor and/or the Minimum Data Set nurse will complete audits of Cart check log and med carts being compliant daily times 2 weeks, weekly times 2 weeks, monthly times 2 months and quarterly times 2 quarters. Results of audits will be reviewed in the monthly quality assurance and performance improvement meeting.</p>		

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F 761	<p>Continued From page 83</p> <p>nurse reported she was unsure but could ask her unit manager for guidance.</p> <p>An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During the interview, the DON reported she had been made aware some medications on the medication carts were identified on 3/3/20 as being expired. A follow-up interview was conducted on 3/4/20 at 9:58 AM with the DON. Upon request, the DON described the facility ' s process to ensure expired medications were removed from the med carts. She reported the 2nd shift supervisor was responsible for checking the meds on the med carts and in the med store rooms once a month. When an expired controlled substance medication was identified, it would be pulled from the med out and signed out on the controlled substance inventory book (along with a second signature). The medication would then be put in bag, sealed, scanned (to let the pharmacy know the expired med was needing to be returned), and then the medication would be locked in the med cart until it was picked up by pharmacy.</p> <p>1-c) Accompanied by Nurse #8, an observation of the 400 Hall medication cart was conducted on 3/3/20 at 2:45 PM. The observation revealed a bubble pack card containing 5/325 milligrams (mg) hydrocodone/acetaminophen (a combination opioid medication) containing 13 tablets for Resident #49 was stored on the cart. The bubble pack card was labeled by the pharmacy with an expiration date of 2/29/20.</p> <p>An interview was conducted on 3/3/20 at 3:09 PM with Nurse #8. During the interview, the nurse confirmed the identified medication was expired.</p>	F 761			

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F 761	<p>Continued From page 84</p> <p>When asked what the facility ' s process was for identifying and removing an expired controlled substance medication from the med cart, the nurse reported she was unsure but could ask her unit manager for guidance.</p> <p>An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During the interview, the DON reported she had been made aware some medications on the medication carts were identified on 3/3/20 as being expired. A follow-up interview was conducted on 3/4/20 at 9:58 AM with the DON. Upon request, the DON described the facility ' s process to ensure expired medications were removed from the med carts. She reported the 2nd shift supervisor was responsible for checking the meds on the med carts and in the med store rooms once a month. When an expired controlled substance medication was identified, it would be pulled from the med out and signed out on the controlled substance inventory book (along with a second signature). The medication would then be put in bag, sealed, scanned (to let the pharmacy know the expired med was needing to be returned), and then the medication would be locked in the med cart until it was picked up by pharmacy.</p> <p>1-d) Accompanied by Nurse #8, an observation of the 400 Hall medication cart was conducted on 3/3/20 at 2:45 PM. The observation revealed a bubble pack card containing 50 milligram (mg) tramadol (an opioid medication) containing 22 tablets labeled for Resident #12 was stored on the cart. The bubble pack card was labeled by the pharmacy with an expiration date of 2/29/20.</p> <p>An interview was conducted on 3/3/20 at 3:09 PM</p>	F 761			

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F 761	<p>Continued From page 85</p> <p>with Nurse #8. During the interview, the nurse confirmed the identified medication was expired. When asked what the facility ' s process was for identifying and removing an expired controlled substance medication from the med cart, the nurse reported she was unsure but could ask her unit manager for guidance.</p> <p>An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During the interview, the DON reported she had been made aware some medications on the medication carts were identified on 3/3/20 as being expired. A follow-up interview was conducted on 3/4/20 at 9:58 AM with the DON. Upon request, the DON described the facility ' s process to ensure expired medications were removed from the med carts. She reported the 2nd shift supervisor was responsible for checking the meds on the med carts and in the med store rooms once a month. When an expired controlled substance medication was identified, it would be pulled from the med out and signed out on the controlled substance inventory book (along with a second signature). The medication would then be put in bag, sealed, scanned (to let the pharmacy know the expired med was needing to be returned), and then the medication would be locked in the med cart until it was picked up by pharmacy.</p> <p>1-e) Accompanied by Nurse #8, an observation of the 400 Hall medication cart was conducted on 3/3/20 at 2:45 PM. The observation revealed a bubble pack card containing 50 milligram (mg) tramadol (an opioid medication) containing 5 tablets labeled for Resident #17 was stored on the cart. The bubble pack card was labeled by the pharmacy with an expiration date of 2/29/20.</p>	F 761			

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F 761	<p>Continued From page 86</p> <p>An interview was conducted on 3/3/20 at 3:09 PM with Nurse #8. During the interview, the nurse confirmed the identified medication was expired. When asked what the facility 's process was for identifying and removing an expired controlled substance medication from the med cart, the nurse reported she was unsure but could ask her unit manager for guidance.</p> <p>An interview was conducted on 3/4/20 at 8:35 AM with the facility 's Director of Nursing (DON) and Administrator. During the interview, the DON reported she had been made aware some medications on the medication carts were identified on 3/3/20 as being expired. A follow-up interview was conducted on 3/4/20 at 9:58 AM with the DON. Upon request, the DON described the facility 's process to ensure expired medications were removed from the med carts. She reported the 2nd shift supervisor was responsible for checking the meds on the med carts and in the med store rooms once a month. When an expired controlled substance medication was identified, it would be pulled from the med out and signed out on the controlled substance inventory book (along with a second signature). The medication would then be put in bag, sealed, scanned (to let the pharmacy know the expired med was needing to be returned), and then the medication would be locked in the med cart until it was picked up by pharmacy.</p> <p>2-a) Accompanied by Nurse #8, an observation of the 400 Hall medication cart was conducted on 3/3/20 at 2:45 PM. The observation revealed a 30 milliliter (ml) bottle of 2 milligram (mg) / ml lorazepam oral concentrate (an antianxiety medication) dispensed from the pharmacy on</p>	F 761			

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F 761	<p>Continued From page 87</p> <p>1/30/20 for Resident #72 was stored on the cart. The bottle was labeled by the pharmacy with an auxiliary sticker which read, "Refrigerate." A second sticker placed on the medication read, "Refrigerate/Do Not Freeze."</p> <p>An interview was conducted on 3/3/20 at 3:09 PM with Nurse #8. During the interview, the nurse reported the lorazepam should have been kept in the refrigerator when it was delivered to the facility.</p> <p>An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During a discussion of the med storage observations, the DON reported she would have expected the lorazepam oral concentrate to have been stored in the med room refrigerator.</p> <p>2-b) Accompanied by Nurse #9, an observation of the 300 Hall medication cart was conducted on 3/3/20 at 3:12 PM. The observation revealed an opened dropper bottle of 1% prednisolone ophthalmic suspension (a steroid eye drop medication) dispensed from the pharmacy on 2/14/20 for Resident #84 was stored lying down on its side in the top drawer of the medication cart. The manufacturer ' s storage instructions printed on the label of the eye drops read, "Store Upright."</p> <p>An interview was conducted on 3/3/20 at 3:20 PM with Nurse #9. During the interview, the nurse was shown the labeling with storage instructions on the eye drop medication. Nurse #9 reported the suspension eye drop bottle would need to be stored in another drawer of the med cart so it could be stored upright.</p>	F 761			

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F 761	Continued From page 88	F 761			
F 867 SS=E	<p>An interview was conducted on 3/4/20 at 8:35 AM with the facility ' s Director of Nursing (DON) and Administrator. During a discussion of the med storage observations, the DON reported she would expect medications to be stored in accordance with the manufacturer ' s instructions.</p> <p>QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)</p> <p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, staff interviews and physician interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee had put into place following the annual recertification survey dated 1/25/2019. This was for four recited deficiencies in the areas of Care Plan Timing and Revision, Drug Regimen Review, Free from Unnecessary Psychotropic Medications, and Labeling and Storage of Drugs that were previously cited on 1/25/2019. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.</p> <p>The findings included:</p> <p>This citation is cross referenced to:</p>	F 867	<p>F867 Quality Assessment and Assurance committee failed to maintain implemented procedures and monitor interventions</p> <p>1. The center Quality Assurance and Performance Improvement Committee has developed revised plans to correct the repeat deficient practice for F657 Nursing assistants in care plan, F756 Pharmacy identification of medication irregularities and pharmacy follow up, F758 labs with psychotropic medications and 14 day stop dates, and F761 expired medications and storage of medications.</p> <p>2. The Regional Nurse and the Center Quality Assurance and Performance Improvement committee reviewed the plans that were implemented as a result of last year's annual survey in response to identified deficient practice to ensure that</p>	4/15/20	

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F 867	<p>Continued From page 89</p> <p>F657-Based on record review and staff interview, the facility failed to incorporate Nursing Assistants into the care planning process for 2 of 2 residents (Residents #33 and #70) reviewed for the care plan process.</p> <p>During the facility's annual recertification survey on 1/25/2019 the facility was cited for failing to incorporate a Nursing Assistant in the care planning process (Resident #2 and #23) for 2 of 2 residents reviewed for participation in care planning.</p> <p>F756- Based on record reviews, and staff, consultant pharmacist, Nurse Practitioner, Psychiatric Mental Health Nurse Practitioner, and physician interviews, the consultant pharmacist failed to identify and report medication irregularities (Residents #71, #76, #24 and #389), failed to complete a monthly medication regimen review (Resident #71), the facility failed to act upon pharmacy recommendations in a timely manner (Residents #71, #14, and #70), and also failed to retain pharmacy consultation reports (Resident #71). This was for 6 of 6 residents reviewed for unnecessary medications.</p> <p>During the facility's recertification survey on 1/25/2019 the facility was cited for failing to act on irregularities in a resident's medication orders which included possible drug interactions and side effects, the use of 3 antidepressants and antidepressants prescribed for Dementia without behaviors for 1 (Resident #52) of 6 residents reviewed for unnecessary medications.</p> <p>F758-Based on record reviews, staff interviews and physician and nurse practitioner interviews, the facility failed to monitor labs for psychotropic</p>	F 867	<p>the remainder of the plans had sustained effective compliance. This was accomplished by completing audits as outlined in the original plans and staff interviews.</p> <p>3. Education was provided by the Regional Nurse with the Quality Assurance Performance Improvement committee in regards to the Quality Assurance Performance Improvement process. This education included ongoing review of plans to ensure that compliance is maintained. This education was completed on or before April 15, 2020.</p> <p>4. The Quality Assessment and Assurance committee will meet monthly and review the plans that have been developed to address the identified deficient practice to ensure that the center has maintained compliance. As part of the Quality Assurance Performance Improvement meeting ongoing reviews of systems will be completed to identify other potential deficient practice. The Administrator is responsible for the Quality Assurance Performance Improvement process and sustaining an effective program. The Regional Nurse will review the Quality Assurance Performance improvement minutes monthly times 3 months to ensure the process is followed to implement and correct identified deficiencies.</p>		

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F 867	<p>Continued From page 90</p> <p>medications as ordered (Residents #76 and #24) and orders written for as needed use of psychotropic medications were time limited (Residents #14 and #71) for 4 of 6 sampled residents reviewed for unnecessary medications.</p> <p>During the facility's recertification survey on 1/25/2019 the facility was cited for failing to act on irregularities in a resident's medication orders regarding possible drug interactions and side effects, the use of 3 antidepressants and an antidepressant prescribed for Dementia without behaviors for 1 (Resident #52) of 6 residents reviewed for unnecessary medications.</p> <p>F761-Based on observations, record review, and staff interviews, the facility: 1) Failed to discard expired medications stored on 2 of 2 medication carts observed (300 Hall med cart and 400 Hall med cart); and, 2) Failed to store medications as specified by the manufacturer on 2 of 2 medication carts observed (300 Hall med cart and 400 Hall med cart).</p> <p>During the facility's recertification survey on 1/25/2019 the facility was cited for failing to discard an opened expired insulin (Resident #34) and failing to store unopened insulin in the refrigerator until opened (Resident #29) for 2 of 2 medication carts reviewed for medication storage.</p> <p>On 03/05/2020 at 2:25 PM an interview was conducted with the facility administrator and the DON regarding repeat deficiencies at F657, 756, F758, and F761. The DON stated unit managers were responsible for making sure staff members were assigned to go to care plan meetings. The absence of a Nursing Assistant during care plan meetings was likely an oversight. In regards to</p>	F 867			

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F 867	Continued From page 91 F756 and F758 the DON and Administrator acknowledge they have been actively working with the Physicians, Nurse Practitioners, and the consult Pharmacist to resolve the issues. The DON further stated medication carts were being checked at the end of each month and expiration dates were being highlighted on the labels. She thought human error might have been a contributing factor along with some labels being difficult to read.	F 867			
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure Nursing Assistants (NAs) completed annual dementia	F 947	F947 Facility failed to ensure Nursing Assistants completed annual dementia care training	4/15/20	

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F 947	<p>Continued From page 92</p> <p>training for 2 of 8 Nursing Assistants reviewed for required in-service training (NA#4 and NA#5).</p> <p>The findings included:</p> <p>a. NA #4 had a hire date of 1/22/2019. Dementia training was assigned to NA #4 on 2/11/2019 via online platform with a due date of 5/12/2019. Facility records indicated the training was not completed. The facility could not provide evidence NA#4 had ever completed dementia training since her hire on 1/22/2019.</p> <p>In an interview with NA#4 on 3/3/2020 at 10:30am she stated the facility did provide dementia training but she did not recall the date of the training.</p> <p>NA#4 was observed providing incontinence care to a resident with dementia on 3/3/2020 at 9:16am. There were no concerns with the NA's interaction with the resident.</p> <p>During an interview with the Director of Nursing (DON) on 3/3/2020 at 4:13pm. She stated the individual responsible for staff development was on vacation and could not be reached. She further stated she did not know why the employees had not completed the required training and she was not certain how training was being tracked.</p> <p>On 3/5/2020 at 12:25pm, an interview was conducted with the DON and the Facility Administrator in which both indicated it was their expectation for all NAs to receive annual dementia training.</p> <p>b. NA #5 had a hire date of 8/21/2018. Dementia</p>	F 947	<p>Element one: changes for residents affected No specific resident was identified</p> <p>Element two: Potential residents affected Dementia related diagnosed patients are at risk of being affected. Inservice education was provided for 100% of Nursing Assistants as per requirement on or before April 15, 2020 by the Nurse Practice Educator, Nursing Supervisor or the Director of Nursing. Any Nursing Assistant who does not complete the Dementia training will not be allowed to work until the training is complete,</p> <p>Element three: Procedures put in place/systemic changes/education Dementia care inservice will be by the Nurse Practice Educator, Nursing Supervisor or the Director of Nursing on or before March 15, 2020 for nursing assistants. Documentation of the inservice will be complete for each Nursing Assistant. Each January of each year Dementia training will be scheduled for all nursing assistants. The Nurse Practice Educator will review progress toward completion of dementia care training monthly and ensure education is complete within that year. New hired nursing assistants will have dementia care training prior to completing their orientation. Education will be provided by the Nurse Practice Educator, Director of Nursing or Unit Managers to all nursing assistants on the responsibility to complete this training within a year on or by April 15, 2020.</p>		

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F 947	<p>Continued From page 93</p> <p>training was assigned to NA#5 on 2/11/2019 via online platform, with a due date of 5/12/2019. Facility records indicated the training was not completed. The facility could not provide evidence NA#5 had ever completed dementia training since her hire date on 8/21/2018.</p> <p>In an interview with NA#5 on 3/3/2020 at 10:35am she stated the facility did provide dementia training but she did not recall when the training occurred.</p> <p>NA#5 was observed providing meal tray set up to a resident with dementia on 3/3/2020 at 12:10pm. There were no concerns with the NA's interaction with the resident.</p> <p>During an interview with the Director of Nursing (DON) on 3/3/2020 at 4:13pm. She stated the individual responsible for staff development was on vacation and could not be reached. She further stated she did not know why the employees had not completed the required training and she was not certain how training was being tracked.</p> <p>On 3/5/2020 at 12:25pm, an interview was conducted with the DON and the Facility Administrator in which both indicated it was their expectation for all NAs to receive annual dementia training.</p>	F 947	<p>Element four: Audits and quality assurance and performance improvement</p> <p>The Nurse Practice Educator will audit dementia care training progress monthly and report progress toward completion in the monthly quality assurance and performance improvement meetings.</p>		