STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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 An unannounced recertification survey was conducted 5/17/2021 through 5/2020/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# GOPI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 05/17/2021 through 05/20/2021. Event ID# FY7411. 2 of the 10 complaint allegations were substantiated resulting in deficiencies and 1 of the 10 complaint allegations was substantiated without deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the area of medications (Residents # 34, #44 & #29), diagnosis (Resident # 19), prognosis (Residents #44 & #29), pain management (Resident #44) and falls (Resident # 44) for 4 of 16 sampled residents reviewed (Residents #34, #44, #19 & #29). Findings included: 1a. Resident #44 was admitted to the facility on 1/9/20 with multiple diagnoses including intracapsular fracture of left femur.	F 641	All assessments identified with coding errors in the areas of 6 month or less prognosis, pain management received, anti-anxiety and injection medications received, other fracture diagnosis and number of falls since last assessment were modified and transmitted to CMS on 5/19/2021. Regional Case Mix/MDS Coordinator audited 10 random resident assessments with ARD□s (Assessment Review Date) in May for each area which is 20% of total	6/17/21

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

Electronically Signed | 06/05/2021

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F 641	Continued From page 1 Resident #44 had a doctor's order dated 4/29/21 for a hospice consult. The significant change in status MDS assessment dated 5/7/21 indicated that Resident #44 was receiving hospice services during the assessment period. The section under prognosis was checked "no" indicating that the resident did not have a condition or chronic disease that may result in a life expectancy of less than 6 months. MDS Nurse #1 was interviewed on 5/19/21 at 2:30 PM. The MDS Nurse verified that Resident #44 was receiving hospice services. She reviewed the MDS assessment dated 5/7/21 and indicated that the prognosis section should have been checked "yes" but it was not. She stated that she would modify the MDS assessment to correct the coding error. The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected the MDS assessments to be coded accurately. b. Resident #44 had a doctor's order on 4/28/21 for oxycodone (a narcotic pain medication) 10 milligrams (mgs) 1 tablet by mouth every 4 hours as needed (PRN) for pain and on 5/5/21 for oxycodone 10 mgs 1 tablet by mouth 3 times a day for pain. The significant change in status MDS assessment dated 5/7/21 indicated that Resident #44 was not on a scheduled pain medication regimen and had not received PRN pain medication during the assessment period.	F 641	census. All miscoded items were modified appropriately and transmitted to CMS on 6/2/2021. Regional Case Mix/MDS Coordinator will educate traveling and current MDS Coordinators at facility by 6/17/21 on appropriate MDS coding for the areas of J1400, prognosis of less than 6 months, J0100 A&B, pain management received, N0300, injections received, N0410 B&H, opioid and anti-anxiety medications received, J1900A falls w/ no injury, I4000, other fracture diagnosis, N0450B, GDR attempt. Regional Case Mix/MDS Coordinator or designee will perform quality improvement monitoring for these MDS areas to ensure coding accuracy on appropriate MDS coding for the areas of J1400, prognosis of less than 6 months, J0100 A&B, pain management received, N0300, injections received, N0410 B&H, opioid and anti-anxiety medications received, J1900A falls w/ no injury, I4000, other fracture diagnosis, N0450B, GDR attempt2 X weekly for 4 weeks then 1 X weekly for 2 months then 1 X monthly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance	

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F 641	Continued From page 2 The May 2021 Medication Administration Records (MARs) revealed that Resident #44 had received oxycodone 10 mgs on 5/1/21, 5/2/21, 5/3/21, 5/4/21, 5/5/21, 5/6/21 and 5/7/21. MDS Nurse #1 was interviewed on 5/19/21 at 2:30 PM. The MDS Nurse verified that Resident #44 had doctor's orders for PRN and scheduled oxycodone. She reviewed the May 2021 MARs and verified that the resident had received PRN and scheduled oxycodone during the assessment period. She reviewed the MDS assessment dated 5/7/21 and indicated that the section under pain management was coded incorrectly and she would complete a modification assessment to correct the coding error. The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected the MDS assessments to be coded accurately. c. Resident #44 had a doctor's order on 4/28/21 for oxycodone (a narcotic pain medication) 10 milligrams (mgs) 1 tablet by mouth every 4 hours as needed (PRN) for pain and on 5/5/21 for oxycodone 10 mgs 1 tablet by mouth 3 times a day for pain. The significant change in status MDS assessment dated 5/7/21 indicated that Resident #44 had not received opioid during the assessment period. The May 2021 Medication Administration Records (MARs) revealed that Resident #44 had received oxycodone 10 mgs on 5/1/21, 5/2/21, 5/3/21, 5/4/21, 5/5/21, 5/6/21 and 5/7/21.	F 641	Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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MDS Nurse #1 was interviewed on 5/19/21 at 2:30 PM. The MDS Nurse verified that Resident #44 had doctor's orders for PRN and scheduled oxycodone. She reviewed the May 2021 MARs and verified that the resident had received PRN and scheduled oxycodone during the assessment period. She reviewed the MDS assessment dated 5/7/21 and indicated that the section under medication (opioid) was coded incorrectly and she would complete a modification assessment to correct the coding error.

The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected the MDS assessments to be coded accurately.

d. Resident #44 had a doctor's order on 4/30/21 for Ativan (anti-anxiety drug) 0.5 milligrams (mgs) 1 tablet by mouth every 4 hours as needed for anxiety.

The May 2021 MARs revealed that Resident #44 had received Ativan on 5/5/21.

The significant change in status MDS assessment dated 5/7/21 indicated that Resident #44 did not receive an anti-anxiety medication during the assessment period.

MDS Nurse #1 was interviewed on 5/19/21 at 2:30 PM. The MDS Nurse reviewed the May 2021 MARs and verified that the resident had received an anti-anxiety medication (Ativan) during the assessment period. She reviewed the MDS assessment dated 5/7/21 and indicated that the section under medication (anti-anxiety) was coded incorrectly and she would complete a

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modification assessment to correct the coding error.

The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected the MDS assessments to be coded accurately.

e. Resident #44's progress notes were reviewed. The note dated 3/11/21 at 8:42 PM revealed that the resident had a fall with no injury. The note dated 3/23/21 at 10:23 PM revealed that the resident had a fall with no injury. The note dated 4/13/21 at 3:04 AM revealed that the resident had a fall with hematoma to his forehead.

The discharge MDS assessment dated 4/22/21 indicated that Resident #44 did not have a fall with no injury during the assessment period.

The Regional MDS Nurse was interviewed on 5/19/21 at 2:40 PM. The MDS Nurse reviewed Resident #44's progress notes and verified that the resident had 3 falls, 2 falls without injury and 1 fall with injury. She stated that the fall with injury was captured on the discharge MDS assessment dated 4/22/21 but not the 2 falls without injury. She indicated that a modification assessment would be completed to capture the 2 falls without injury.

The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected the MDS assessments to be coded accurately.

2. Resident # 19 was originally admitted to the facility on 12/18/14. On 3/8/21, pathological fracture of left ulna was added to the diagnosis

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list.

Resident #19's progress notes revealed that her fracture was treated with a soft cast.

Resident #19's quarterly Minimum Data Set (MDS) assessment dated 4/9/21 indicated that the resident did not have other fracture.

The Regional MDS Nurse was interviewed on 5/19/21 at 3:15 PM. She stated that she reviewed Resident#19's medical records and verified that the resident had a left ulna fracture and was treated with a soft cast. She stated that the MDS assessment dated 4/9/21, the diagnosis section (other fracture) was coded incorrectly, and a modification assessment would be completed to correct the coding error.

The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected the MDS assessments to be coded accurately.

3. Resident #34 was originally admitted to the facility on 9/22/19 with multiple diagnoses including B12 deficiency.

Resident #34 had a doctor's order dated 3/19/21 for B12 1000 micrograms (mcg)/milliliter (ml) - inject 100 mcg intramuscularly (IM) once a day for B12 deficiency for 7 days, then inject 100 mcg daily every other day for 13 days, then inject 100 mcg IM daily every 3 days for 14 days.

Resident #34's Medication Administration Records (MARs) were reviewed. The MARs revealed that the resident had received B12

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F 641	Continued From page 6	F 641		

injection on 4/1/21, 4/3/21, 4/5/21 and 4/7/21.

The quarterly Minimum Data Set (MDS) assessment dated 4/7/21 revealed that Resident #34 did not receive injections during the assessment period.

The Regional MDS Nurse was interviewed on 5/19/21 at 2:30 PM. The MDS Nurse reviewed Resident #34's MARS and verified that the resident had received B12 injection during the assessment period.
She stated that the MDS assessment dated 4/7/21 was coded incorrectly under medications (injection) and a modification assessment would be completed to correct the coding error.

The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected the MDS assessments to be coded accurately.

4. Resident #29 was admitted to the facility on 2/19/21 with diagnoses that included dementia with behavioral disturbance and cerebral infarction (stroke).

4a. A physician ' s order dated 2/19/21 indicated Aripiprazole (antipsychotic medication) 5 milligrams (mg) once daily for Resident #29.

A physician ' s order dated 2/22/21 indicated a Gradual Dose Reduction (GDR) was implemented for Resident #29 ' Aripiprazole decreasing it to 2 mg once daily from 5 mg once daily.

The admission Minimum Data Set (MDS) assessment dated 2/26/21 indicated Resident

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#29 ' s cognition was intact. She received routine antipsychotic medication on 7 of 7 days. She was noted with no GDR of her antipsychotic medication. The medications section of the MDS was coded by the former Regional MDS Consultant.

The Regional MDS Consultant was interviewed on 5/19/21 at 3:20 PM. Resident #29 ' s physician ' s order for Aripiprazole that indicated a GDR was implemented on 2/22/21 and the MDS assessment dated 2/26/21 that coded the resident with no GDR attempts were reviewed with the Regional MDS Consultant. She stated that if a GDR was conducted it should have been coded on Resident #29 ' s MDS assessment.

During a phone interview with the former Regional MDS Consultant on 5/20/21 at 10:20 AM she indicated that she was unable to answer questions related to Resident #29 ' s 2/26/21 MDS assessment.

An interview was conducted with the Director of Nursing and Regional Clinical Resources on 5/20/21 at 12:14 PM. They both stated they expected the MDS to be coded accurately.

4b. A physician ' s order dated 2/19/21 indicated Aripiprazole (antipsychotic medication) 5 milligrams (mg) once daily for Resident #29.

A physician ' s order dated 2/22/21 indicated a Gradual Dose Reduction (GDR) was implemented for Resident #29 ' Aripiprazole decreasing it to 2 mg once daily from 5 mg once daily.

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The significant change Minimum Data Set (MDS) assessment dated 4/15/21 indicated Resident #29 ' s cognition was moderately impaired. She received routine antipsychotic medication on 7 of 7 days. She was noted with no GDR of her antipsychotic medication. The medications section of the MDS was coded by the former Regional MDS Consultant.

The Regional MDS Consultant was interviewed on 5/19/21 at 3:20 PM. Resident #29 ' s physician ' s order for Aripiprazole that indicated a GDR was implemented on 2/22/21 and the MDS assessment dated 4/15/21 that coded the resident with no GDR attempts were reviewed with the Regional MDS Consultant. She stated that if a GDR was conducted it should have been coded on Resident #29 ' s MDS assessment.

During a phone interview with the former Regional MDS Consultant on 5/20/21 at 10:20 AM she indicated that she was unable to answer questions related to Resident #29 ' s 4/15/21 MDS assessment.

An interview was conducted with the Director of Nursing and Regional Clinical Resources on 5/20/21 at 12:14 PM. They both stated they expected the MDS to be coded accurately.

4c. The significant change Minimum Data Set (MDS) assessment dated 4/15/21 indicated Resident #29 ' s cognition was moderately impaired. She was coded with a prognosis of less than 6 months and was not coded for hospice services. The prognosis section of the MDS was coded by the former Regional MDS Consultant.

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F 641	Continued From page 9 The psychotropic medication Care Area Assessment (CAA) related to the 4/15/21 significant change MDS assessment indicated Resident #29 was admitted to the facility on hospice services, but she was doing well and services were no longer needed at this time. During an interview with Nurse #5 on 5/19/21 at 11:50 AM she stated that Resident #29 was discharged from hospice services on 4/7/21. The Regional MDS Consultant was interviewed on 5/19/21 at 3:20 PM. Resident #29 ' s hospice discharge date of 4/7/21 and the significant change MDS dated 4/15/21 that indicated Resident #29 was no longer on hospice services, but still had Resident #29 coded with a prognosis of less than 6 months were reviewed with the Regional MDS Consultant. She stated that she was not sure what information the former Regional MDS Consultant utilized to code the section of the MDS for prognosis, but she expected this to be coded accurately. During a phone interview with the former Regional MDS Consultant on 5/20/21 at 10:20 AM she indicated that she was unable to answer questions related to Resident #29 ' s 4/15/21 MDS assessment. An interview was conducted with the Director of Nursing and Regional Clinical Resources on 5/20/21 at 12:14 PM. They both stated they expected the MDS to be coded accurately.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		6/17/21

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F 655	Continued From page 10 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be	F 655		

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F 655	Continued From page 11 administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to develop a baseline care plan for 2 of 2 residents (Resident #250 and Resident #251) reviewed for baseline care plans. Findings included: 1. Resident #250 was admitted to the facility on 5/11/2021 with diagnoses that included encephalopathy, major depressive disorder, and anxiety. The resident's Minimum Data Set (MDS) was not available. Resident #250's physician's orders revealed the resident was on two antipsychotic medications as well as two benzodiazepines. Progress notes revealed the resident had displayed behaviors such as yelling, cussing, and hitting staff as well as refusing care and medications. A review of the electronic medical record revealed the baseline care plan was not completed. A review of Resident #250's paper chart revealed it did not contain a baseline care plan. On 5/19/2021 at 2:00pm an interview was conducted with the MDS nurse. She stated it was the responsibility of the admitting nurse to complete the baseline care plan at the time of	F 655	Missing baseline Care Plans were completed and reviewed with resident/RP with copy provided. Current residents admitted in last 21 days were audited for Baseline Care Plan completion by MDS Nurse on 6/2/2021. Audits reviewed and copy provided. Any issue identified were addressed and brought into compliance. Education will be provided to Director of Nursing by the Divisional Director of Nursing by 6/17/2021 on the baseline care plan policy. The Director of Nursing, Assistant Director of Nursing, and Divisional Director of Nursing will provide education to licensed nurses on the policy for Baseline Care Plans by 6/17/21. The expectation is the facility will develop and implement an Individualized Person-Centered baseline plan of care within 48 hours of admission. On admission the admitting licensed nurse will initiate the baseline care plan. The admitting nurse will review with the resident and/or Responsible Party and sign. If Responsible Party is not present, the nurse will call via telephone to review	

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F 655	Continued From page 12 admission. She further stated the facility's baseline care plans were paper and would be found on the hard chart/paper chart if one was completed. 05/19/21 02:03pm a phone interview was conducted with Nurse #4 who stated she did the resident's admission on 5/11/2021. She stated she did not recall if she completed a care plan on Resident #250. She further stated it would be paper and it would be found in the resident's hard chart if she completed one. She was aware all newly admitted residents required a baseline care plan be initiated within 48 hours of admission. At 12:37pm on 05/20/21 an interview was conducted with the Director of Nursing (DON). She stated she had reviewed the paper chart for #250 and was unable to locate a baseline care plan. She further stated she expected all residents newly admitted to have a baseline care plan within 48 hours of admission. 2. Resident #251 was admitted to the facility on 5/14/2021 with diagnoses that included abnormal gait, cognitive dysfunction, and diabetes. The resident's Minimum Data Set (MDS) was not available. A review of the electronic medical record revealed the baseline care plan was not completed. A review of Resident #251's paper chart revealed it did not contain a baseline care plan. On 5/19/2021 at 2:00pm an interview was conducted with the MDS nurse. She stated it was the responsibility of the admitting nurse to	F 655	care plan with another nurse present. Once completed the nurse will file the baseline care plan in the green binder located at the nurses station labeled Baseline Care Plans. The MDS nurse will be responsible for bringing the binder to clinical morning meeting daily to review with the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Social Worker, Therapy, Dietary, and Activities). Once completed the baseline care plan will be filed in resident s medical record. The DCS or designee will perform Quality Improvement Monitoring of the baseline care plan process to ensure process is followed 2 X weekly for 4 weeks then 1 X weekly for 2 months than 1 X monthly for 3 months. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the DCS or designee for 6 months and/or until substantial compliance is obtained.	

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F 655	Continued From page 13 complete the baseline care plan at the time of admission. She further stated the facility's baseline care plans were paper and would be found on the hard chart/paper chart if one was completed. 05/19/21 02:03pm a phone interview was conducted with Nurse #4 who stated she did the resident's admission on 5/14/2021. She stated she did not recall if she completed a care plan on Resident #251. She further stated it would be paper and it would be found in the resident's hard chart if she completed one. She was aware all newly admitted residents required a baseline care plan be initiated within 48 hours of admission. At 12:37pm on 05/20/21 an interview was conducted with the Director of Nursing (DON). She stated she had reviewed the paper chart for #251 and was unable to locate a baseline care plan. She further stated she expected all residents newly admitted have a baseline care plan completed within 48 hours of admission.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to ensure a resident who was dependent on staff assistance for incontinence care received assistance when needed for 1 of 3 residents (Resident #29) reviewed for Activities of Daily	F 677	1) Incontinence care was provided to Resident#29 by NA#2 around 10:35am after waiting greater than 45 minutes. NA#1 and NA#2 were immediately educated by the Director of Nursing regarding providing timely incontinence	6/17/21

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F 677	Continued From page 14	F 677		

Living (ADLs).

The findings included:

Resident #29 was admitted to the facility on 2/19/21 with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke).

The significant change Minimum Data Set (MDS) assessment dated 4/15/21 indicated Resident #29's cognition was moderately impaired and she no behaviors or rejection of care. She required the extensive assistance of 1 for bed mobility, dressing, toileting and personal hygiene and the extensive assistance of 2 or more for transfers. Resident #29 had impairment on 1 side of her upper and 1 side of her lower extremities and she was frequently incontinent of bladder and bowel.

Resident #29 ' s active care plan included the focus area of an Activity of Daily Living (ADL) self-care deficit. The interventions included extensive assistance with toileting and to encourage her to use the call bell for assistance. She also had an active care plan with a focus area of bowel and bladder incontinence which included the intervention of cleaning Resident #29 ' s peri-area with each incontinence episode.

During an interview with Resident #29 on 5/17/21 at 9:50 AM when asked how she was doing she stated that she was not doing well because she had a bowel and bladder movement and she needed staff assistance to be changed. She indicated she rang her call bell several minutes ago and Nursing Assistant (NA) # 1 came into the room, asked her what she needed, and she

care and on answering resident call lights.

2) On 6/2/21 Nursing Management, to include: Director of Nursing, Assistant Director of Nursing and MDS Nurse completed 100% skin sweeps on residents with a BIMS (Brief Interview for Mental Status) of less than 8 who are dependent on staff for assistance with incontinence care. Also on 6/2/21 the facility Social Worker conducted resident interviews of interviewable residents (BIMS 8 and greater) who are dependent on staff for assistance with incontinence care to ensure residents are receiving timely incontinence care. Issues identified were addressed.

3) The Director of Nursing/Assistant Director of Nursing/Nurse Management will reeducate licensed nurses and certified nursing assistants regarding providing timely incontinence care to resident dependent on staff for assistance. Additionally staff will be educated on answering call lights. If staff answering call light is unable to provide the care requested, they are to leave the call light on and retrieve someone who can. The Interdisciplinary Team will make observations during Mock Survey Rounds to ensure incontinence care and call lights are being answered timely through interviews/observations. Education will be on-going, no staff will return to work until they have completed the mandatory education on providing timely incontinence care and answering call lights. This education will be provided to

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F 677	Continued From page 15 turned off the call bell and said someone would be back to change her. Resident #29 ' s roommate, Resident #41 (5/6/21 MDS indicated Resident #41 ' s cognition was fully intact), confirmed this information. During observations and interviews with Resident #29 and Resident #41 on 5/17/21 at 10:10 AM and 10:25 AM both residents indicated staff had not returned to attend to Resident #29 ' s incontinence care needs. During an observation on 5/17/21 at 10:45 AM Resident #29 ' s door was closed indicating that care was being provided in the room. An interview was conducted with Resident #29 and Resident #41 on 5/17/21 at 12:35 PM. They both stated that it was 10:35 AM when NA #2 came into their room to provide incontinence care to Resident #29. They reported there was clock in the room and they were both able to see and report the time. The clock was observed on the wall opposite of the beds. An interview was conducted with NA #1 on 5/17/21 at 2:15 PM. She confirmed that she answered the call bell for Resident #29 that morning and the resident told her she needed to be changed. She indicated this was sometime during breakfast, but she was unable to recall the specific time. NA #1 verified that she shut off the call bell and informed Resident #29 that someone would be back to provide incontinence care. She reported that after she shut off the call bell she informed the NA who was assigned to Resident #29, NA #2, that this resident needed incontinence care. The interview and observations that revealed a greater than 45	F 677	all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. 4) A member of the Interdisciplinary Team to include: Director of Nursing, Assistant Director of Nursing, MDS Nurse, Activities Director, and Social Worker will perform a quality review by auditing through observations and interviews of 5 residents dependent on staff for incontinence care; to ensure timely incontinence care and timely call light response time 2 x weekly for 4 weeks, 1 x weekly for 2 months, 1 x monthly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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minute time frame (9:50 AM to 10:35 AM) for which Resident #29 was waiting for incontinence care were reviewed with NA #1. NA #1 reported that she was not sure why it had taken so long for Resident #29 to receive incontinence care. She stated that maybe NA #2 was busy on her other hall and had forgotten to come back to Resident #29 ' s hall to attend to her. She explained that NA #2 was assigned 1 room on Resident #29 ' s hall and the remainder of her rooms were on a different hall.

A phone interview was conducted with NA #2 on 5/18/21 at 3:40 PM. She verified she was assigned to Resident #29 during the first shift on 5/17/21. She stated that Resident #29 was dependent on staff for assistance with incontinence care. The interviews and observations that revealed a greater than 45 minute time frame (9:50 AM to 10:35 AM) for which Resident #29 was waiting for incontinence care were reviewed with NA #2. She reported that she was unable to recall what time NA #1 informed her that Resident #29 needed incontinent care, but that she attended to Resident #29 within 5 minutes of this notification. She stated that maybe NA #1 had not notified her right away of Resident #29 ' s needs and that since the call bell was turned off by NA #1 that she would not have known the resident needed anything without this notification. NA #2 revealed that she would never have intentionally left Resident #29 wet and soiled for an extended timeframe without providing her care.

An interview was conducted with the Director of Nursing and Regional Clinical Resources on 5/20/21 at 12:14 PM. They both stated that they expected residents ' ADL needs to be met. The

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F 677	Continued From page 17 Regional Clinical Resources stated that the call bell should not have been turned off without the care being provided.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to implement care plan interventions to prevent further falls and fall related injury for 1 of 1 sampled resident reviewed for accidents (Resident #44). Findings included: Resident #44 was admitted to the facility on 1/9/20 with multiple diagnoses including cerebral infarction. The significant change in status Minimum Data Set (MDS) assessment dated 5/7/21 indicated that Resident #44 had moderate cognitive impairment, needed extensive assistance with transfers and had no falls since prior assessment. Resident #44's progress notes were reviewed. The notes revealed that the resident had a fall on 9/16/20, 3/11/21, 3/23/21 and 4/13/21. Review of Resident #44's care plan for falls	F 689	Resident #44 has had a significant change in condition and is currently being followed by Hospice services. Resident#44 is mostly bed bound at this time and is at low risk for falls. Fall risk assessment completed on 6/3/21 indicating resident low risk. Interdisciplinary team reviewed fall interventions and decided to remove sensor light in room and dycem to wheelchair from plan of care. Floor mats to both sides of bed was put back in place on 5/20/21, with bed in lowest position. On 6/2/21 a quality review was performed by Divisional Director of Nursing, Assistant Director of Nursing, and MDS Nurse on residents who fell in the past 60 days to ensure fall interventions are correct on the care plan and are in place at the bed side. Issues identified were addressed.	6/17/21

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F 689	Continued From page 18 initiated on 1/15/20 and was last reviewed on 5/13/21 was conducted. The care plan problem was Resident #44 was at risk for falls related to history of falls, cerebro vascular accident (CVA), impaired self -mobility and forgetful at times to ask for assistance. The goal was to minimize the risk of fall related injuries through next review. The approaches included bed low position (9/16/20), dycem to wheelchair (3/11/21), sensor night light in room (3/23/21) and to reinstate floor mats to sides of bed (4/13/21). Resident #44 was observed in bed on 5/19/21 at 8:50 AM. His bed was in normal position (not in lowest position) and there were no floor mats on both sides of the bed. Resident #44 was again observed in bed on 5/19/21 at 2:50 PM. His bed was in normal position and there were no floor mats on both sides of the bed. Nurse Aide (NA) #1 was interviewed. She reported that she was assigned to Resident #44. NA #1 stated that the resident's bed should have been in low position. She explained that she fed the resident for lunch and forgot to lower the bed down. She also reported that she had not seen any floor mats in his room for more than a week. The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected the care plan interventions to be implemented to prevent falls and fall related injuries.	F 689	The Director of Nursing/Assistant Director of Nursing/Nurse Management will reeducate licensed nurses and certified nursing assistants regarding following care plan interventions for falls to include notifying management (Director of Nursing and/or Administrator) when equipment/device (example: floor mat) is not available. Also to remember to lower bed back to lowest position after providing care or feeding a resident who has a fall intervention in place to keep bed in lowest position. Nurses are to implement a fall intervention at the time of the fall. The Interdisciplinary team will review fall incident during clinical morning meeting daily to ensure appropriate interventions are in place. Also the Interdisciplinary Team will make observations during Mock Survey Rounds to ensure fall interventions are in place. Education will be on-going, no staff will return to work until they have completed the mandatory education on fall management. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. The Director of Nursing and/or Nursing designee to perform Quality Improvement monitoring observations of 5 residents who are at risk or actually had a fall to ensure fall interventions are in place at the beside and reflect on the care plan to be completed 2 x a week for 4 weeks, then weekly x 2 months, and then 1 x monthly for 3 months.	

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F 689	Continued From page 19	F 689	The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	
F 742 SS=E	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with the Psychiatric Nurse Practitioner and staff, the facility failed to develop and implement person-centered and individualized approaches to care for a resident with a history of trauma (Resident #20) for 1 of 1 resident reviewed for Preadmission Screening and Resident Review. The findings included:	F 742	On 5/20/21 the facility social worker implemented person-centered and individualized approaches regarding history of abuse and trauma to Resident#20 care plan. On 6/2/21 the facility Social Worker performed an audit of resident on Psychiatric Services by reviewing the Psychiatric Nurse Practitioner□s progress notes for the past 30 days to ensure	6/17/21

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F 742	Continued From page 20 Resident #20 was most recently admitted to the facility on 1/23/19 with multiple diagnoses that included bipolar disorder, depression, dementia, cognitive communication deficit, aphasia. A physician ' s note dated 3/13/20 indicated Resident #20 had a history of trauma and was a victim of abuse. The annual Minimum Data Set (MDS) assessment dated 4/9/21 indicated Resident #20 ' s cognition was severely impaired. She had no behaviors and no rejection of care. A Psychiatric Nurse Practitioner (PNP) note dated 1/25/21 indicated Resident #20 had a significant history of trauma. A psychosocial evaluation completed by the Social Worker dated 4/9/21 indicated Resident #20 had a history of trauma and was a victim of abuse. A review of Resident #20 ' s active care plan was conducted on 5/19/21. This care plan had not addressed person centered and individualized approaches to care for Resident #20 related to her history of trauma. An interview was conducted with Nursing Assistant (NA) #3 on 5/19/21 at 10:55 AM. She indicated that she was unaware Resident #20 had a history of trauma. She further indicated there were no specific interventions or approaches to care for Resident #20. An interview was conducted with Nurse #5 on 5/19/21 at 12:00 PM. She stated that she was	F 742	residents are care planned with person-centered and individualized approaches. The Social Worker also reviewed the Psychosocial Evaluations for these residents for the past 30 days. Issues identified were addressed. The Regional Director of Clinical Services or Divisional Director of Nursing will reeducate the facility Social Worker on the importance of developing/implementing person-centered and individualized approaches regarding residents with a history of abuse and trauma by 6/17/21. The Social Worker will review the Psychiatric Nurse Practitioner□s progress notes after each visit and review Psychosocial Evaluations to determine when to implement person-centered and individualized approaches on care plan for residents as needed. The Social Worker and/or designee will perform Quality Improvement monitoring of 5 residents who are receiving psychiatric services 2 x a week for 4 weeks, 1 x weekly x 2 months, and then 1 x monthly for 3 months to ensure person-centered and individualized approaches are on care plan and kardex for residents who have history of abuse and trauma. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly	

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aware that Adult Protective Services (APS) were involved with Resident #20, but she was unaware of the resident's personal history of trauma. She indicated that there were no specific interventions or approaches to care for Resident #20.

An interview was conducted with Nurse #1 on 5/19/21 at 1:30 PM. She indicated that she was unaware Resident #20 had a history of trauma. She further indicated there were no specific interventions or approaches to care for Resident #20.

During an interview with the SW on 5/20/21 at 8:50 AM she stated that she was aware of APS involvement with Resident #20 and that she knew the resident suffered trauma and abuse in her past. She verified that Resident #20 ' s care plan included no person centered and individualized approaches to care for Resident #20 in relation to her history of trauma. The SW revealed that prior to the pandemic when residents were able to congregate in communal areas and group settings that Resident #20 experienced some behaviors that included crying spells, but since that time the environment has been much more socially isolated and Resident #20 has not exhibited these behaviors. She acknowledged that a care plan that provided the staff with non-pharmacological interventions and approaches to care was essential for the staff to know how best to care for Resident #20 in relation to her history of trauma.

During a phone interview with the Psychiatric Nurse Practitioner (PNP) on 5/20/21 at 9:54 AM she verified that Resident #20 had a significant history of trauma and had suffered abuse. She stated that it was essential for the facility staff to

and as needed.

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F 742	Continued From page 22 have a care plan in place that provided them with person-centered approaches to care for Resident #20 in relation to her history of trauma. The PNP explained that an example of this would be to monitor for behavioral symptoms in an effort to identify possible behavioral triggers and then if triggers were identified these would then need to be addressed in the care plan in order for staff to know what approaches to employ and what approaches to avoid. An interview was conducted with the Director of Nursing and Regional Clinical Resources on 5/20/21 at 12:14 PM. They both indicated their expectation was for a care plan to be developed that included person-centered and individualized approaches to care for residents who had a history of trauma.	F 742		
F 755 SS=D	Pharmacy Srvcs/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	F 755		6/17/21

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F 755	Continued From page 23 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 reconciliation; and §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 record review and interviews with the Nurse Practitioner, Pharmacist, and staff, the facility failed to acquire routine medications for administration resulting in failure to administer medications as ordered by the physician for 2 of 7 residents (Residents #18 and #251) whose medications were reviewed. The findings included: 1. Resident #18 was admitted to the facility on 4/9/21 with diagnoses that included heart disease and diabetes mellitus. A physician ' s order dated 3/9/21 indicated Lidocaine Patch (pain relieving patch) 5% applied to skin topically in the morning for pain for Resident #18. The quarterly Minimum Data Set (MDS) assessment dated 4/9/20 indicated Resident #18 ' s cognition was moderately impaired. She was assessed with no pain.	F 755	1) Nurse #4, Nurse#6, Nurse#7, and Nurse#8 were reeducated by Director of Nursing on Medication Availability (Ordering/Reordering Medications, Omnicell (Emergency Medications), and Back-up Pharmacy Process) on 6/2/21. Divisional Director of Clinical Services was reeducated by Regional Director of Clinical Services on medication order entry 6/2/21. Resident #18 medication (Lidocaine Patch) ordered and delivered on 5/20/21 by Central Supply Clerk. Medication Error Report completed for Resident#251□s Ciprofloxacin eye drops. Medication Error Report also completed for Resident#18□s lidocaine patch. Physician notification for both medication errors. 2) Medications carts audited to ensure all medications are available for residents on 6/2/21 by Regional Director of Nursing and Divisional Director of Nursing. Medication Administration Records	

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F 755	Continued From page 24 The April 2021 Medication Administration Record (MAR) and electronic MAR (eMAR) notes for Resident #18 revealed the Lidocaine Patch was not administered as ordered on the following dates: - 4/6/21 Nurse #6 indicated the Lidocaine Patch was not administered as it was not available - 4/8/21 Nurse #6 indicated the Lidocaine Patch was not administered as it was not available - 4/25/21 Nurse #8 indicated the Lidocaine Patch was not administered due to it being reordered - 4/28/21 Nurse #6 indicated the Lidocaine Patch was not administered as it was not available A review of the pain monitoring documentation on the MAR indicated Resident #18 had pain levels of 0 throughout the month. The May 2021 MAR and eMAR notes through 5/20/21 for Resident #18 revealed the Lidocaine Patch was not administered as ordered on the following dates: - 5/4/21 Nurse #6 indicated the Lidocaine Patch was not administered as it was not available - 5/6/21 Nurse #6 indicated the Lidocaine Patch was not administered as it was not available - 5/7/21 Nurse #7 indicated the Lidocaine Patch was not administered due to it being reordered A review of the pain monitoring documentation on the MAR indicated Resident #18 had pain levels of 0 throughout the month. A phone interview was attempted with Nurse #6 on 5/20/21 at 10:50 AM. She was unable to be reached. A phone interview was attempted with Nurse #7 on 5/20/21 at 11:10 AM. She was unable to be reached.	F 755	reviewed to identify documentation of medication not available. Issues identified were addressed. 3) The Director of Nursing/Assistant Director of Nursing/Nurse Management will reeducate licensed nurses on Medication Availability (Ordering/Reordering Medications, Omnicell (Emergency Medication), and Back-up Pharmacy Process) by 6/17/21. Central Supply Clerk will be reeducated on ordering and stocking over the counter medications by Director of Nursing and/or Administrator by 6/17/21. Licensed nurses will be educated to review and compare orders to discharge summary once entered into system to ensure accuracy by 6/17/21. Director of Nursing (DON) and Assistant Director of Nursing (ADON) will review new admissions during clinical morning meeting to include verifying orders to discharge summary. DON and/or ADON will check cart to verify receipt of medications for new admissions. Also during clinical morning meeting the DON and ADON will run an EMAR-Progress Note report to identify medications not available for residents. Education will be on-going, no staff will return to work until they have completed the mandatory education on pharmacy services to include medication availability. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. 4)Nurse Management/Administrative	

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F 755	Continued From page 25 A phone interview was conducted with the Pharmacist on 5/20/21 at 3:23 PM. The Pharmacist reviewed the records for Resident #18 ' s Lidocaine Patch and indicated that the facility had not ordered and acquired the Lidocain Patch from the pharmacy for the dates in which the medication was noted to be not available. An interview was conducted with the Nurse Practitioner on 5/20/21 at 11:30 AM. She stated that she expected medications to be administered as ordered and for the facility to ensure procedures were in place for acquiring medications needed for administration. She revealed that she had been informed by a couple of residents in the past that they had not received their Lidocaine Patch as ordered as they were told it wasn ' t in stock. An interview as conducted with the Director of Nursing and the Regional Clinical Resources on 5/20/21 at 12:14 PM. They both stated that it was their expectation that medications be acquired from the pharmacy and administered as ordered. 2.Resident #251 was admitted to the facility on 5/14/2021 with diagnoses that included bacterial conjunctivitis and cognitive dysfunction. The resident's Minimum Data Set (MDS) was not available. A baseline care plan was not completed on Resident #251. The hospital discharge summary dated 5/14/2021 revealed Resident #251 had a new diagnosis of bacterial conjunctivitis and was to continue 0.3% Ciprofloxacin ophthalmic solution with instructions	F 755	Nursing (Director of Nursing, Assistant Director of Nursing, Divisional Director of Nursing, and MDS Nurse) will audit medication carts 2x week for 4 weeks, then 1x week for 2 months and then 1x monthly for 3 months to ensure medications available. Nurse Management (Director of Nursing, Assistant Director of Nursing, and MDS Nurse) will audit 5 residents Medication Administration Records 2 x weekly for 4 weeks, 1 x weekly for 2 months, 1 x monthly for 3 months to ensure residents are receiving medications and if nurses are documenting medication not available. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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to instill two drops in each eye four times a day.

The resident's active orders included a physician's order for Ciprofloxacin ointment 0.3% with instructions to instill two drops in each eye four times a day for conjunctivitis. The order had a start date of 5/14/2021at 5:00pm and an end date of 5/16/2021 at 10:52am. The resident also had an order for Ciprofloxacin ophthalmic solution 0.3% with instructions to instill two drops in each eye four times a day for infection. The order start date was 5/17/2021 at 1:00pm with no end date entered.

Resident #251's Medication Administration Record (MAR) for the month of May revealed the resident did not received a dose of Ciprofloxacin on the day he was admitted to the facility, May 14th. He did not receive Ciprofloxacin as ordered on May 15th or May 16th. Resident #251 received his first dose of Ciprofloxacin on May 17th at 1:000pm.

On 5/19/21 at 2:03pm a phone interview was conducted with Nurse #4. She stated she completed the resident's admission on 5/14/2021 but she did not enter the resident's medication orders into the electronic medical record (eMR). She further stated she did not recall who entered the medications into the eMR.

On 5/19/2021 at 2:30pm and interview was conducted with the Divisional Director of Clinical Services. She stated she entered Resident #251's medications into the eMR on 5/14/2021 and Nurse #4 confirmed them. The medication was erroneously entered as an ointment with instructions to instill drops, causing a delay in the medications being delivered by pharmacy. She

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further stated the fact that it was a late Friday admission and a weekend also added to the delay.

A phone interview was conducted with pharmacist on 05/19/21 at 2:51pm. He stated the order for Ciprofloxacin ointment was put in on 5/14/2021 at 7:14pm. He stated the cut off time for deliveries is 5:30pm but the pharmacy is open until 6:30pm then everything goes to the backup pharmacy. On 5/15/2021 the pharmacy opened at 8:00am and at 8:35am a call was made to the facility asking for clarification on the Ciprofloxacin order followed by a fax at 8:37am. The ordered required clarification because it was entered as an ointment with directions to give drops. The pharmacist stated he did not have any notes indicating a person from the facility returned the call or responded to the fax request to clarify the order. The pharmacist further stated on Sunday, May 16th, the pharmacy was closed but the facility clarified the order in the eMR at 10:55am. The order was transferred to the backup pharmacy at 1:17pm on Sunday and the medication was available at 3:30pm on Sunday May 16th.

On 5/19/2021 at 4:35pm a phone interview was conducted with Nurse #2. She stated she worked on Monday May 17th and recalled giving the morning dose of Ciprofloxacin to Resident #251. She stated she may have forgotten to document the administration but she was certain the medication was in the facility on Monday.

An interview was conducted with the Director of Nursing (DON) on 5/20/21at 12:30pm. She stated she expects medications to be available for administration per physician's order.

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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 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.	F 756		6/17/21

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F 756	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Pharmacy Consultant, Psychiatric Nurse Practitioner, Nurse Practitioner, and staff, the Pharmacy Consultant failed to identify and address drug irregularities for Residents #19 and #34 and a lack of behavior monitoring and side effect monitoring for Resident #29. In addition, the facility failed to act upon pharmacy recommendations for Resident #4. This was for 4 of 6 residents reviewed for unnecessary medications. The findings included: 1. Resident #4 was initially admitted to the facility on 5/31/16 and most recently readmitted on 9/1/20 with multiple diagnoses that included dementia without behavioral disturbance and depression. The quarterly Minimum Data Set (MDS) assessment dated 3/6/21 indicated Resident #4 ' s cognition was severely impaired. She was assessed with delusions as well as other behavioral symptoms 1 to 3 days during the MDS review period. Resident #4 was administered antipsychotic medication, antidepressant medication, and antianxiety medication on 7 of 7 days. 1a. A Pharmacy Consultant Report dated 4/12/21 indicated Resident #4 was receiving multiple antidepressants without documentation in the medical record of an inadequate response to monotherapy. These antidepressant medications were noted to be Remeron 15 milligrams (mg) once daily at night and Sertraline 150 mg once	F 756	1) Resident#29 received orders for behavior and side effect monitoring on 5/19/21. Resident#4□s pharmacy recommendations to decrease Remeron 15mg to 7.5mg and to discontinue Diazepam was completed on 6/2/21. On 6/4/21 Resident#19□s Levemir order was updated to include supplemental documentation to record blood sugar prior to administering medication. On 6/2/21 Resident#34□s metoprolol order was updated to include supplemental documentation to record blood pressure and pulse before administering medication. Medication Error Reports completed with Physician notification. 2) On 6/2/21 Nursing Management (Divisional Director of Nursing, Regional Director of Clinical Services, Assistant Director of Nursing, and MDS Nurse) performed a quality review of current resident receiving psychotropic medications to ensure behavior and side effect monitoring orders in place. On 6/2/21 Nursing Management (Divisional Director of Nursing, Regional Director of Clinical Services, Assistant Director of Nursing, and MDS Nurse) performed a quality review of Pharmacy Recommendations for the past 3 months to ensure completion.	

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F 756	Continued From page 30 daily. The Pharmacy Consultant recommended a reduction of Remeron from 15 mg to 7.5 mg with the end goal of discontinuation. The Nurse Practitioner (NP) reviewed the recommendation on 4/29/21 and noted her agreement to reduce Remeron to 7.5 mg for Resident #4. Resident #4 ' s active physician ' s orders were reviewed on 5/19/21 and revealed Remeron 15 mg once daily at night (initiated on 11/3/20) was still an active order. A review of the May 2021 Medication Administration Record (MAR) from 5/1/21 through 5/19/21 indicated Resident #4 was administered Remeron 15 mg once daily. An interview was conducted with the NP on 5/20/21 at 11:30 AM. The Pharmacy Consultant ' s recommendation dated 4/12/21 in which the NP indicated her agreement on 4/29/21 with reducing Remeron from 15 mg to 7.5 mg for Resident #4 was reviewed with the NP. The active physician ' s orders and the MAR for Resident #4 indicating that the order for Remeron 15 mg remained in place and administered daily were reviewed with the NP. She reported that when she signed this Pharmacy Consultation Report and returned it to the Director of Nursing (DON) that she expected it to be implemented and for the medication to be discontinued as indicated. During a phone interview with the Pharmacy Consultant on 5/20/21 at 3:35 PM she stated that she expected her recommendations to be responded to and acted upon by the time of her next monthly review. She indicated that she completed her May 2021 review remotely and she therefore was not able to review the hard copy	F 756	On 6/2/21 Nursing Management (Divisional Director of Nursing, Regional Director of Clinical Services, Assistant Director of Nursing, and MDS Nurse) performed a quality review on residents who have medication orders with parameters. Supplemental documentation was added to orders to prompt nurses to take blood pressure/heart rate and to record blood sugar before administering medication. 3) The Regional Director of Clinical Services will educate the Pharmacy Consultant on identifying the need for Behavior/ Side Effect Monitoring for residents receiving psychotropic medications and addressing irregularities regarding medications with parameters during monthly drug regimen review (DRR). Additionally the expectation is for the Pharmacy Consultant to make an in person visit at least monthly. Education will be completed by 6/17/21. The Regional Director of Clinical Services will educate the facility Director of Nursing on acting on Pharmacy Recommendations within a few days of the provider□s review. Education will be completed by 6/17/21.	

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F 756	Continued From page 31 Pharmacy Consultation Reports from April 2021 to ensure that recommendations agreed upon by the physician were implemented. An interview was conducted with the DON and Regional Clinical Resources on 5/20/21 at 12:14 PM. The DON indicated that she was responsible for implementing the April 2021 pharmacy recommendations as indicated by the provider. She revealed this recommendation related to a reduction in Resident #4 ' s Remeron from 15 mg to 7.5 mg had been overlooked. The DON and Regional Clinical Resources both indicated they expected pharmacy recommendations to be responded to and acted upon within a few days of the provider ' s review. 1b. A Pharmacy Consultant Report dated 4/12/21 indicated Resident #4 was prescribed PRN (as needed) Diazepam (antianxiety medication) oral solution without a stop date. The Pharmacy Consultant recommended a discontinuation of the PRN Diazepam or documentation from the prescribed on the indication of use, the intended duration or therapy, and the rationale for the extended time period. The Nurse Practitioner (NP) reviewed the recommendation on 4/29/21 and noted her agreement to discontinue PRN Diazepam oral solution for Resident #4. Resident #4 ' s active physician ' s order were reviewed on 5/19/21 and revealed the following PRN (as needed) antianxiety medication orders were in place since 11/30/20 without stop dates: - Diazepam oral solution concentrate 25 milligrams (mg)/5 milliliter (ml)- give 10 mg (2ml) every 4 hours PRN - Diazepam oral solution concentrate 25mg/5ml-	F 756	Licensed Nurses will be educated by Nursing Management (Director of Nursing, Assistant Director of Nursing, and Divisional Director of Nursing) on initiating behavior/side effect monitoring orders for resident on psychotropic medications on admission or when a new order is received; they will also be educated on administering medications with parameters as ordered. Nurses are to obtain vital signs prior to administering medications to determine whether to hold or administer medications with parameters. The nurses are not to rely on the certified nursing assistance for vital signs when administering medications with parameters. Education will be completed by 6/17/21. Education will be on-going, no staff will return to work until they have completed the mandatory education on pharmacy services to include: behavior and side effect monitoring, pharmacy recommendations, and administering medications with parameters as ordered. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. During Clinical Morning Meeting the Director of Nursing and Assistant Director of Nursing will review the Point Click Care Dashboard titled Psychotropic Medications Ordered to identify residents	

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F 756	Continued From page 32 give 5mg (1ml) every 4 hours PRN - Diazepam oral solution concentrate 25mg/ 5ml- give 2.5 (0.5ml) every 4 hours PRN These 3 PRN orders for Diazepam were entered into the Electronic Medical Record (EMR) by Nurse #2. A review of the May 2021 Medication Administration Record (MAR) from 5/1/21 through 5/19/21 indicated Resident #4 was administered PRN Diazepam oral solution 5 times (5/1/21, 5/2/21, 5/7/21, 5/16/21, and 5/17/21). An interview was conducted with the NP on 5/20/21 at 11:30 AM. The Pharmacy Consultant ' s recommendation dated 4/12/21 in which the NP indicated her agreement on 4/29/21 with discontinuing PRN Diazepam for Resident #4 was reviewed with the NP. The active physician ' s orders and the MAR for Resident #4 indicating that the PRN Diazepam orders remained in place and had been administered 5 times in May 2021 were reviewed with the NP. She reported that when she signed this Pharmacy Consultation Report and returned it to the Director of Nursing (DON) that she expected it to be implemented and for the medication to be discontinued as indicated. During a phone interview with the Pharmacy Consultant on 5/20/21 at 3:35 PM she stated that she expected her recommendations to be responded to and acted upon by the time of her next monthly review. She indicated that she completed her May 2021 review remotely and she therefore was not able to review the hard copy Pharmacy Consultation Reports from April 2021 to ensure that recommendations agreed upon by the physician were implemented.	F 756	who need behavior and side effect monitoring. Also the Held Per Parameters report will be viewed to ensure compliance for medications with parameters. The Pharmacy Consultant will conduct a drug regimen monthly, drug regimen irregularities identified that require urgent action will be communicated to the DON/designee at the time of visit for resolution with the attending physician and or Medical Director. The DON will download and print Pharmacy Recommendations to review with MD/NP. Once reviewed the nurses will process the physician orders and completed any assessments per MD recommendation in a timely manner. The Director of Nursing will keep a copy of the completed Pharmacy Recommendations in a binder located in the DON□s office. 4) Nurse Management (Director of Nursing, Assistant Director of Nursing, and MDS Nurse) will audit 5 residents receiving psychotropic medications to ensure behavior and side effect monitoring is being completed and 5 residents with pharmacy recommendations, these audits will be completed 2 x weekly for 4 weeks, 1 x weekly for 2 months, 1 x monthly for 3 months to ensure completion.	

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F 756	Continued From page 33 An interview was conducted with the Director of Nursing and Regional Clinical Resources on 5/20/21 at 12:14 PM. The DON indicated that she was responsible for implementing the April 2021 pharmacy recommendations as indicated by the provider. She revealed this recommendation related to a discontinuation of Resident #4 ' s PRN Diazepam had been overlooked. The DON and Regional Clinical Resources both indicated they expected pharmacy recommendations to be responded to and acted upon within a few days of the provider ' s review. 2. Resident #29 was admitted to the facility on 2/19/21 with diagnoses that included dementia with behavioral disturbance, anxiety, and depression. The admission Minimum Data Set (MDS) assessment dated 2/26/21 indicated Resident #29 ' s cognition was intact. She was assessed with no psychosis, no behaviors, and no rejection of care. She received antipsychotic, antianxiety, and antidepressant medication on 7 of 7 days. Resident #29 ' s active physician ' s orders were reviewed on 5/19/21 and revealed the following psychotropic medications: - Buspirone (antianxiety medication) 5 milligrams (mg) twice daily (start date 2/19/21) - Aripiprazole (antipsychotic medication) 2 mg once daily (start date 2/23/21) - Fluoxetine (antidepressant medication) 20 mg once daily (start date 5/1/21) These active physician ' s orders revealed there	F 756	Nurse Management (Director of Nursing, Assistant Director of Nursing, and MDS Nurse) will observe 2 medication pass observations 2 x weekly for 4 weeks, 1 x weekly for 2 months, 1 x monthly for 3 months to ensure nurses are checking vital signs and blood sugar prior to administering medications with parameters. Nurse Management (Director of Nursing, Assistant Director of Nursing, and MDS Nurse) will audit 5 residents receiving psychotropic medications 2 x weekly for 4 weeks, 1 x weekly for 2 months, 1 x monthly for 3 months to ensure behavior and side effect monitoring is being completed. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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was no behavior monitoring and no side effect monitoring ordered for Resident #29.

A review of Resident #29 ' s Medication Administration Records (MARs) from admission (2/19/21) through 5/19/21 revealed Resident #29 had received Aripiprazole, Buspirone, and Fluoxetine as ordered. There were no target behaviors identified, no behavior monitoring, and no side effect monitoring documented on these MARs for the psychotropic medications in use for Resident #29.

An interview was conducted with Nurse #8 on 5/19/21 at 11:00 AM. He stated that the facility utilized the MAR to document behavior monitoring and side effect monitoring for all residents on psychotropic medications.

An interview was conducted with Nurse #5 on 5/19/21 at 11:05 AM. She stated that the facility utilized the MAR to document behavior monitoring and side effect monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any of behaviors and/or side effects.

A phone interview was conducted with the facility ' s Psychiatric Nurse Practitioner (PNP) on 5/20/21 at 9:54 AM. She stated it was her expectation that behavior monitoring and side effect monitoring were completed for the use of psychotropic medications. The PNP explained that Resident #29 was on multiple psychotropic medications and it was essential to have behavior monitoring conducted in order to determine if the medications were effective. She further explained that the use of psychotropic

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medications, particularly antipsychotic medications, required close monitoring for the presence of side effects as these medications had the potential to cause serious and harmful adverse consequences.

During a phone interview with the Pharmacy Consultant on 5/20/21 at 3:35 PM she stated that that she expected behavior monitoring and side effect monitoring to be completed in accordance with the facility ' s normal protocol for all residents on psychotropic medications. A review of Resident #29 ' s Medication Administration Records (MARs) from admission (2/19/21) through 5/19/21 that revealed Resident #29 had received Aripiprazole, Buspirone, and Fluoxetine and that no behavior monitoring or no side effect monitoring were documented on the MARs were reviewed with the Pharmacy Consultant. She revealed that this had been overlooked and should have been addressed during her monthly medication regimen review.

An interview was conducted with the Director of Nursing and the Regional Clinical Resources on 5/20/21 at 12:14 PM. They both stated that they expected behavior monitoring and side effect monitoring to be completed in accordance with the facility ' s normal protocol which was for the nurse to document behavior monitoring and side effect monitoring on the MAR once per shift. They additionally reported that they expected the Pharmacy Consultant to identify any behavior monitoring and/or side effect monitoring that was not in place for all residents on psychotropic medications.

3. Resident #19 was originally admitted to the facility on 12/18/14 with multiple diagnoses including diabetes mellitus. The quarterly

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Minimum Data Set (MDS) assessment dated 4/9/21 indicated that the resident's cognition was intact.

Resident #19 had doctor's orders dated 8/7/19 for accucheck twice a day at 6:30 AM and 4:30 PM and on 12/18/20 for Levemir 5 units subcutaneously (SQ) daily at 8:00 AM and to hold if the blood sugar was below 110.

Review of the Medication Administration Records (MARs) revealed that Levemir was administered to Resident #19 when the blood sugar was below 110. Resident #19 received Levemir on the following dates:

3/10/21 - blood sugar 109
3/14/21 - blood sugar 88
3/18/21 - blood sugar 101
3/19/21 - blood sugar 90
3/28/21 - blood sugar 100
4/2/21 - blood sugar 79
4/10/21 - blood sugar 92
4/11/21 - blood sugar 92
4/16/21 - blood sugar 91
4/21/21 - blood sugar 96
4/25/21 =- blood sugar 93
4/30/21 - blood sugar 91
5/5/21 - blood sugar 77
5/8/21 - blood sugar 94
5/9/21 - blood sugar 94
5/19/21 - blood sugar 109

Review of the monthly drug regimen (DRR) completed by the Pharmacy Consultant was conducted. The monthly DRR did not address the irregularity of not holding the Levemir when the blood sugar was below 110 as ordered.

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The Pharmacy Consultant was interviewed on 5/20/21 at 3:35 PM. She reviewed the doctor's order to hold the Levemir if the blood sugar was below 110 and the MARs. She verified that the Levemir should have been held when the blood sugar was below 110. She added that she tried to review the MARs, but she missed it.

The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected medications with parameters to be administered as ordered.

4. Resident #34 was originally admitted to the facility on 9/22/19 with multiple diagnoses including hypertension and atrial fibrillation. The quarterly Minimum Data Set (MDS) assessment dated 4/7/21 indicated that Resident #34's cognition was intact.

Resident #34 had a doctor's order dated 3/31/21 for metoprolol 25 milligrams (mgs) - give 0.5 tablet by mouth every 12 hours (9 AM & 9 PM) and to hold metoprolol for systolic blood pressure (SBP) of less than 110 or heart rate (HR) of less than 60.

Review of Resident #34's Medication Administration Records (MARs) was conducted for March, April and May 2021. The MARs revealed that the blood pressure and the heart rate were monitored 3 times a day (1st, 2nd and 3rd shift), but it did not specify what time they were taken. The following dates revealed that metoprolol was administered despite SBP was less than 110 or heart rate was less than 60 (1st and 3rd shift):

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3/20/21 - SBP 106/45 (1st shift)
3/23/21 - HR 54 (3rd shift)
3/26/21 - SBP 108/58 (1st shift)
4/8/21 - SBP 98/59 (3rd shift)
4/11/21 - SBP 107/64 (3rd shift)
4/17/21 - SBP 100/64 (3rd shift)
4/24/21 - SBP 108/68 (3rd shift)
4/26/21 - SBP 102/62 (3rd shift)
4/28/21 - HR 54 (3rd shift)
4/29/21 - SBP 98/60 (3rd shift)
5/4/21 - HR 56 (1st shift)
5/7/21 - HR 58 (3rd shift)
5/11/21 - SBP 104/58 and HR 58 (1st shift)
5/16/21 - SBP 105/70 (1st shift)

Nurse #1 (assigned to Resident #34) was interviewed on 5/19/21 at 9:50 AM. She stated that the vital signs including the blood pressure and the heart rate documented on the MARs were taken by the nursing assistants (NAs) and given to the nurse to document. She reported that those vital signs were taken anytime during the shift (1st, 2nd and 3rd shift).

Nurse #2 was interviewed on 5/20/21 at 9:42 AM. Nurse #2 verified that there were no blood pressure and heart rate documented prior to the administration of metoprolol for Resident #34 (9AM and 9 PM). She stated that she would revise the MAR to include the BP and HR at 9AM and 9 PM. She also reported that the vital signs recorded on the MARs were taken by the NAs anytime during the shift and not specifically prior to the medication administration.

Review of the monthly drug regimen (DRR) completed by the Pharmacy Consultant was conducted. The monthly DRR (3/8/21, 4/12/21

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F 756	Continued From page 39 and 5/11/21) did not address the irregularity of not holding the metoprolol when the blood pressure was less than 110 or the heart rate was less than 60 as ordered. The Pharmacy Consultant was interviewed on 5/20/21 at 3:35 PM. She reviewed the doctor's order to hold the metoprolol when the systolic blood pressure (SBP) was less than 110 or heart rate (HR) was less than 60 and the MARs. She stated that the staff were taking the BP and HR and documented under vital signs and this was good. She reported that she had not noticed any issues with the parameters not being followed and had not addressed it. The Pharmacy Consultant stated that the staff should be following the parameters as ordered by the physician. The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected medications with parameters to be administered as ordered.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		6/17/21

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F 757	Continued From page 40 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to hold the medications as ordered for 2 of 6 sampled residents reviewed for unnecessary medications (Residents #34 & #19). Findings included: 1. Resident #19 was originally admitted to the facility on 12/18/14 with multiple diagnoses including diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated 4/9/21 indicated that the resident's cognition was intact. Resident #19 had doctor's orders dated 8/7/19 for accucheck twice a day at 6:30 AM and 4:30 PM and on 12/18/20 for Levemir 5 units subcutaneously (SQ) daily at 8:00 AM and to hold if the blood sugar was below 110. Review of the Medication Administration Records (MARs) revealed that Levemir was administered to Resident #19 when the blood sugar was below 110. Resident #19 received Levemir on the following dates:	F 757	1) On 6/2/21 Resident#34□s metoprolol order was updated to include supplemental documentation to record blood pressure and pulse before administering medication. On 6/4/21 Resident#19□s Levemir order was updated to include supplemental documentation to record blood sugar prior to administering medication. Medication Error Report completed for Resident#34□s metoprolol. Medication Error Report also completed for Resident#19□s Levemir. Physician notified for both medication errors. 2) On 6/2/21 Nursing Management (Divisional Director of Nursing, Regional Director of Clinical Services, Assistant Director of Nursing, and MDS Nurse) performed a quality review on residents who have medication orders with parameters. Supplemental documentation was added to orders to prompt nurses to take blood pressure/heart rate and to record blood sugar before administering medication.	

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F 757	Continued From page 41 3/10/21 - blood sugar 109 3/14/21 - blood sugar 88 3/18/21 - blood sugar 101 3/19/21 - blood sugar 90 3/28/21 - blood sugar 100 4/2/21 - blood sugar 79 4/10/21 - blood sugar 92 4/11/21 - blood sugar 92 4/16/21 - blood sugar 91 4/21/21 - blood sugar 96 4/25/21 - blood sugar 93 4/30/21 - blood sugar 91 5/5/21 - blood sugar 77 5/8/21 - blood sugar 94 5/9/21 - blood sugar 94 5/19/21 - blood sugar 109 Nurse #1 was interviewed on 5/19/21 at 12:59 PM. Nurse #1 was the nurse who administered Levemir to Resident #19 on 3/10/21, 3/14/21, 3/19/21, 4/2/21, 4/10/21, 4/11/21, 4/16/21, 4/21/21, 4/30/21, 5/5/21 and 5/19/21 when the blood sugar was below 110. She stated she was aware that Resident #19 had a doctor's order for Levemir, but she did not have a parameter order to hold it. When asked to check the order, Nurse #1 verified that there was an order to hold the Levemir if the blood sugar was below 110. She explained that the hall where Resident #19 resided was not her usual hall assignment, so she was not familiar with the orders. She also reported the blood sugar was checked by the night nurse at 6:30 AM. The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected medications with parameters to be administered as ordered.	F 757	3) Licensed Nurses will also be educated on administering medications with parameters as ordered. Nurses are to obtain vital signs prior to administering medications to determine whether to hold or administer medications with parameters. The nurses are not to rely on the certified nursing assistance for vital signs when administering medications with parameters. Licensed nurses will ensure supplemental documentation is added to orders with parameters on admission and when new order are received. The Director of Nursing and Assistant Director of Nursing will review new admissions and new orders during Clinical Morning Meeting daily to ensure compliance. Education will be completed by 6/17/21. Education will be on-going, no staff will return to work until they have completed the mandatory education on administering medications with parameters. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. 4) Nurse Management (Director of Nursing, Assistant Director of Nursing, and MDS Nurse) will audit 5 residents□ medication administration record who receive medications with parameters, these audits will be completed 2 x weekly for 4 weeks, 1 x weekly for 2 months, 1 x monthly for 3 months to ensure	

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F 757	Continued From page 42 2. Resident #34 was originally admitted to the facility on 9/22/19 with multiple diagnoses including hypertension and atrial fibrillation. The quarterly Minimum Data Set (MDS) assessment dated 4/7/21 indicated that Resident #34's cognition was intact. Resident #34 had a doctor's order dated 3/31/21 for metoprolol (used to treat hypertension) 25 milligrams (mgs) - give 0.5 tablet by mouth every 12 hours (9 AM & 9 PM) and to hold metoprolol for systolic blood pressure (SBP) of less than 110 or heart rate (HR) of less than 60. Review of Resident #34's Medication Administration Records (MARs) was conducted for March, April and May 2021. The MARs revealed that the blood pressure and the heart were monitored 3 times a day (1st, 2nd and 3rd shift), but it did not specify what time they were taken. The following dates revealed that metoprolol was administered despite SBP was less than 110 or heart rate was less than 60: 3/20/21 - SBP 106/45 (1st shift) 3/23/21 - HR 54 (3rd shift) 3/26/21 - SBP 108/58 (1st shift) 4/8/21 - SBP 98/59 (3rd shift) 4/11/21 - SBP 107/64 (3rd shift) 4/17/21 - SBP 100/64 (3rd shift) 4/24/21 - SBP 108/68 (3rd shift) 4/26/21 - SBP 102/62 (3rd shift) 4/29/21 - HR 54 (3rd shift) 4/29/21 - SBP 98/60 (3rd shift) 5/4/21 - HR 56 1st shift) 5/7/21 - HR 58 (3rd shift) 5/11/21 - SBP 104/58 and HR 58 (1st shift)	F 757	medications are being administered as ordered. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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F 757	Continued From page 43 5/16/21 - SBP 105/70 (1st shift) Nurse #1 (assigned to Resident #34) was interviewed on 5/19/21 at 9:50 AM. She stated that the vital signs including the blood pressure and the heart rate documented on the MARs were taken by the nursing assistants (NAs) and given to the nurse to document. She reported that those vital signs were taken anytime during the shift. Nurse #1 further indicated that when a parameter was ordered to hold a medication, she checks the blood pressure and the heart rate 30 minutes to 1 hour prior to administration but did not document. Nurse #2 was interviewed on 5/20/21 at 9:42 AM. She stated that when a parameter was ordered to hold a medication, the blood pressure (BP) and heart rate (HR) were checked prior to the medication administration and should have been documented on the MAR. Nurse #2 verified that there were no blood pressure and heart rate documented prior to the administration of metoprolol (9AM & 9 PM) for Resident #34. She stated that she would revise the MAR to include the BP and HR at 9AM and 9 PM. She also reported that the vital signs recorded on the MARs were taken by the NAs anytime during the shift and not specifically prior to the medication administration. The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected medications with parameters to be administered as ordered.	F 757		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		6/17/21

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F 758	Continued From page 44 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 45 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Psychiatric Nurse Practitioner, Nurse Practitioner, and staff, the facility failed to discontinue psychotropic medications as ordered (Resident #4), failed to ensure PRN (as needed) psychotropic medications were time limited in duration (Residents #4, #17, and #44), and failed to conduct behavior monitoring and side effect monitoring for a resident on psychotropic medications (Resident #29). This was for 4 of 6 residents reviewed for unnecessary medications. The findings included: 1. Resident #4 was initially admitted to the facility on 5/31/16 and most recently readmitted on 9/1/20 with multiple diagnoses that included dementia without behavioral disturbance and depression. The quarterly Minimum Data Set (MDS) assessment dated 3/6/21 indicated Resident #4 ' s cognition was severely impaired. She was assessed with delusions as well as other behavioral symptoms 1 to 3 days during the MDS review period. Resident #4 was administered antipsychotic medication, antidepressant medication, and antianxiety medication on 7 of 7	F 758	Resident#4□s pharmacy recommendations to decrease Remeron 15mg to 7.5mg and to discontinue Diazepam was completed on 6/2/21. Resident#29 received orders for behavior and side effect monitoring on 5/19/21. Resident#17□s order for PRN (as needed) Lorazepam was reviewed by Nurse Practitioner on 6/3/21 and order was discontinued. Resident#44□s order for PRN (as needed) Ativan was reviewed by Nurse Practitioner on 6/3/21 and new order received to include stop date. Nursing Management (Divisional Director of Nursing, Regional Director of Clinical Services, Assistant Director of Nursing, and MDS Nurse) performed a quality review of Pharmacy Recommendations for the past 3 months to ensure completion. Issues identified were addressed. Nursing Management (Divisional Director of Nursing, Regional Director of Clinical Services, Assistant Director of Nursing, and MDS Nurse) performed a quality review of current resident receiving psychotropic medications to ensure	

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F 758	Continued From page 46 days. She was on hospice services. 1a. A Pharmacy Consultant Report dated 4/12/21 indicated Resident #4 was receiving multiple antidepressants without documentation in the medical record of an inadequate response to monotherapy. These antidepressant medications were noted to be Remeron 15 milligrams (mg) once daily at night and Sertraline 150 mg once daily. The Pharmacy Consultant recommended a reduction of Remeron from 15 mg to 7.5 mg with the end goal of discontinuation. The Nurse Practitioner (NP) reviewed the recommendation on 4/29/21 and noted her agreement to reduce Remeron to 7.5 mg for Resident #4. Resident #4 ' s active physician ' s orders were reviewed on 5/19/21 and revealed Remeron 15 mg once daily at night (initiated on 11/3/20) was still an active order. A review of the May 2021 Medication Administration Record (MAR) from 5/1/21 through 5/19/21 indicated Resident #4 was administered Remeron 15 mg once daily. An interview was conducted with the NP on 5/20/21 at 11:30 AM. The Pharmacy Consultant ' s recommendation dated 4/12/21 in which the NP indicated her agreement on 4/29/21 with reducing Remeron from 15 mg to 7.5 mg for Resident #4 was reviewed with the NP. The active physician ' s orders and the MAR for Resident #4 indicating that the order for Remeron 15 mg remained in place and was administered daily were reviewed with the NP. She reported that when she signed this Pharmacy Consultation Report and returned it to the Director of Nursing (DON) that she expected it to be implemented and for the	F 758	behavior and side effect monitoring orders in place. Issues identified were addressed. Nursing Management (Divisional Director of Nursing, Regional Director of Clinical Services, Assistant Director of Nursing, and MDS Nurse) performed a quality review of current resident receiving PRN psychotropic medications to ensure stop date in place. Issues identified were addressed. During Clinical Morning Meeting the Director of Nursing and Assistant Director of Nursing will review the Point Click Care Dashboard titled Psychotropic Medications Ordered to identify new orders for PRN Psychotropic medication and to ensure stop date. Divisional Director of Nursing, Director of Nursing and/or Regional Director of Clinical Services will provide education to facility Nurse Practitioner and Hospice Services regarding stop date for PRN (as needed) psychotropic medications. Licensed Nurses will be educated by Nursing Management (Director of Nursing, Assistant Director of Nursing, and Divisional Director of Nursing) regarding stop date for PRN (as needed) psychotropic medications. When processing new admission orders or when receiving new orders for PRN psychotropic medications, the nurse should inquire about stop date. Education will be completed by 6/17/21. Education will be on-going, no staff will return to work until they have completed the mandatory education on pharmacy	

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F 758	Continued From page 47 medication to be discontinued as indicated. An interview was conducted with the DON and Regional Clinical Resources on 5/20/21 at 12:14 PM. The DON indicated that she was responsible for implementing the April 2021 pharmacy recommendations as indicated by the provider. She revealed this recommendation related to a reduction in Resident #4 ' s Remeron from 15 mg to 7.5 mg had been overlooked. They DON and Regional Clinical Resources both indicated they expected orders from the physician and NP to be implemented and for medications to be administered as ordered. 1b. A Pharmacy Consultant Report dated 4/12/21 indicated Resident #4 was prescribed PRN (as needed) Diazepam (antianxiety medication) oral solution without a stop date. The Pharmacy Consultant recommended a discontinuation of the PRN Diazepam or documentation from the prescribed on the indication of use, the intended duration or therapy, and the rationale for the extended time period. The Nurse Practitioner (NP) reviewed the recommendation on 4/29/21 and noted her agreement to discontinue PRN Diazepam oral solution for Resident #4. Resident #4 ' s active physician ' s order were reviewed on 5/19/21 and revealed the following PRN (as needed) antianxiety medication orders were in place since 11/30/20 without stop dates: - Diazepam oral solution concentrate 25 milligrams (mg)/5 milliliter (ml)- give 10 mg (2ml) every 4 hours PRN - Diazepam oral solution concentrate 25mg/5ml- give 5mg (1ml) every 4 hours PRN - Diazepam oral solution concentrate 25mg/ 5ml-	F 758	services to include: behavior and side effect monitoring, pharmacy recommendations, and PRN Psychotropic medications. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. Nurse Management (Director of Nursing, Assistant Director of Nursing, and MDS Nurse) will audit 5 residents receiving psychotropic medications 2 x weekly for 4 weeks, 1 x weekly for 2 months, 1 x monthly for 3 months to ensure behavior and side effect monitoring is being completed. ¿ Nurse Management (Director of Nursing, Assistant Director of Nursing, and MDS Nurse) will audit 5 residents receiving PRN (as needed) psychotropic medications 2 x weekly for 4 weeks, 1 x weekly for 2 months, 1 x monthly for 3 months to ensure PRN psychotropic medications have a stop date. Nurse Management (Director of Nursing, Assistant Director of Nursing, and MDS Nurse) will 5 residents with pharmacy recommendations, these audits will be completed 2 x weekly for 4 weeks, 1 x weekly for 2 months, 1 x monthly for 3 months to ensure completion. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality	

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F 758	Continued From page 48 give 2.5 (0.5ml) every 4 hours PRN These 3 PRN orders for Diazepam were entered into the Electronic Medical Record (EMR) by Nurse #2. A review of the May 2021 Medication Administration Record (MAR) from 5/1/21 through 5/19/21 indicated Resident #4 was administered PRN Diazepam oral solution 5 times (5/1/21, 5/2/21, 5/7/21, 5/16/21, and 5/17/21). A phone interview was conducted with Nurse #2 on 5/19/21 at 4:35 PM. The 3 PRN Diazepam orders for Resident #4 initiated on 11/30/20 with no stop date that were entered into the EMR by Nurse #2 were reviewed. She was asked if she was aware of the regulations related to PRN psychotropic medications needing to be time limited in duration. She revealed that she was aware of this regulation, but she had not thought about contacting the prescriber to obtain a stop date when she entered these 3 PRN Diazepam orders for Resident #4. She explained that she thought this was the prescriber ' s responsibility to provide a stop date. An interview was conducted with the NP on 5/20/21 at 11:30 AM. She stated she was aware that physician ' s orders for PRN psychotropic medications were required to be time limited in duration for all residents. The NP indicated that Resident #4 was receiving hospice services and she was not sure who was responsible for ensuring that PRN psychotropic medications had stop dates for residents on hospice. The Pharmacy Consultant ' s recommendation dated 4/12/21 in which the NP indicated her agreement on 4/29/21 with discontinuing PRN Diazepam for Resident #4 was reviewed with the NP. The	F 758	Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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active physician ' s orders and the MAR for Resident #4 indicating that the PRN Diazepam orders remained in place and had been administered 5 times in May 2021 were reviewed with the NP. She reported that when she signed th Pharmacy Consultation Report and returned it to the Director of Nursing (DON) that she expected it to be implemented and for the medication to be discontinued as indicated.

An interview was conducted with the Director of Nursing and Regional Clinical Resources on 5/20/21 at 12:14 PM. The DON indicated that she was responsible for implementing the April 2021 pharmacy recommendations as indicated by the provider. She revealed this recommendation related to a discontinuation of Resident #4 ' s PRN Diazepam had been overlooked. They DON and Regional Clinical Resources both indicated they expected orders from the physician and NP to be implemented and for medications to be administered as ordered. Additionally, they further indicated they expected orders for PRN psychotropic medications to be time limited in duration in accordance with the regulations.

2. Resident #17 was most recently admitted to the facility on 3/22/21 with multiple diagnoses that included anxiety and depression.

The quarterly Minimum Data Set (MDS) assessment dated 4/8/21 indicated Resident #17 ' s cognition was intact. She had no behavioral symptoms during the MDS review period.

A physician ' s order dated 4/22/21 for Resident #17 indicated Lorazepam (antianxiety medication)

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0.5 milligrams (mg) PRN (as needed) every 24 hours. This PRN Lorazepam order had no stop date and it was entered into the Electronic Medical Record (EMR) by the Nurse Practitioner (NP).

A review of the active physician ' s orders for Resident #17 on 5/19/21 revealed the PRN order for Lorazepam (initiated 4/22/21) remained an active order.

An interview was conducted with the Nurse Practitioner (NP) on 5/20/21 at 11:30 AM. She stated she was aware that physician ' s orders for PRN psychotropic medications were required to be time limited in duration for all residents. The PRN Lorazepam physician ' s order that had been in place since 4/22/21 and had no stop date was reviewed with the NP. The NP revealed that this was an oversight and she should have included a 14 day timeframe for the PRN Lorazepam order for Resident #17.

An interview was conducted with the Director of Nursing and Regional Clinical Resources on 5/20/21 at 12:14 PM. They both indicated they expected orders for PRN psychotropic medications to be time limited in duration in accordance with the regulations.

3. Resident #29 was admitted to the facility on 2/19/21 with diagnoses that included dementia with behavioral disturbance, anxiety, and depression.

The admission Minimum Data Set (MDS) assessment dated 2/26/21 indicated Resident #29 ' s cognition was intact. She was assessed

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with no psychosis, no behaviors, and no rejection of care. She received antipsychotic, antianxiety, and antidepressant medication on 7 of 7 days.

Resident #29 ' s active physician ' s orders were reviewed on 5/19/21 and revealed the following psychotropic medications:
- Buspirone (antianxiety medication) 5 milligrams (mg) twice daily (start date 2/19/21)
- Aripiprazole (antipsychotic medication) 2 mg once daily (start date 2/23/21)
- Fluoxetine (antidepressant medication) 20 mg once daily (start date 5/1/21)
These active physician ' s orders revealed there was no behavior monitoring and no side effect monitoring ordered for Resident #29.

A review of Resident #29 ' s Medication Administration Records (MARs) from admission (2/19/21) through 5/19/21 revealed Resident #29 had received Aripiprazole, Buspirone, and Fluoxetine as ordered. There were no target behaviors identified, no behavior monitoring, and no side effect monitoring documented on this MAR for the psychotropic medications in use for Resident #29.

An interview was conducted with Nurse #8 on 5/19/21 at 11:00 AM. He stated that the facility utilized the MAR to document behavior monitoring and side effect monitoring for all residents on psychotropic medications. He reported that each shift the nurse was supposed to document on the MAR if the resident had any behaviors and/or side effects. He indicated that he was not aware of any behavioral symptoms for Resident #29.

An interview was conducted with Nurse #5 on

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5/19/21 at 11:05 AM. She stated that the facility utilized the MAR to document behavior monitoring and side effect monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any of behaviors and/or side effects. She stated that there normally was a physician ' s order entered for behavior monitoring and side effect monitoring on admission if the resident was on any psychotropic medications. The physician ' s orders and MARs that revealed no behavior monitoring or side effect monitoring had been documented since Resident #29 ' s admission (2/19/21) were reviewed with Nurse #5. She confirmed that this monitoring was not in physician ' s orders or on the MAR. Nurse #5 revealed that she had noticed this was missing for Resident #29 and she was unable to explain why she had not addressed it. She stated that she would contact the physician for a verbal order and would enter the order into the electronic medical record. She reported that she was unaware of Resident #29 experiencing any behavioral symptoms.

A phone interview was conducted with the facility ' s Psychiatric Nurse Practitioner (PNP) on 5/20/21 at 9:54 AM. She stated it was her expectation that behavior monitoring and side effect monitoring were completed for the use of psychotropic medications. She reported that the facility ' s normal protocol was to document behavior monitoring and side effect monitoring on the MAR once per shift. The PNP explained that Resident #29 was on multiple psychotropic medications and it was essential to have behavior monitoring conducted in order to determine if the medications were effective. She further

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explained that the use of psychotropic medications, particularly antipsychotic medications, required close monitoring for the presence of side effects as these medications had the potential to cause serious and harmful adverse consequences.

An interviw was conducted with the Director of Nursing and the Regional Clinical Resources on 5/20/21 at 12:14 PM. They both stated that they expected behavior monitoring and side effect monitoring to be completed in accordance with the facility ' s normal protocol which was for the nurse to document behavior monitoring and side effect monitoring on the MAR once per shift.
4. Resident #44 was originally admitted to the facility on 1/9/20 with multiple diagnoses including cerebral infarction. The significant change in status Minimum Data Set (MDS) assessment dated 5/7/21 indicated that Resident #44 had moderate cognitive impairment, no behavioral symptoms and was receiving hospice care during the assessment period.

Resident #44 had a doctor's order dated 4/29/21 for a hospice consult and on 4/30/21 for Ativan (an anti -anxiety drug) 0.5 milligrams (mgs) by mouth every 4 hours as needed (PRN) for anxiety (indefinitely).

The Nurse Practitioner (NP) was interviewed on 5/20/21 at 11:45 AM. She stated that she didn't see residents everyday and she was not aware that Resident #44 had a PRN Ativan order with no stop date. She reported that she was aware that PRN psychotropic medications should have a stop date of 14 days. She stated that Resident #44 was a hospice resident, and she was not sure who was responsible to make sure PRN

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F 758	Continued From page 54 psychotropic medication has a stop date for hospice residents. The Director of Nursing (DON) and the Regional Clinical Resources were interviewed on 5/20/21 at 12:14 PM. They both stated that they expected orders for PRN psychotropic medications to have a stop date. Nurse #3 was interviewed on 5/20/21 at 1:13 PM. Nurse #3 verified that she wrote the order for the PRN Ativan for Resident #44. She reported that it was ordered by the hospice nurse for comfort measures and she didn't know if PRN psychotropic medication for hospice residents needed to have a stop date.	F 758		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		6/17/21

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F 842	Continued From page 55 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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F 842	Continued From page 56 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner (NP) interview, and staff interview, the facility failed to discontinue a physician ' s order for hospice services when Resident #29 was discharged from hospice care for 1 of 1 sampled residents. The findings included: Resident #29 was admitted to the facility on 2/19/21 with diagnoses that included cerebrovascular accident (CVA) with hemiplegia (paralysis of one side of the body). The admission Minimum Data Set (MDS) assessment dated 2/26/21 indicated Resident #29 ' s cognition was intact. She was coded with hospice services. The significant change MDS assessment dated 4/15/21 indicated Resident #29 ' s cognition was moderately impaired. She was not coded for hospice services. The psychotropic medication Care Area Assessment (CAA) related to the 4/15/21 significant change MDS assessment indicated Resident #29 was admitted to the facility on hospice services, but she was doing well and services were no longer needed at this time. The active physician ' s order for Resident #29	F 842	On 5/19/21 clarification order received to discontinue Resident#29 from Hospice Services as of 4/7/21. 2) On 6/2/21 a Quality Review was performed by Divisional Director of Nursing and Social Worker regarding residents currently receiving hospice services to ensure appropriate orders in place and that any resident discharged from hospice services did not have an order in place. Issues identified were addressed. 3) Administrator, Divisional Director of Nursing and/or Social Worker will educate Hospice Services to exit with the Director of Nursing and/or Assistant Director of Nursing at the end of visits to review resident□s plan of care and to communicate any new orders by 6/17/21. The Director of Nursing and/or Assistant Director of Nursing will educate license nurses regarding processing hospice orders by 6/17/21. Hospice nurse will communicate new orders directly to the nurse assigned to hospice resident and the nurse will process the orders. The Director of Nursing and Assistant Director of Nursing will review orders during clinical morning meeting to ensure compliance. Education will be on-going, no staff will return to work until they have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 57 were reviewed on 5/19/21. The orders indicated Resident #29 was on hospice services. During an interview with Nurse #5 on 5/19/21 at 11:05 AM she was asked if Resident #29 was on hospice services. She stated that she was not sure. Nurse #5 explained that Resident #29 was admitted to the facility with hospice services but she uncertain if she was still receiving services. Nurse #5 reviewed the medical record for Resident #29 and indicated that she needed to call the hospice provider to verify if Resident #29 was still receiving hospice services. A follow up interview was conducted with Nurse #5 on 5/19/21 at 11:50 AM. She stated that she verified with the hospice provider that Resident #29 was discharged from hospice services on 4/7/21. She reported that the nurse who was working at the time Resident #29 was discharged from hospice services should have contacted the physician for an order to discontinue hospice services. She indicated she believed this was Nurse #1. During an interview with Nurse #1 on 5/19/21 at 1:30 PM she stated that she had not known Resident #29 was discharged from hospice services and she additionally stated that she had not known Resident #29 was ever on hospice services. She explained that she worked part-time at the facility and was not familiar with all of the residents. During an interview with the Nurse Practitioner (NP) on 5/20/21 at 11:30 AM she stated that the physician ' s order for hospice services should have been discontinued when Resident #29 was discharged from hospice services.	F 842	completed the mandatory education on hospice services. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. 4) Nurse Management (Director of Nursing, Assistant Director of Nursing, and MDS Nurse) or Social Worker will audit 5 residents receiving hospice services 2 x weekly for 4 weeks, 1 x weekly for 2 months, 1 x monthly for 3 months to ensure appropriate hospice orders in place and residents discharged have order discontinued. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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F 842	Continued From page 58 An interview was conducted with the Director of Nursing and Regional Clinical Resources on 5/20/21 at 12:14 PM. They both indicated the physician ' s order for hospice services should have been discontinued by the nurse assigned to Resident #29 at the time of her discharge from hospice services. They both acknowledged that nursing staff should be able to easily determine if a resident was on hospice services.	F 842		