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	345397	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORELAND HLTH CARE & RETIREME	200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation survey of 12/08/16. Event ID# Q50J11.	F 000		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on nurse practitioner (NP) interview, staff interview, and record review the facility failed to put nutrition recommendations, made by the registered dietitian (RD) and signed off on by the nurse practitioner (NP), into place for 1 of 4 sampled residents (Resident #33) with pressure ulcers who was admitted to the facility with a pressure ulcer and developed a new pressure ulcer prior to being discharged home. The facility also failed to put nutrition interventions, made by the RD and signed off on by the physician, into place within time parameters considered	F 314	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be	1/5/17

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

Electronically Signed | 12/21/2016

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F 314	Continued From page 1 acceptable by the NP and the Director of Nursing (DON) for 1 of 4 sampled residents (Resident #49) with pressure ulcers who experienced a worsening of the wound while waiting on the interventions to be implemented. Findings included: 1. Resident #33 was admitted to the facility on 09/08/16. The resident's documented diagnoses included coccyx pressure ulcer, left buttock pressure ulcer, diabetes, Parkinson's disease, and vitamin D deficiency. The 09/08/16 Pressure Ulcer Review documented Resident #33 had an unstageable pressure ulcer measuring 5 x 5.5 centimeters (cm) on the coccyx. The wound bed was 75% of slough and 25% granulation tissue with no exudate, no odor, and no pain. The wound was cleansed with normal saline and Santyl was applied every three days and as needed. The resident was admitted on 09/08/16 with physician orders for a mechanically soft/chopped low concentrated sweet (LCS) diet and for a diabetic bedtime snack. A 09/13/16 physician order changed the resident's diet to LCS regular texture. The 09/14/16 Weekly Pressure Ulcer Review documented Resident #33's stage II pressure ulcer to the coccyx measured 4 x 5 cm. The wound bed was 100% epitheleal tissue, there was light serosanguineous drainage, no odor, and pain caused by the wound was controlled by medication. The resident's 09/14/16 lab results documented	F 314	corrected by the dates indicated. F 314 A corrective action for Affected Resident has been accomplished by: Resident #33 discharged from the facility on 10/05/2016. For resident # 49, the recommendations made by the Registered Dietician for Med Pass 2.0 was put in place on 12/05/2016 and Prostat AWC was put in place on 12/04/2016. A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: All current residents that have had nutritional recommendations made by the Registered Dietician (RD) are potentially affected. The nurse management team will audit all nutritional recommendations made by the RD since 09/15/2016 to ensure that the nutritional recommendation has been addressed by the MD and if agreed to, that it has been put in place for the resident. This audit and corrections if needed will be completed by 1/5/2017. Systemic changes made were: On 12/21/2016 an in-service will be conducted by the Clinical Nurse Consultant to the Director of Nursing (DON), Dietary Manager, Unit Manager,	

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F 314	Continued From page 2 her albumin level was 3.1 grams per deciliter (g/dL) with the normal range being 3.6 - 5.1 g/dL, and her total protein level was 6.1 g/dL with the normal range being 6.1 - 8.1 g/dL. The resident's 09/15/16 admission minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors, she required extensive assistance from a staff member with her activities of daily living (ADLs) except for eating, she was at risk for pressure ulcers, she had an unhealed pressure ulcer (one stage II ulcer), and she had no nutrition/hydration interventions in place to promote wound healing. A 09/15/16 Dietitian Note documented Resident #33 weighed 217.2 pounds, gradual weight loss might be beneficial for the resident, meal intake was mostly over 50%, the resident had a stage II ulcer to the coccyx, and 09/08/16 lab results documented the resident's albumin level was low at 2.3 g/dL with the normal range being 3.6 - 5.1 g/dL. The registered dietitian (RD) documented, "Recommend Prostat SF (Sugar Free protein supplement) 30 ml BID (milliliters twice daily) until wound closed, Vit C 500 mg (milligrams) BID x 30 days, Zinc 220 mg once daily x 14 days, and MVI (multi-vitamin) for wound healing aid. Prostat SF will aid with low albumin as well. Recommend add Cardiac to current diet orders due to medical history/dx (diagnosis)." On 09/16/16 on the Nutritional Recommendation sheet the NP placed a check mark beside the RD's recommendation to begin protein supplementation, vitamin C, zinc, and a multi-vitamin, but placed a X by the recommendation to change the diet.	F 314	and Staff Development Coordinator on the following topics: • When nutritional recommendations are made by the RD, an email will be sent to the DON and the Dietary Manager on the day the recommendation is made. • The DON will print off the recommendations and will give them to the Unit Manager to either fax to the MD or give the recommendation to the Nurse Practitioner for review. • Once a response is received from the MD/NP, the approved dietary recommendations will be put in place within 72 hours of receipt. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all management employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Dietary Manager will monitor this issue using the QA for RD recommendations Tool for monitoring to ensure dietary recommendations made have been implemented timely within 72 hours of receipt from the MD. This will be completed on 5 residents weekly x 4 weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as	

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F 314	Continued From page 3 Review of Resident #33's September 2016 and October 2016 medication administration records (MARs) documented protein supplementation, vitamin C, zinc, and a multi-vitamin were never initiated. The 09/21/16 Weekly Pressure Ulcer Review documented Resident #33's stage II pressure ulcer to the coccyx measured 4 x 5 x 0.2 cm. The wound bed was 100% epitheleal tissue, there was light serosanguineous drainage, no odor, and pain caused by the wound was controlled by medication. On 09/23/16 Resident #33's care plan identified, "I currently have a pressure ulcer to my coccyx" as a problem. Interventions to this problems included, "I require supplemental protein, amino acids, minerals, as ordered to promote wound healing." The 09/28/16 Weekly Pressure Ulcer Review documented Resident #33's stage II pressure ulcer to the coccyx measured 3.9 x 4.2 cm. The wound bed was 100% epitheleal tissue, there was moderate serous drainage, no odor, and no pain. A 10/05/16 Weekly Pressure Ulcer Review documented Resident #33's stage II pressure ulcer to the coccyx measured 1 x 1.3 x 0.3 cm stage II coccyx. The wound bed was 100% epitheleal tissue, there was moderate serous drainage, no odor, and no pain. A 10/05/16 Pressure Ulcer Review documented Resident #33 developed a stage II pressure ulcer to the left buttock measuring 0.2 x 1.7 cm. The wound bed was 100% epitheleal tissue, and there was light serous exudate, no odor, and no pain.	F 314	appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator.	

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Record review documented resident #33 was discharged home on 10/05/16.

At 10:05 AM on 12/08/16 the NP stated nutrition supplements played a very important role in wound healing. She reported she worked with the RD to start Prostat, vitamin C, and zinc quickly after wounds were discovered. The NP commented she found the RD's Nutritional Recommendation sheet to be confusing at first because there were bullets with multiple suggestions, but only two boxes to check--agree or disagree at the bottom of the sheet. For the last year and a half she stated she solved the problem by putting checks or Xs by each individual suggestion, checks documenting to initiate the recommendation and the Xs documenting not to implement the recommendation. She reported the Director of Nursing (DON) reviewed all nutrition recommendations, and made sure orders were initiated for the recommendations she (the NP) approved. The NP commented she would expect nutrition interventions she approved to be put in place 1 - 2 days after she signed off on them. She stated she was in the facility daily for half days Monday - Friday. After reviewing the RD's Nutrition Recommendation sheet she signed on 09/16/16 for Resident #33 she stated she meant she wanted the resident to receive protein supplementation, vitamin C, zinc, and a multi-vitamin, but she did not want the resident's diet order to be changed.

At 10:18 AM on 12/08/16 the DON stated she reviewed all nutrition and pharmacy recommendations. She reported she thought the RD Nutritional Recommendation sheets were

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confusing at first because many recommendations were listed on one form, and there was only one line on the bottom of the sheets for the physician to check whether he/she agreed or disagreed with recommendations and a line for comments. She commented she had not noticed any checks and x's on the RD recommendation sheets. Instead, she reported the NP was writing agree or disagree beside each individual recommendation (this was not observed during record review). However, after reviewing Resident #33's recommendation sheet, she stated she would interpret the NP's notations (checks and x's) to mean she wanted the nutrition supplements implemented, but did not want the diet changed. The DON explained the only reason the supplements would not be implemented would be if the resident's ulcer was resolved. She commented at the maximum, she would expect RD recommendations approved by the NP, to be implemented within a week.

At 11:46 AM on 12/08/16, during a telephone interview, the facility's RD stated she tried to be in the facility for a couple of hours weekly. She reported it was very important to start nutrition interventions as soon as possible after a pressure ulcer was identified. She commented she recommended Prostat, a multi-vitamin, vitamin C, and zinc for stage II pressure ulcers, and for stage III to unstageable ulcers she recommended AWC (advance wound care) Prostat which already had vitamins and minerals in it to promote wound healing. According tot he RD, she checked weekly to make sure her recommendations were approved by the physician or NP, and if they were, she also made sure they were initiated. She commented if they were not initiated within 1 1/2 weeks then she

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resubmitted her recommendation.

2. Resident #49 was admitted to the facility on 11/09/16. The resident's documented diagnoses included
left heel pressure ulcer, anemia, hypertension, and atrial fibrillation.

The resident's 11/09/16 admission nursing review documented she had no pressure ulcers.

The resident's 11/14/16 Weekly Pressure Ulcer Review documented the presence of an unstageable pressure ulcer to the left heel which measured 1.7 x 1.3 centimeters (cm). There was no exudate and no odor.

A 11/15/16 physician order initiated the administration of vitamin C 500 milligrams (mg) twice daily (BID) x 30 days and sureprep to Resident #49's left heel.

A 11/16/16 physician order started the administration of a multi-vitamin and zinc sulfate 220 mg daily x 14 days for Resident #49.

The resident's 11/16/16 admission minimum data set (MDS) documented Resident #49 had severe cognitive impairment, exhibited no behaviors, required extensive assistance from the staff with her activities of daily living (ADLs) except eating, was at risk for pressure ulcers, and had an unhealed pressure ulcer (the stage was not specified, but the wound bed was documented as having eschar).

The resident's 11/16/16 Weekly Pressure Ulcer Review documented Resident #49's ulcer to the left heel now presented as a suspected deep

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tissue injury (SDTI), measuring 1.3 x 1 cm with no exudate and no odor.

On 11/17/16 "I currently have a pressure ulcer to my left heel" was identified as a problem in the resident's care plan. Interventions to this problem included, ""I require supplemental protein, amino acids, minerals, as ordered to promote wound healing."

A 11/17/16 Dietician Note documented the resident's weight was 121.7 pounds, gradual weight gain might be beneficial, meal intake was less than 50%, the resident's albumin level was within normal limits at 3.6 grams per deciliter (g/dL) on 11/03/16, and the resident had an unstageable pressure ulcer to her left heel. The registered dietitian (RD) recommended Prostat AWC SF (sugar-free advance wound care protein supplement) 30 cubic centimeters three times daily (cc TID) until the wound closed and Med Pass (liquid nutrition supplement) 120 cc BID x 60 days for poor meal intake.

On 11/22/16 the physician placed check marks beside recommendations for Prostat and Med Pass on RD's 11/17/16 Nutritional Recommendation sheet.

The resident's 11/23/16 Weekly Pressure Ulcer Review documented Resident #49's left heel SDTI had increased in size, now measuring 3.4 x 1.1 cm with no exudate or odor.

A 11/25/16 physician order initiated use of a heel medix boot to Resident #49's left foot, worn at all times except when in therapy.

The resident's 11/30/16 Weekly Pressure Ulcer

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Review documented Resident #49's left heel measured 1.7 x 1 cm with no exudate or odor.

Resident #49's treatment administration record (TAR) documented from 12/01/16 through 12/15/16 she was to wear knee high support hose on her bilateral lower extremities at all times unless showering.

A 12/04/16 physician order started administration of Prostat AWC 30 cc TID (this intervention was recommended by the RD on 11/17/16 and signed off on by physician on 11/22/16).

A 12/05/16 physician ordered initiated the administration of med pass 2.0 120 cc BID x 60 days (this intervention was recommended by the RD on 11/17/16 and signed off on by physician on 11/22/16).

During a 12/07/16 2:30 PM observation and interview the facility's Treatment Nurse and Treatment Aide stated they were unsure how the ulcer on Resident #49's heel developed, but they reported it was found by the hall nurse shortly after the resident was admitted to the facility. They remarked sureprep had been used on the ulcer since its discovery. Before they began the treatment, the resident was in bed with the medix boot and TED hose in place. The left heel SDTI was about 1 x 1 cm and light purple in coloration.

At 10:05 AM on 12/08/16 the nurse practitioner (NP) stated nutrition supplements played a very important role in wound healing. She reported she worked with the RD to start Prostat, vitamin C, and zinc quickly after wounds were discovered. The NP commented she found the RD's Nutritional Recommendation sheet to be

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confusing at first because there were bullets with multiple suggestions, but only two boxes to check--agree or disagree at the bottom of the sheet. For the last year and a half she stated she solved the problem by putting checks or Xs by each individual suggestion, checks documenting to initiate the recommendation and the Xs documenting not to implement the recommendation. She reported the Director of Nursing (DON) reviewed all nutrition recommendations, and made sure orders were initiated for the recommendations she (the NP) approved. The NP commented she would expect nutrition interventions she approved to be put in place 1 - 2 days after she signed off on them. She stated she was in the facility daily for half days Monday - Friday. After reviewing the RD's Nutrition Recommendation sheet signed on 11/22/16 for Resident #49 she stated the resident should have received Prostat and Med Pass earlier than it ended up being initiated by the facility.

At 10:18 AM on 12/08/16 the DON stated she reviewed all nutrition and pharmacy recommendations. She reported she thought the RD Nutritional Recommendation sheets were confusing at first because many recommendations were listed on one form, and there was only one line on the bottom of the sheets for the physician to check whether he/she agreed or disagreed with recommendations and a line for comments. She commented she had not noticed any checks and x's on the RD recommendation sheets. Instead, she reported the NP was writing agree or disagree beside each individual recommendation (this was not observed during record review). She commented at the maximum, she would expect RD

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F 314	Continued From page 10 recommendations approved by the physician or NP, to be implemented within a week. At 11:46 AM on 12/08/16, during a telephone interview, the facility's RD stated she tried to be in the facility for a couple of hours weekly. She reported it was very important to start nutrition interventions as soon as possible after a pressure ulcer was identified. She commented she recommended Prostat, a multi-vitamin, vitamin C, and zinc for stage II pressure ulcers, and for stage III to unstageable ulcers she recommended AWC (advance wound care) Prostat which already had vitamins and minerals in it to promote wound healing. According tot he RD, she checked weekly to make sure her recommendations were approved by the physician or NP, and if they were, she also made sure they were initiated. She commented if they were not initiated within 1 1/2 weeks then she resubmitted her recommendation.	F 314		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 325		1/5/17

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F 325	Continued From page 11 (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on nurse practitioner (NP) interview, staff interview, and record review the facility failed to put nutrition interventions, made by the RD and signed off on by the NP, into place within time parameters considered acceptable by the NP and the Director of Nursing (DON) for 1 of 2 sampled residents (Resident #94) reviewed for weight loss. Findings included: Resident #94 was admitted to the facility on 09/23/16. The resident's documented diagnoses included anemia, hypertension, hyperlipidemia, and chronic kidney disease (stage III). The resident's Weight Summary documented she weighed 158.6 pounds on 09/24/16 and 149.4 pounds on 10/03/16. On 09/28/16 "I have a potential nutritional problem r/t (in regard to) receiving therapeutic diet" was identified as a problem in Resident #94's care plan. Interventions to this problem included, "RD to evaluate and make diet change recommendations PRN (as needed)." Resident #94's 09/30/16 admission minimum data set (MDS) documented her cognition was moderately impaired, she exhibited no behaviors, she required extensive assist with all her activities of daily living (ADLs) including eating, her weight was stable at 162 pounds, and she was on a therapeutic diet.	F 325	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 325 A corrective action for Affected Resident has been accomplished by: Resident #94 the nutritional recommendation for Med Pass was initiated on 11/17/2016 by the Director of Nursing (DON). A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: All current residents that have had nutritional recommendations made by the Registered Dietician (RD) are potentially affected. The nurse management team	

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SHORELAND HLTH CARE & RETIREME	200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472

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F 325	Continued From page 12 A 10/06/16 Dietician Note documented the resident experienced over a 5% weight loss since 09/26/16 (when the resident weighed 161.7 pounds), weight maintenance was desired, staff was working to review accuracy of all weights, the resident was on a regular cardiac diet, and the resident was eating at least 50% of most meals. The registered dietitian (RD) documented, "If weight loss noted to continue, recommend Med Pass (liquid nutrition supplement) 120 cubic centimeters twice daily (cc BID) given with med pass x 60 days." Record review revealed there was not a RD Nutritional Recommendation sheet in Resident #94's chart which documented the RD's recommendation for Med Pass to help the resident prevent further weight loss. The resident's Weight Summary documented she weighed 147.2 pounds on 10/10/16, 148.4 pounds on 10/18/16, and 149.2 pounds on 11/15/16. A 11/17/16 physician order initiated Med Pass 2.0 120 cc BID x 60 days for Resident #94. (The RD's recommendation for this nutrition intervention was made on 10/06/16). The resident's Weight Summary documented she weighed 147.4 pounds on 12/05/16. At 10:05 AM on 12/08/16 the NP stated nutrition supplements played a very important role in preventing weight loss. She reported she worked with the RD to address weight loss quickly when a significant problem was first identified. The NP commented she depended on the RD's Nutritional Recommendation sheets to identify the	F 325	will audit all nutritional recommendations made by the RD since 09/15/2016 to ensure that the nutritional recommendation has been addressed by the MD and if agreed to, that it has been put in place for the resident. This audit and corrections if needed will be completed by 1/5/2017. A new process for delivering nutritional recommendations to the DON was implemented on 11/17/2016. The RD emails all nutritional recommendations made to the DON and the Dietary Manager. Systemic changes made were: On 12/21/2016 an in-service will be conducted by the Clinical Nurse Consultant to the Director of Nursing (DON), Dietary Manager, Unit Manager, and Staff Development Coordinator on the following topics: • When nutritional recommendations are made by the RD, an email will be sent to the DON and the Dietary Manager on the day the recommendation is made. • The DON will print off the recommendations and will give them to the Unit Manager to either fax to the MD or give the recommendation to the Nurse Practitioner for review. • Once a response is received from the MD/NP, the approved dietary recommendations will be put in place within 72 hours of receipt. This information has been integrated into the standard orientation training and in the required in-service refresher courses for	

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F 325	Continued From page 13 best interventions for halting weight loss. According to the NP, she could not remember if she reviewed a RD Nutritional Recommendation sheet for Resident #94, but thought the Director of Nursing (DON) kept all the recommendation sheets in a notebook after she (the NP) signed off on them, either approving or rejecting the recommendations. The NP remarked she approved almost all of the RD's recommendations for supplements and food interventions, but occasionally rejected recommendations to change resident diet orders. The NP commented she would expect nutrition interventions she approved to be put in place 1 - 2 days after she signed off on them. She stated she was in the facility daily for half days Monday - Friday. The NP reported if a resident needed a nutrition supplement to prevent further weight loss, waiting for over a month to implement the supplement recommendation was not a good practice. At 10:18 AM on 12/08/16 the DON stated she reviewed all nutrition and pharmacy recommendations. She reported she thought the RD Nutritional Recommendation sheets were confusing at first because many recommendations were listed on one form, and there was only one line on the bottom of the sheets for the physician to check whether he/she agreed or disagreed with recommendations and a line for comments. She also commented she thought the wording on some of the RD recommendations was confusing. According to the DON, at the maximum, she would expect RD recommendations approved by the NP to be implemented within a week. At 11:46 AM on 12/08/16, during a telephone	F 325	al management employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Dietary Manager will monitor this issue using the QA for RD recommendations Tool for monitoring to ensure dietary recommendations made have been implemented timely within 72 hours of receipt from the MD. This will be completed weekly x 4weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator.	

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F 325	Continued From page 14 interview, the facility's RD stated she tried to be in the facility for a couple of hours weekly. She reported it was very important to start nutrition interventions as soon as possible when a weight loss issue was identified. According tot he RD, she checked weekly to make sure her recommendations were approved by the physician or NP, and if they were, she also made sure they were initiated. The RD commented if they were not initiated within 1 1/2 weeks then she resubmitted her recommendation. At 11:56 AM on 12/08/16 the DON stated she kept all RD Nutritional Recommendation sheets in a notebook, and there was no 10/06/16 sheet from the RD for Resident #94. At 2:35 PM on 12/08/16, during a follow-up telephone conversation with the RD, she stated she was unsure whether she completed a Nutritional Recommendation sheet for Resident #94. She reported she shredded her original copies of these sheets when her recommendations were acted upon.	F 325		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		1/5/17

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F 329	Continued From page 15 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (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 and Consultant Pharmacist interviews the facility failed to attempt a gradual dose reduction (GDR) of three antipsychotic medications as required for 1 of 5 sampled residents (Resident #62) reviewed for unnecessary medications. Findings included: Review of the Quarterly Minimum Data Set (MDS) dated 10/19/16 revealed Resident #62 was admitted to the facility on 01/17/09. Diagnoses included psychotic disorder and Schizophrenia. Review of the Psychotherapy Services notes dated 10/12/15 revealed a recommendation for an attempted GDR of Zyprexa (an anti-psychotic medication) to 5 mg (milligrams) by mouth every hour of sleep. Review of the Medication Administration Records (MAR) from 11/01/15 through 12/07/16 revealed Resident #62 was being given the following anti-psychotic medications: Abilify 15 mg (milligrams) by mouth every day, Zyprexa 5 mg by mouth at bedtime, and Geodon 60 mg by mouth twice each day. The MAR's also revealed Resident #62 had minimal behaviors noted by staff during 11/01/15 through 12/07/16. Review of Resident #62's Care Plan revised on 11/23/16 revealed interventions of observation and reporting of behavioral symptoms and a	F 329	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 329 Corrective Action for Resident Affected For resident # 62, Kelli King, NP was contacted on 12/08/2016 and a Risk/Benefit statement was written for anti-psychotic medications Geodon and Abilify. In addition to this, a Gradual Dose Reduction of Zyprexa was initiated on 12/08/2016 by Kelli King, NP. Zyprexa dose was reduced to 2.5mg at HS. Corrective Action for Resident Potentially	

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F 329	Continued From page 16 pharmacy review per protocol to consider dosage reduction when clinically appropriate. Review of the Psychotherapy Progress Notes dated 11/24/15 through 11/22/16 revealed no further recommendations or orders for attempting a GDR of anti-psychotic medications for Resident #62. Review of the monthly Consulting Pharmacist Notes dated 11/27/15 through 11/28/16 revealed no mention of conducting a GDR for Resident #62. In an interview on 12/08/16 the Nurse Practitioner (NP) stated she had not received a recommendation from the Consultant Pharmacist that a GDR attempt was needed for Resident #62. She indicated she relied on the Consultant Pharmacist to let her know when GDR attempts for anti-psychotic medications were required. She stated she had just been informed by the Director of Nursing (DON) that a GDR statement or reduction was needed. In an interview on 12/08/16 at 10:15 AM the DON stated she had been unable to find any documentation which showed GDR's had been attempted for Resident #62's anti-psychotic medications in the last year. She indicated the NP had written a risk versus benefit statement that morning for Abilify and Geodon. In a telephone interview on 12/08/16 at 10:18 AM the Consultant Pharmacist stated she performed monthly medication reviews for each resident. She indicated if a GDR was needed she sent a recommendation to the physician. She indicated that if a resident was a long term resident in the facility a GDR was only needed one time. The Consultant Pharmacist stated once a risk versus benefit statement was written there was no need for another GDR. She indicated she had not made recommendations for a GDR for Resident	F 329	Affected All current residents receiving anti-psychotic medications have the potential to be affected by the alleged deficient practice. The pharmacy consultant will complete a medication regimen review for all residents receiving an anti-psychotic medication for the need of a Gradual Dose Reduction. This review will be completed by 12/30/2016. If any Gradual Dose Reductions are identified as needed, it will be forwarded to the Director of Nursing to contact the attending physician or nurse practitioner for a response. Systemic Changes The Administrator, and Director of Nursing were in-serviced by the Clinical Nurse Consultant on the regulations for anti-psychotic monitoring. Topics included: The regulation addressing the use of antipsychotic medications identifies the process of tapering as a “gradual dose reduction (GDR)” and requires a GDR, unless clinically contraindicated.Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. For any individual who is receiving an	

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F 329	Continued From page 17 #62 because she did not realize one was needed every year. In an interview on 12/08/16 at 3:48 PM the DON stated she expected GDR's to be completed per the regulations and expected the Consultant Pharmacist to notify the facility and the physician when a GDR was needed.	F 329	antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: • The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and • The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated, if: • The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or • The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability	

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F 329	Continued From page 18	F 329	by exacerbating an underlying medical or psychiatric disorder. Monthly, the DON will complete the Anti-psychotic Review QA form to monitor for GDR and Risk/Benefit statements for all residents receiving Anti-psychotic medications. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all pharmacy consultants and management employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance The Clinical Nurse Consultant will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Antipsychotics. The monitoring will include auditing Antipsychotics for the need of a Gradual Dose Reduction monthly for 3 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary	

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F 329	Continued From page 19	F 329	Manager and Social Worker.	
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to air dry tray pans prior to stacking them in storage overnight and failed to discard kitchenware with abraded interior surfaces. Findings included: 1. At 9:25 AM on 12/07/16 3 of 7 tray pans stacked on top of one another on a storage shelf	F 371	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction	1/6/17

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F 371	Continued From page 20 had moisture trapped inside. At this time a dietary employee operating the 3-compartment sink stated she had not run any tray pans through the sink system all morning so the tray pans with moisture found inside were stacked wet the night before. At 1:13 PM on 12/08/16 the dietary manager (DM) stated since she became the DM in this facility in mid-June 2016 she had held in-servicing which included information about the storage of kitchenware. According to the DM, dietary staff was instructed not to stack kitchenware wet because bacteria could grow in trapped moisture. At 1:30 PM on 12/08/16 the PM cook stated she was taught that kitchenware should be clean and dry before stacking it in storage. She commented if kitchenware was stacked wet overnight bacteria could from which might make residents sick. 2. During kitchenware inspection, beginning at 10:12 AM on 12/07/16, 3 of 20 small plastic dessert cups were abraded inside, 10 of 29 plastic soup/cereal bowls were abraded inside, and 6 of 18 coffee mugs were abraded inside. 19 of 67 pieces of kitchenware or 28% of kitchenware was found to be compromised by abraded interior surfaces. At 1:13 PM on 12/08/16 the dietary manager (DM) stated dietary staff were taught to dispose of kitchenware that was compromised by cracks, chips, and abrasions. She reported her staff was supposed to inform her when they disposed of kitchenware so she could reorder replacements. However, she commented she tried to keep extra kitchenware in the facility as back-up so she did not have to wait for replacement stock to be	F 371	constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 371 Corrective Action for Resident Affected On 12/08/2016, the dietary manager audited all kitchen pans for moisture trapped inside and kitchenware for abraded interior surfaces and discarded or corrected any items noted to be affected. On 12/8/16 replacement kitchenware was Implemented from storage. Back up Kitchenware will be ordered 12/22/16. Staff will continue to monitor for moisture trapped pans and abraded kitchenware and discard or correct as needed on a daily basis. Corrective Action for Resident Potentially Affected On 12/08/2016, the dietary manager audited all kitchen pans for moisture trapped inside and kitchenware for abraded interior surfaces and discarded or corrected any items noted to be affected. On 12/22/16 replacement kitchenware will be ordered. Staff will continue to monitor for moisture trapped pans and abraded kitchenware and discard or correct as needed on a daily basis. Systemic Changes An in-service will be completed on	

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F 371	Continued From page 21 shipped. The DM stated utilizing kitchenware with abraded interior surfaces posed the risk that bacteria and contamination could be harbored and affect the health of residents eating eat out of or off of it. At 1:30 PM on 12/08/16 the PM cook stated staff gathered compromised kitchenware, informed the DM, threw the damaged kitchenware away, and the DM reordered replacements. She commented she had not noticed any abraded kitchenware recently.	F 371	12/21/2016 by the clinical nutrition specialist (registered dietitian). Those who attended were dietary staff employees -FT and PT. Any in-house dietary staff member who did not receive in-service training will not be allowed to work until training has been completed. Staff was in-serviced on the following topics: Food Service Sanitation: Cleaning & Sanitizing. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all kitchen employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance The dietary manager will monitor the issue using the Quality Assurance Dietary Monitor Tool for monitoring Cleaning and Sanitation. This will be completed 5 times a week for 2 weeks and then monthly x 3 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the weekly Quality of Life- Quality Assurance committee and corrective action initiated as appropriate. The Quality of Life/Quality Assurance Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Managers, Support Nurses, Social Workers, Dietary Manager and Business Office Manager.	
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		1/5/17

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F 428	Continued From page 22	F 428		

c) Drug Regimen Review

(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(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.

(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

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F 428	Continued From page 23 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Consultant Pharmacist interviews the facility failed to recognize an attempt at gradual dose reductions (GDR) of three antipsychotic medications was required for 1 of 5 sampled residents (Resident #62) reviewed for unnecessary medications. Findings included: Review of the Quarterly Minimum Data Set (MDS) dated 10/19/16 revealed Resident #62 was admitted to the facility on 01/17/09. Diagnoses included psychotic disorder and Schizophrenia. Review of the Psychotherapy Services notes dated 10/12/15 revealed a recommendation for an attempted GDR of Zyprexa (an anti-psychotic) to 5 mg (milligrams) by mouth every hour of sleep. Review of the Medication Administration Records (MAR) from 11/01/15 through 12/07/16 revealed Resident #62 was being given the following anti-psychotic medications: Abilify 15 mg (milligrams) by mouth every day, Zyprexa 5 mg by mouth at bedtime, and Geodon 60 mg by mouth twice each day. The MAR's also revealed Resident #62 had minimal behaviors noted during 11/01/15 through 12/07/16.	F 428	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 428 Corrective Action for Resident Affected For resident # 62, Kelli King, NP was contacted on 12/08/2016 and a Risk/Benefit statement was written for anti-psychotic medications Geodon and Abilify. In addition to this, a Gradual Dose Reduction of Zyprexa was initiated on 12/08/2016 by Kelli King, NP. Zyprexa dose was reduced to 2.5mg at HS.	

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	345397	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 24 Review of Resident #62's Care Plan revised on 11/23/16 revealed interventions of observation and reporting of behavioral symptoms and a pharmacy review per protocol to consider dosage reduction when clinically appropriate. Review of the monthly Consulting Pharmacist Notes dated 11/27/15 through 11/28/16 revealed no mention of conducting a GDR for Resident #62. In an interview on 12/08/16 the Nurse Practitioner (NP) stated she had not received a recommendation from the Consultant Pharmacist that a GDR attempt was needed for Resident #62. She indicated she relied on the Consultant Pharmacist to let her know when the GDR attempts for anti-psychotics were required. In an interview on 12/08/16 at 10:15 AM the DON stated she had been unable to find any documentation which showed GDR's had been attempted for Resident #62's anti-psychotic medications in the last year. In a telephone interview on 12/08/16 at 10:18 AM the Consultant Pharmacist stated she performed monthly medication reviews for each resident. She indicated if a GDR was needed she sent a recommendation to the physician. She indicated that if a resident was a long term resident in the facility a GDR was only needed one time. The Consultant Pharmacist stated once a risk versus benefit statement was written there was no need for another GDR. She indicated she had not made recommendations for a GDR for Resident #62 because she did not realize one was needed every year. In an interview on 12/08/16 at 3:48 PM the DON stated she expected GDR's to be completed per the regulations and expected the Consultant Pharmacist to notify the facility and the physician when a GDR was needed.	F 428	Corrective Action for Resident Potentially Affected All current residents receiving anti-psychotic medications have the potential to be affected by the alleged deficient practice. The pharmacy consultant will complete a medication regimen review for all residents receiving an anti-psychotic medication for the need of a Gradual Dose Reduction. This review will be completed by 12/30/16. If any Gradual Dose Reductions are identified as needed, it will be forwarded to the Director of Nursing to contact the attending physician or nurse practitioner for a response. Systemic Changes The Pharmacy Consultant was in-serviced by the Clinical Nurse Consultant on the regulations for anti-psychotic monitoring for GDR. Topics included: The regulation addressing the use of antipsychotic medications identifies the process of tapering as a “gradual dose reduction (GDR)” and requires a GDR, unless clinically contraindicated.Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted	

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F 428	Continued From page 25	F 428	annually, unless clinically contraindicated. For any individual who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: • The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and • The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated, if: • The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or • The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time	

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F 428	Continued From page 26	F 428	would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all pharmacy consultants and management employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance The Clinical Nurse Consultant will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Antipsychotics. The monitoring will include auditing Antipsychotics for the need of a Gradual Dose Reduction monthly for 3 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	