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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID # PMMZ11.	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 interviews the facility failed to accurately code tobacco use and type of urinary catheter utilized in admission Minimum Data Set (MDS) assessments for 2 of 20 residents (Residents #57 and #12). The findings included: 1. Resident #57 was admitted to the facility 05/25/17 with diagnoses which included depression and dependence with withdrawal delirium. A review of Resident #57's medical record revealed a facility smoking assessment form. The form was dated 05/25/17 and signed by the admitting nurse. The form contained documentation which specified Resident #57 was deemed a safe smoker. A review of an admission MDS dated 06/05/17 revealed in section J1300 Current Tobacco Use, no was checked. An interview with the MDS Coordinator on 01/10/18 at 4:20 PM revealed she knew Resident #57 smoked when admitted to the facility. The	F 641	After an internal root cause analysis was completed, it was determined that the Minimum data Set Nurse inaccurately coded residents with catheters and residents who smoked by not choosing the options on the MDS for these items. The MDS nurse modified the resident assessment for resident's #12 and #57 on 1-10-18 to accurately reflect the residents status. The Director of Clinical Services performed Quality Improvement Monitoring of the most recent assessment for smokers and residents with catheters for accurate coding on 1-19-18. No further issues were identified. The MDS nurse was re-educated by the regional Case Mix/MDS coordinator on accurate coding on 1-22-18 The DCS and or nursing supervision to perform Quality Improvement Monitoring of MDS assessments of residents who smoke and who have catheters for accurate coding one time a week for one month then monthly thereafter for 11	2/7/18

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

Electronically Signed | 01/26/2018

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

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F 641	Continued From page 1 MDS Coordinator confirmed the admission MDS specified the resident did not use tobacco. She explained she made an error when she checked no in section J1300. During an interview on 01/10/18 at 4:27 PM, the Director of Nursing stated she expected MDS assessments to be coded correctly. 2. Resident #12 was admitted to the facility 11/03/16 with diagnoses which included multiple sclerosis. A review of the quarterly Minimum Data Set (MDS) dated 10/12/17 in section H0100 indicated Resident #12 had an external catheter. A review of the care plan revised on 10/05/17 identified the problem of intermittent self-catheterization with the goal not to develop a urinary tract infection by the next review date. The interventions included keep self-catheter supplies at the bedside. During an interview on 01/11/18 at 1:49 PM, the MDS Coordinator revealed Resident #12 used self-catheter supplies kept at the bedside to perform intermittent self-catheterization. The MDS Coordinator confirmed section H0100 of the quarterly MDS was incorrect and indicated the resident had an external catheter. She explained an error was made and she would modify the MDS to reflect the resident performed intermittent self-catheterization and did not have an external catheter. During an interview on 01/11/18 at 5:08 PM, the Director of Nursing revealed it was her expectation for the MDS to be coded correctly and reflect resident care needs. The DON also	F 641	month. New residents who have catheters and or who smoke will be monitored weekly for 3 months then weekly for 9 months. The DCS to be responsible for implementing this plan. The DCS to present this plan of correction to the QAPI committee on 2-6-18. The results of the QIM to be reported to the QAPI committed by the DCS. QAPI committee consist of by not limited to Medical Director, Administrator, DCs, CTRS, Social Worker, Dietary Manger, Maintenance Supervisor, MDS RN and at a minimum on direct care giver. QIM schedule modified based on findings.	

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F 641	Continued From page 2 revealed it was her expectation for the MDS to be coded and reflect Resident #12 performed intermittent self-catheterization.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		2/7/18

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F 656	Continued From page 3 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop care plans for residents requiring extensive assistance with activities of daily living (ADL) for 3 of 20 residents reviewed for developing and implementing a comprehensive person-centered care plan (Resident #4, #23, #46). Findings included: 1. Resident #4 was admitted to the facility on 03/07/17 with diagnoses including dementia without behaviors and difficulty walking. Review of the annual Minimum Data Set (MDS) dated 01/04/17 indicated Resident #4 was cognitively impaired and needed extensive assistance with 2 person assist with bed mobility, transfers, toileting, and dressing. The MDS also indicated Resident #4 was incontinent of bowel and had an indwelling urinary catheter. The care area assessment (CAA) of the MDS indicated the resident was a long term care Skilled Nursing Facility resident requiring extensive up to maximum assist in meeting all of her ADL needs. A review the comprehensive care plan revised 10/04/17 revealed an ADL care plan had not been developed for Resident #4 requiring extensive	F 656	After an internal root cause analysis was completed, it was determined that the MDS nurse failed to develop an ADL care plan based on the MDS and CAA's. Resident #4, #23, #46 had an ADL care plan developed on 1-19-18 by the MDS nurse to accurately reflect care required. The DCS and or nursing supervisor med QIM of residents ADL care plans/Kardex to determine if care plan was reflective of care that the residents required on 1-19-18. Any issues identified were addressed. The MDS nurse was re-educated by the regional Case Mix/MDS Coordinator on accurate coding on 1-22-18. The DCS and or nursing supervisor to perform QIM of residents ADL care plans based on the MDS schedule, to make sure they reflect resident status two times week for two months, then one time a week for one month then monthly thereafter for 10 months. The DCS to be responsible for implementing this plan. The DCS to present this plan of correction to the QAPI	

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F 656	Continued From page 4 assistance. During an interview on 01/11/18 at 9:56 AM, the MDS Coordinator explained she was responsible for the MDS assessments and developing resident care plans. She explained if the staff provided extensive assistance for residents they should have an ADL care plan. The MDS Coordinator reviewed the annual MDS dated 10/04/17 under section G for functional status and confirmed the resident required extensive assistance by 1 to 2 persons and should have an ADL care plan. During an interview on 01/11/18 at 5:08 PM, the Director of Nursing (DON) revealed it was her expectation the MDS reflected resident care needs with a comprehensive care plan addressing those needs. The DON revealed it was her expectation Resident #4 had an ADL care plan showing extensive assistance was provided by staff. 2. Resident #46 was admitted to the facility 09/22/17 with the diagnoses including chronic obstruction pulmonary disease and diabetes mellitus. Review of the quarterly MDS dated 12/23/17 indicated Resident #46 required extensive assistance by 2 persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS also indicated range of motion impairment on both sides of the lower extremities. A review of the comprehensive care plans revised 12/31/17 revealed an ADL care plan had not been developed for Resident #46 requiring extensive assistance.	F 656	committee on 2-6-18. The results of the QIM to be reported to the QAPI committed by the DCS. QAPI committee consist of by not limited to Medical Director, Administrator, DCS, CTRS, Social Worker, Dietary Manger, Maintenance Supervisor, MDS RN and at a minimum on direct care giver. QIM schedule modified based on findings.	

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F 656	Continued From page 5	F 656		

During an interview on 01/11/18 at 10:14 AM, the MDS Coordinator explained she was responsible for the MDS assessments and developing resident care plans. She explained if the staff provided extensive assistance for residents they should have an ADL care plan. MDS Coordinator reviewed the annual MDS dated 09/29/17 under section G for functional status and confirmed the resident continued to require extensive assistance of 2 persons and should have an ADL care plan.

During an interview on 01/11/18 at 5:08 PM, the Director of Nursing (DON) revealed it was her expectation the MDS reflected resident care needs with a comprehensive care plan addressing those needs. The DON revealed it was her expectation Resident #46 had an ADL care plan showing extensive assistance was provided by staff.

3. Resident #23 was admitted to the facility on 07/13/17 with diagnoses including Alzheimer's disease, Parkinson's disease and dysphagia (difficulty swallowing).

Review of the admission Minimum Data Set (MDS) dated 07/21/17 indicated Resident #23 was cognitively impaired with continuous disorganized thinking. The MDS indicated Resident #23 required extensive assistance with activities of daily living (ADL's).

A review of the comprehensive care plan revealed no ADL plan of care for Resident #23 although the MDS indicated extensive assistance

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F 656	Continued From page 6 with ADL's was required. During an interview on 01/11/18 at 9:56 AM, The MDS Coordinator stated she was responsible for the MDS assessments and the development of resident care plans. She also stated if staff provided extensive assistance for residents there should be an ADL care plan. She reviewed the admission MDS dated 07/21/17 and verified Resident #23 should have had an ADL care plan. During an interview on 01/11/18 at 10:21 AM, the Director of Nursing (DON) revealed it was her expectation for a resident requiring extensive assistance with ADL's to have a comprehensive care plan addressing those ADL areas.	F 656		
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 observation, record review, and staff and resident interview, the facility failed to assist with oral care for 1 of 2 residents reviewed for activities of daily living (Resident #123). The findings included: Resident #123 was admitted to the facility 01/03/18 with diagnoses which included a fractured ankle. A review of Resident #123's medical record revealed an undated interim care plan. Oral	F 677	After an internal root cause analysis was completed, it was determined that an accurate kardex/care plan was not complete and reflective of resident required assistance to perform ADL's. Resident #123 had oral care performed by nursing assistant on 1-11-18. QIM of residents requiring mouth care was completed by the DCS and or nursing supervisor. Residents ere provided oral care on 1-11-18 by the nursing assistants. The DCS re-educated nursing assistants	2/7/18

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F 677	Continued From page 7 hygiene was checked on the care plan and specified the resident required staff assistance before and after the task of cleaning teeth. Continued medical record review revealed a physician's order dated 01/04/18 for non-weight bearing of right lower extremity. The order was signed by Resident #123's physician. An interview was conducted 01/09/18 at 11:33 AM with Resident #123. The resident accurately answered questions regarding how long she had been in the facility and the status of her broken ankle. A family member was present during the interview and made no corrections to any of the information Resident #123 provided. During the interview Resident #123 stated her teeth had not been brushed since she had been in the facility. The resident added normally she brushed her teeth once a day. She was not able to go to the sink to brush her teeth and no staff member had offered to assist her with obtaining supplies to clean her teeth while lying in bed. An observation at this time revealed a toothbrush and toothpaste were observed in a plastic bag that was located on the resident's bedside table. An observation of Resident #123's teeth revealed debris caked on the gum line of each visible upper and lower tooth. On 01/10 18 at 12:29 PM, Resident #123 was observed sitting in a wheelchair in her room with her broken ankle resting in a wheelchair leg support elevating that leg. The wheelchair was located on the right side of the resident's bed. The resident stated facility staff had helped her get dressed this morning. An observation of her teeth revealed all visible teeth had debris caked on the gum line of each visible upper and lower	F 677	on providing oral care to dependent residents based on kardex/care plans on 1-16-18 - 2-6-18. The DCS and or nursing supervisor to provide QIM for oral care for dependent residents 5 times a week for one month, then three times a week for one month then one time a week for one month and then monthly thereafter for 9 months. The DCS to be responsible for implementing this plan. The DCS to present this plan of correction to the QAPI committee on 2-6-18. The results of the QIM to be reported to the QAPI committed by the DCS. QAPI committee consist of by not limited to Medical Director, Administrator, DCS, CTRS, Social Worker, Dietary Manger, Maintenance Supervisor, MDS RN and at a minimum on direct care giver. QIM schedule modified based on findings.	

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F 677	Continued From page 8	F 677		

tooth. Resident #123 stated no one offered to help her brush her teeth. A toothbrush and tooth paste were observed in a plastic bag on her bedside table which was located on the left side of the bed.

On 01/11/18 at 8:30 AM Resident #123 was lying in her bed in a lot of pain with her ankle. She stated her teeth had not been brushed yesterday or today. When asked if her teeth could be observed, she stated no one wanted to look at them and added they felt awful.

An interview was conducted with Nurse Aide (NA) #2 on 01/11/18 at 1:54 PM. NA #2 stated she had worked on Resident #123's hall for 5 days this week. NA #2 was unaware of a care guide or instructions provided by the facility that would inform each NA on the needs of each resident. She explained all the NAs on the hall work together to provide care for the residents. NA #2 stated she had not offered to assist Resident #123 with brushing her teeth.

An interview was conducted with the Assistant Director of Nursing (ADON) on 01/11/18 at 2:02 PM. During the interview, the ADON was informed of staff not offering assistance with brushing Resident #123's teeth. The ADON stated a Kardex was provided to direct NAs regarding the needs of each resident. The ADON added the Kardex was filled out for each resident upon admission and updated as needed. The ADON confirmed nothing had been filled out in the personal hygiene section of Resident #123's Kardex page. She stated she would correct this and see that Resident #123 received assistance with oral care.

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F 677	Continued From page 9 An interview was conducted with the Director of Nursing (DON) on 01/11/18 at 2:47 PM. The DON stated her expectation was that each resident be provided oral care daily and as needed. An interview was conducted with NA #3 on 01/11/18 at 3:10 PM. NA #3 stated she had been assigned to Resident #123's hall 2 days this week. The NA added she had not offered to assist Resident #123 with oral care.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		2/7/18

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F 690	Continued From page 10 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to secure catheter tubing after cleaning for 1 of 3 residents reviewed for catheter care (Resident #4). Findings included: Resident #4 was admitted to the facility on 03/07/17 with diagnoses including dementia without behaviors and urinary retention due to neurogenic bladder. Review of the annual Minimum Data Set (MDS) dated 01/04/17 indicated Resident #4 was cognitively impaired and needed extensive assistance with toileting with an indwelling urinary catheter placed. Review of the care plan revised on 10/04/17 identified the problem urinary catheterization related to urinary retention and neurogenic bladder. The goals included not to develop recurring urinary tract infections. The interventions included secure catheter to facilitate the flow of urine and secure catheter tubing to the body.	F 690	After an internal root cause analysis was completed, it was determined that the CNA failed to secure the leg catheter after providing peri care. Re-education on securing catheter(s) when providing care to NA #1 was completed on 1-10-18 by the nursing supervisor. Resident #4 had her catheter tubing secured via catheter leg strap by the nursing supervisor on 1-10-18. Resident #4 continues to have catheter secured as needed. QIM was completed on residents with catheters for securement on 1-10-18 by the nursing supervisor. Any issues identified were addressed. The DCS educated nursing staff on securing catheters on 1-10-18 to 2-6-18. The DCS and or nursing supervisor to complete QIM on residents for securement of catheter(s) five times a week for four weeks, then 2 times a week for 4 weeks, the one time a week for four weeks then monthly for 9 months. The DCS to be responsible for	

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F 690	Continued From page 11 During an observation on 01/10/18 at 10:02 AM, Nurse Aide (NA) #1 was providing catheter care for Resident #4 and no catheter tube securing device was observed on the body/leg or in the room. After NA #1 finished cleaning the tubing and catheter care was complete, the tubing remained unsecured to the body/leg. During an interview on 01/10/18 at 11:02 AM, NA #1 confirmed she provided catheter care for Resident #4. NA #1 also confirmed she had not secured the tubing after completing catheter care and should have secured it to the body/leg. During an interview on 01/10/18 at 12:24 PM, the Director of Nursing revealed it was her expectation staff providing catheter care secure the tubing to the body/leg to prevent injury and for nurses to ensure the tubing was secured to the leg. During an interview on 01/10/18 at 12:47 PM, Nurse #1 revealed she was present during catheter care for Resident #4 and had not noticed the tubing was not secured to the body/leg after being cleaned. Nurse #1 explained tubing was secured to the body/leg to prevent damage and injury and nurses were also responsible for checking catheter tubing.	F 690	implementing this plan. The DCS to present this plan of correction to the QAPI committee on 2-6-18. The results of the QIM to be reported to the QAPI committed by the DCS. QAPI committee consist of by not limited to Medical Director, Administrator, DCS, CTRS, Social Worker, Dietary Manger, Maintenance Supervisor, MDS RN and at a minimum on direct care giver. QIM schedule modified based on findings.	
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	F 757		2/7/18

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F 757	Continued From page 12 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff, pharmacist and physician interviews the facility failed to monitor a medication by not collecting a lab value as ordered for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #23). Findings included: Resident #23 was admitted to the facility on 07/13/17 with diagnoses including epilepsy and Alzheimer's disease. The admission Minimum Data Set (MDS) dated 7/21/17 indicated Resident #23 required extensive assistance with all activities of daily living. Record review of physician's orders dated 07/13/17 indicated an order for the anti-seizure medication Primidone to be given twice a day at a dosage of a 125-milligram tablet each time. Record review was conducted of the physician's	F 757	After an internal root cause analysis was completed, it was determined that an effective system was not in place to monitor pharmacy recommendations related to labs and obtaining results. Resident #23 had Primidone and Phenobarbital levels drawn on 1-10-18 by a licensed nurse. Results given to physician with no new orders. Primidone level was within normal limits. Phenobarbital level was 8.8 on 11-15-17 and 1.0 on 1-10-16. No new orders at this time. The DCS and or nursing supervisor performed QIM observations of the last two months of pharmacy recommendations for labs being completed and the last three months of orders being obtained 11-6-17 to 2-6-18.	

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F 757	Continued From page 13 order sheet dated 10/27/17 and levels for the primidone and phenobarbital (as it is a metabolite of primidone). The physician's order written on 10/27/17 was "CBC, Primidone, Phenobarbitol levels 11/15/17." Record review of the lab report dated 11/15/17 revealed lab results for the phenobarbital and not for the primidone. The lab results for the primidone were not in the medical chart and the facility was unable to provide the documentation to support the lab was collected. The lab results indicated the phenobarbital was low at 8.8 ug/ml. During an interview with the consultant pharmacist on 01/10/18 at 8:47 AM, he acknowledged if labs were requested for both the primidone and the phenobarbital then the report received by the facility needed to indicate lab values had been drawn and the results given for each. During an interview with the Director of Nursing (DON) on 01/10/18 at 9:50 AM, the DON verified the lab had orders for both the primidone and the phenobarbital and stated she expected them both to be done per physician's order. The DON also stated she had contacted the physician and he indicated both the primidone and the phenobarbital were to be drawn again. During an interview with the physician on 01/11/18 at 2:05 PM, he stated the labs not being done was an unfortunate oversight and no harm was done in only receiving lab results for only the phenobarbital.	F 757	The DCS and or nursing supervisor to perform QIM of pharmacy recommendations for labs and physician orders during the morning clinical meeting five times a week for four weeks, then three times a week for four weeks, then two times a week for four weeks then weekly for nine months. The DCS to be responsible for implementing this plan. The DCS to present this plan of correction to the QAPI committee on 2-6-18. The results of the QIM to be reported to the QAPI committed by the DCS. QAPI committee consist of by not limited to Medical Director, Administrator, DCS, CTRS, Social Worker, Dietary Manger, Maintenance Supervisor, MDS RN and at a minimum on direct care giver. QIM schedule modified based on findings.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		2/7/18

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

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F 758	Continued From page 15 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and physician interviews, the facility failed to provide a qualifying diagnosis for use of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #47). The findings included: Resident #47 was admitted to the facility 11/29/17 with diagnoses which included dementia with behavioral symptoms. A review of admission physician orders revealed an order dated 11/29/17 for Zyprexa (an antipsychotic medication used to treat schizophrenia and bipolar disorder) 2.5 milligrams (mg) daily for dementia with behaviors. A care plan dated 11/29/17 specified Resident #47 took antipsychotic medication for dementia with behaviors. The care plan goal stated medication side effects would not impede the resident's daily routine over the next 92 days. Care plan interventions included monitor behavioral symptoms and medication side effects and medication administered as ordered.	F 758	After an internal root cause analysis was completed, it was determined that an effective system was not in place to monitor medications for active diagnoses. Resident #47 Zyprexa was discontinued on 1-11-18 by the physician. Resident #47 has had no further behaviors. The DCS and or nursing services performed QIM of residents on psychotropic medications for appropriate diagnosis on 1-16-18 to 2-6-18. Any issues identified were addressed. The DCS re-educated licensed nurses on obtaining accurate diagnosis. The DCS and or nursing supervisor to perform QIM of new orders for psychotropic medications and appropriate diagnosis during the morning clinical meeting five times a week for eight weeks, then three times a week for four weeks, then two times a week for four weeks, then weekly for 8 months The DCS to be responsible for implementing this plan. The DCS to present this plan of correction to the QAPI	

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F 758	Continued From page 16 A review of a history and physical (H&P) written by the facility's Medical Director (MD) dated 11/30/17 specified Resident #47's dementia baseline as "chronic and stable". Home medications included Aricept and olanzapine (generic name of Zyprexa). The H&P further specified the MD had assessed the course of the resident's dementia and would continue to monitor for complications of dementia. An admission Minimum Data Set (MDS) dated 12/06/17 indicated the resident's cognition and long and short term memory were severely impaired. The MDS further described Resident #47 with clear speech, could be understood, sometimes understands others and demonstrated disorganized thinking that fluctuated and inattention that came and went. There were no behaviors coded for Resident #47 on the admission MDS. A care area assessment (CAA) associated with the admission MDS dated 12/06/17 described Resident #47 had impaired thought processes and impaired cognition related to dementia, and was alert with confusion. The CAA specified the resident was unable to follow simple commands, able to answer yes/no questions at times but when instructed to do something the resident generally did not respond in an appropriate way. An interview was conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 01/11/18 at 8:47 AM. The ADON stated when Resident #47 was admitted, she did the facility psych medication assessment. The form dated 11/29/17 and signed by the ADON revealed "aggressive behaviors" was checked. The ADON stated she checked aggressive	F 758	committee on 2-6-18. The results of the QIM to be reported to the QAPI committed by the DCS. QAPI committee consist of by not limited to Medical Director, Administrator, DCS, CTRS, Social Worker, Dietary Manger, Maintenance Supervisor, MDS RN and at a minimum on direct care giver. QIM schedule modified based on findings.	

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F 758	Continued From page 17 behaviors because that was what she was told by the admitting hospital during a report. The DON explained the resident's behaviors consisted of wandering and going in and out of other residents' rooms on 1 particular hall. Neither the ADON or DON could recall any other behaviors demonstrated by Resident #47. An observation on 01/11/18 at 7:55 AM revealed Resident #47 sitting on the side of his bed eating breakfast. When asked, the resident stated his breakfast was good. The resident was not observed wandering the halls during the survey. An interview was conducted with the MD on 01/11/18 at 2:52 PM. He stated Resident #47 should have a diagnosis of psychosis if Zyprexa was being administered. The MD added the resident had no psychosis diagnosis. The MD further stated he missed the dementia with behaviors diagnosis. He explained he should have addressed this issue when Resident #47 was admitted. After review of the resident's medical record, the MD confirmed the resident had taken the medication prior to admission to the facility and no diagnosis involving psychosis was contained in the resident's medical history. The MD stated 2.5 mg was the lowest recommended dose for Zyprexa and he could find no reason for the resident to receive the medication. The MD discontinued the use of Zyprexa for Resident #47 and stated the resident would be monitored for behaviors and treated appropriately if they occurred.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		2/7/18

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F 880	Continued From page 18	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 19 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to implement contact precautions by not placing signage to identify isolation precautions for 1 of 1 resident reviewed for transmittal precautions (Resident #46). Findings included: A review of the facility policy titled, "Isolation-Categories of Transmission-Based Precautions," review date 09/01/17 read in part, Signs: The facility will implement a system to alert staff to the type of precaution the resident	F 880	After an internal root cause analysis was completed, it was determined that there was an ineffective monitoring system for contact isolation signs once posted. The DCS put the sign back up on 1-9-18 once it was recognized it was missing. On 1-10-18 resident #46 was removed from contact isolation after completion of his course of antibiotics. The DCS and or nursing supervisor completed QIM of residents requiring contact isolation was conducted on	

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F 880	Continued From page 20 requires. A review of physician's orders for Resident #46 revealed on 12/31/17 at 12:15 PM, Nurse #2 received an order for contact precautions for the diagnosis of extended spectrum beta lactamase (ESBL). An observation on 01/08/18 at 2:30 PM revealed no contact precaution signage was posted outside the room entrance door for Resident #46. An observation on 01/08/18 at 5:48 PM revealed no contact precaution signage was posted outside the room entrance door for Resident #46. An observation on 01/09/18 at 8:42 AM revealed no contact precaution signage was posted outside the room entrance door for Resident #46. During an interview on 01/09/18 at 9:23 AM, Housekeeper #1 explained a precaution sign on the resident's entrance door is used to identify the precaution and the personal protective equipment (PPE) needed before entering the room. During an interview on 01/09/18 at 3:58 PM, the Director of Nursing, DON explained nurses were notified of the type of infection and would initiate precautions which included placing a sign on the resident's entrance door of their room. The DON revealed her expectation was for the nurse receiving the physician's order would implement contact precautions including placing a contact precaution sign on the room entrance door for Resident #46. The DON also revealed it was her expectation the contact precaution sign would remain on the resident's door for the duration of the precaution and was part of the facilities	F 880	1-10-18. At that time there were no other residents requiring contact isolation. Nursing staff, housekeeping staff and therapy staff and management staff were educated regarding isolation signage on 1-16-18 - 2-6-18 by the DCS. The DCS and or the nursing supervisor to provide QIM of residents requiring contact isolation signs five times a week for one month then weekly for 11 months. The DCS to be responsible for implementing this plan. The DCS to present this plan of correction to the QAPI committee on 2-6-18. The results of the QIM to be reported to the QAPI committed by the DCS. QAPI committee consist of by not limited to Medical Director, Administrator, DCS, CTRS, Social Worker, Dietary Manger, Maintenance Supervisor, MDS RN and at a minimum on direct care giver. QIM schedule modified based on findings.	

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F 880	Continued From page 21 system used to alert the type of precaution the resident required. During an interview on 01/11/18 at 1:28 PM, Nurse #2 explained when she gets a physician order for isolation she immediately places the appropriate isolation signage outside the resident's room entrance door to alert others isolation precautions were in place. Nurse #2 also revealed she had received the physician order to initiated contact precautions for Resident #46 and had placed a contact precaution sign on the room entrance door. She also explained she did not know why it wasn't there and had not noticed it was gone and would have replaced it immediately.	F 880		