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	345358	A. BUILDING _____ B. WING _____	C 04/19/2018

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LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

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F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		4/27/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/07/2018

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F 578	Continued From page 1 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to consistently document a resident ' s advanced directive (code status) on the medical record for 1 of 20 residents reviewed for advanced directives (Resident #163). The findings included: Resident #163 was admitted to the facility on 9/22/17 and had a diagnosis of congestive heart failure. The resident ' s code status on admission was full code indicating that in the event of pulmonary and/or cardiac arrest, the staff would initiate life saving measures for the resident. The resident ' s code status was listed on the face sheet on the physical chart as full code and on the face sheet in the computer as full code along with a physician ' s order for the resident to be a full code. On 4/5/18 a physician ' s order was written for the resident ' s code status to be changed to Do Not Resuscitate (DNR) and a gold DNR sheet was signed by the responsible party and placed on the resident ' s medical record. Review of the resident ' s medical record on 4/17/18 revealed the face sheet on the electronic record noted the resident ' s code status was full code and the face sheet on the physical chart noted the resident was a full code. On 4/17/18 at 1:25 PM Nurse #1 stated in an	F 578	The Plan of Correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not in any manner constitute an admission to the validity of the alleged deficient practice. The Medical Records Clerk failed to update the face sheet of Resident #163 to reflect the change of code status from Full Code to Do Not Resuscitate (DNR) on return from a hospitalization. The QAPI committee agreed to remove the Code Status of all residents from the Face Sheets on April 19, 2018. The Medical Records Clerk and Quality Assurance Nurse removed the code status from all face sheets on 04/20/2018. The Quality Assurance Nurse retrained nurses on 04/20/2018 to observe the chart for code status under the Code Status Tab located in the medical record. The facility also post the code status of each resident in the wardrobe of each resident and on the Resident Care Guide. All new hires will receive the in-service training. The Director of Nursing and the Quality Assurance Nurse were retrained by the Administrator on 04/24/2018 to audit physician orders for code status and code	

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F 578	Continued From page 2 interview if she needed to know a resident ' s code status she could look in the computer, on the chart or on the inside of the resident ' s closet door. On 4/17/18 at 1:27 PM Nurse #2 stated in an interview she could look on the paper chart, in the computer on inside of the resident ' s closet door to identify a resident ' s code status. On 4/17/18 at 1:35 PM an interview was conducted with the facility ' s Regional Director, Nurse Consultant and the Administrator. The Nurse Consultant stated in an interview to determine a resident ' s code status the staff could look in the chart, the computer or inside a resident ' s closet door. The Regional Director stated as part of a plan of correction they had started placing residents ' code status inside their closet door. The Regional Director further stated when the code status for Resident #163 was changed it would have been discussed in the morning meeting the next day and at that point the face sheet should have been changed along with the care guide for the nursing assistants and the resident ' s Care Plan. The Administrator stated their medical records person was usually the one to change the code status on the face sheet and they had recently been without a medical records person and that nursing would have been responsible for changing the code status on the face sheet. On 4/17/18 at 1:55 PM the Director of Nursing (DON) stated in an interview that she took off the DNR order for Resident #163. The DON further stated she was not aware the resident ' s code status was on the face sheet and would need to be changed if a resident ' s code status changed.	F 578	status changes during morning clinical meetings and to audit medical record, resident care guide and code status (located in resident wardrobe) for posting of code status. The Director of Nursing and Quality Assurance will complete a Code Status Audit Tool to monitor for changes in status during morning clinical meetings. A monthly code status audit will be completed by the Director of Nursing and Quality Assurance Nurse. Results of the audits will be forwarded to the QAPI Committee monthly for three months for review and recommendations. The Director of Nursing and Quality Assurance will complete a Code Status Audit Tool to monitor for changes in status during morning clinical meetings. A monthly code status audit will be completed by the Director of Nursing and Quality Assurance Nurse. Results of the audits will be forwarded to the QAPI Committee monthly for three months for review and recommendations. Director of Nursing/Quality Assurance Nurse will be responsible for implementing the acceptable plan of correction.	

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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 and pharmacist interviews, the facility failed to accurately code an antipsychotic medication on the Minimum Data Set (MDS) Assessment for 1 of 4 residents reviewed for antipsychotic medications (Resident #43). The findings included: Resident #43 was admitted to the facility on 9/5/17 and had a diagnosis of Parkinson ' s disease. Review of the medical record revealed the resident was admitted to the facility on Nuplazid 17mg (milligrams) twice a day. Nuplazid is an antipsychotic medication used to treat delusions and hallucinations in patients with Parkinson ' s disease. Review of the January 2018 Medication Administration Record revealed the resident received Nuplazid twice a day as ordered. Review of the Quarterly MDS with an assessment reference date (ARD) of 1/30/18, Section N0410 for antipsychotics noted no antipsychotic medications were given. Section N0450 noted antipsychotics not received. On 4/19/18 at 10:27 AM an interview was conducted with the facility ' s consulting pharmacist. The Pharmacist stated Nuplazid was a new antipsychotic that had been on the market	F 641	The MDS nurse and pharmacist failed to identify Nuplazid as antipsychotic drug. The MDS nurse's attempt to identify Nuplazid's drug classification did not identify Nuplazid as a antipsychotic. The First Data Bank software used by the pharmacy "list the medication drug classification as unclassified, an atypical antipsychotic, Code 99 none of the above." First Data Bank does not identify Nuplazid as a antipsychotic. As a result, the contracting pharmacy must manually change the drug classification for their purposes. The MDS for Resident #43 was modified by the MDS Nurse on 04/23/2018 to note 7 days in which the resident received an antipsychotic (Section N0410) and Antipsychotics received on Section (N0450). The MDS nurses were retrained on 05/01/2018 by the Regional Nurse Consultant to note administration of all antipsychotics on the MDS and to consult the pharmacy if in doubt as to a drugs classification. A 100% audit of MDS was completed by	5/7/18

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F 641	Continued From page 4 for about one and a half years and had not been added to the list of antipsychotic medications provided for the facility and would needed to be added to the list. On 4/19/18 at 11:08 AM an interview was conducted with the MDS Nurse that completed Section N of the MDS. The Nurse stated she looked up the Nuplazid on line and the medication was used for residents with Parkinson ' s disease. The Nurse stated she did not see that the Nuplazid was an antipsychotic medication and would do a correction of the MDS. On 4/19/18 at 4:34 PM the Administrator stated in an interview she expected the MDS to be coded accurately.	F 641	the Administrator and Quality Assurance Nurse on 04/25/2018 utilizing the antipsychotic list provided by the pharmacy to ensure all antipsychotics were noted on the MDS. Results of the audit were forwarded to the MDS nurses for modifications. All modifications were completed on 05/06/2018. The Director of Nursing and Quality Assurance Nurse will utilize the Antipsychotic List provided by the pharmacy to audit MDS for antipsychotic usage monthly times 3 months. The results of the audit will be forwarded to the QAPI committee monthly times 3 months for review and recommendations. MDS Nurses, Director of Nursing and Quality Assurance Nurse will be responsible for implementing the acceptable plan of correction.	
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	F 656		5/6/18

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F 656	Continued From page 5 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 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 reviews and staff interviews, the facility failed to care plan 1 of 4 residents on antipsychotic medication (Resident #50). The facility also failed to care plan a catheter for 1 of 2 residents reviewed. (Resident #22). The findings include: 1. Resident #50 was originally admitted to the facility on 11/16/17, with diagnoses including	F 656	The MDS nurse failed to care plan the use of antipsychotic medication (Seroquel) for resident #50 and to care plan a catheter for Resident #22. The MDS Nurse care planned the use of Seroquel by resident #50 on 04/23/2018 and the catheter for Resident #22 on 04/24/2018.	

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F 656	Continued From page 6 Anxiety Disorder, Major Depressive Disorder, Unspecified Psychosis and Unspecified Dementia without Behavior Disturbance. According to the most recent Minimum Data Set (MDS) dated 2/28/18, Resident #50 was severely cognitively impaired. The resident required extensive assistance to total dependence in most areas of activities of daily living. Review of Section I on the MDS revealed Resident #50 was coded for psychosis. According to Resident #50's April doctor's orders, signed by the facility physician, Resident #50 received Quetiapine fumarate (Seroquel) 25mgs., one tablet by mouth daily at 8:00 PM and Quetiapine fumarate (Seroquel) 25mgs., 1/2 tablet (12.5mgs.) by mouth daily at 8:00 AM. Review of Resident #50's care plan dated 10/1/17, which was available for review and had not been updated, revealed Resident #50 was not care planned for antipsychotic medication. During an interview on 4/19/18 at 11:08 AM, the Minimum Data Set Coordinator (MDS) revealed she worked part time at the facility and the plan was to update care plans as needed. She stated some care plans had been printed and she was updating some of the care plans. During an interview on 4/19/18 at 12:10 PM, the facility Quality Assurance Nurse stated they were in the process of updating care plans and doing audits. During another interview on 4/19/18 at 12:45 PM, the facility Quality Assurance Nurse revealed care plans would be updated during resident's quarterly review.	F 656	The MDS nurses were retrained on 05/01/2018 by the Regional Nurse Consultant to include all services that are to be furnished to maintain well being and any specialized services or rehabilitative services that the facility will provide on the Comprehensive Care Plan (to include anti-psychotic meds and catheters). A 100% audit of Care Plans was completed by the Administrator and Quality Assurance Nurse on 04/25/2018 utilizing the monthly Psychotropic list provided by the pharmacy to ensure all psychotropic medications to include anti-psychotics, anti-depressants, antianxiety and anti-hypnotic meds were noted on the comprehensive care plans. An additional 100% audit of Care Plans for catheter use was completed by the Administrator and Quality Assurance Nurse on 04/25/2018. Results of the audit were forwarded to the MDS nurses for modifications. All modifications were completed on 05/06/2018. The Director of Nursing and Quality Assurance Nurse will utilize the Psychotropic Med List provided by the pharmacy to audit Comprehensive Care Plans for antipsychotic usage monthly times 3 months. The Director of Nursing and Quality Assurance Nurse will utilize the Foley Catheter audit tool to audit Comprehensive Care Plan monthly times 3 months. The results of the audit will be forwarded to the QAPI committee monthly	

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F 656	Continued From page 7 During an interview on 4/19/18 at 5:18 PM, the Administrator stated care plans should be accurate in identifying those on medications. 2. Resident #22 was originally admitted to the facility on 9/20/17 and was readmitted on 3/28/18 with diagnoses including Huntington's Disease, Pressure Ulcer on right buttock, stage 2, Pressure Ulcer of right hip, stage 4 and indwelling urethral catheter. Review of Section H of a Quarterly Minimum Data Set (MDS) dated 1/2/18, revealed Resident #22 was coded for an indwelling catheter. According to the most recent Quarterly Minimum Data Set dated 2/23/18, Resident #22's cognition was intact and he was totally dependent in all areas of activities of daily living. Review of Resident #22's Care Plan dated 10/1/17, which was available for review, revealed he was incontinent of bowel and bladder related to disease process, impaired mobility, impaired balance and contractures. There was no care plan to address Resident #22's Foley catheter for which there was a doctor's order on 12/26/17 for a catheter after his return from the hospital in December. Resident #22's care plan had not been updated to include the catheter after Quarterly Minimum Data Sets (MDS) were completed on 1/2/18 and 2/23/18. During an interview on 4/19/18 at 11:08 AM, the Minimum Data Set Coordinator (MDS) revealed she worked part time at the facility and the plan was to update care plans as needed. She stated some care plans had been printed and she was updating some of the care plans.	F 656	times 3 months for review and recommendations. MDS Nurse, Director of Nursing, Quality Assurance Nurse will be responsible for implementing the acceptable plan of correction.	

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F 656	Continued From page 8 During an interview on 4/19/18 at 12:10 PM, the Quality Assurance Nurse explained they were in the process of updating care plans. She revealed care plans would be updated during resident's quarterly review. During an interview on 4/19/18 at 5:18 PM, the Administrator acknowleged there was a problem with care plans being done timely. She also expressed that Resident #22's care plan was just about due since he had been in and out of the hospital.	F 656		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 756		5/7/18

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resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and pharmacist interviews the pharmacist failed to request a gradual dose reduction of an antipsychotic medication and failed to identify and report a drug irregularity that a medication was being given twice a day instead of once a day as ordered for 1 of 5 residents whose medications were reviewed (Resident #43).

The findings included:

Resident #43 was admitted to the facility on 9/5/17 and had a diagnosis of Parkinson ' s disease and hyperlipidemia (high cholesterol).

a. Review of the medical record revealed the resident was admitted to the facility with an order for Nuplazid 17mg (milligrams) twice a day. Nuplazid is an antipsychotic medication used to treat delusions and hallucinations in patients with Parkinson ' s disease. Review of the facility ' s consulting pharmacist ' s notes revealed no information regarding a gradual dose reduction

The pharmacy consultant failed to recognize Nuplazid as a psychotropic medication and a result, did not request a gradual dose reduction of an antipsychotic medication for Resident #43.
Nursing staff failed to identify a duplication in medication when entering a change in medication administration time and the pharmacy consultant failed to identify the duplication of the medication after two drug regimen reviews.

The Nurse Practitioner referred Resident #43 to neurology on 04/11/2018. The Nurse Practitioner declined a gradual dose reduction for the Nuplazid as she referred to neurology for management of the Nuplzaid. Resident #43 was seen by neurology on 04/30/2018 with no recommendation for a dose reduction.

The Quality Assurance Nurse

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F 756	Continued From page 10 (GDR) for the antipsychotic medication. There was no information in the chart to indicate a GDR had been considered for the antipsychotic medication. On 4/19/18 at 11:10 AM the facility ' s Consulting Pharmacist stated in an interview that technically she should have requested the physician consider a GDR of the Nuplazid but the resident was on a low dose and was stable on the medication so she did not request a GDR. On 4/19/18 at 4:25 PM the Director of Nursing stated in an interview that she would expect the pharmacist to alert the physician to the need for a GDR of an antipsychotic medication. On 4/19/18 at 4:34 PM the Administrator stated in an interview she expected the pharmacist to make the physician aware of the need for the GDR for an antipsychotic medication. b. Review of the physician ' s orders revealed an order for Rosuvastatin Calcium 5mg (milligrams) once a day. Rosuvastatin is a medication used to treat hyperlipidemia (high cholesterol). Review of the March 2018 electronic Medication Administration Record (MAR) revealed an entry for Rosuvastatin Calcium 5mg to be given at 6:00 PM daily and was documented as administered to the resident for the month of March. There was an entry on the MAR for Rosuvastatin Calcium 5mg to be given at 9:00 AM daily with a start date of 3/26/18. The first dose was documented as given on 3/27/18 and given for the rest of the month of March. The April 2018 electronic MAR contained an entry	F 756	discontinued the 6am dose of Rosuvastatin Calcium on 4/18/2018 and received an order to continue the medication at 9:00pm starting 04/19/2018. The pharmacy consultant completed a 100% audit of psychotropic drugs to include Nuplazid on 05/06/2018. Recommendations for Gradual Dose Reductions will be forwarded to the physician for review. Results of the reviews will be forwarded to the QAPI committee monthly for review and recommendation. The AHT software utilized by the facility provides an error message/validation warning to alert nurses that the resident has an active order for a drug and the opportunity to make corrections (discontinue any previous/duplicate order). The Quality Assurance Nurse and Director of Nurses provided inservice training to 100% of nurses on 04/20/2018 on the error message and the process for making corrections to the order to prevent duplicate medications/excessive dose. All new hire nurses will be trained to the error message and the process for making corrections to the order to prevent duplicate medications/excessive dose. The Director of Nursing and Quality Assurance Nurse will conduct an 1)audit of the monthly physician orders for duplicate medications/excessive dose and 2) an audit for Gradual Dose Reduction utilizing the monthly psychotropic list provided by the pharmacy monthly times 3	

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	345358	A. BUILDING _____ B. WING _____	C 04/19/2018

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F 756	Continued From page 11 for Rosuvastatin Calcium 5mg to be given at 9:00 AM daily. There was a second entry on the MAR for the Rosuvastatin Calcium 5mg to be given at 6:00 PM daily. The MAR showed documentation that both doses of the medication had been administered to the resident during the month of April. Review of the pharmacist notes revealed the resident ' s medications were reviewed by the pharmacist on 3/29/18 and 4/17/18 that revealed no irregularities and read: "No recommendations." An interview was conducted with the Director of Nursing (DON) on 4/18/18 at 2:52 PM. The DON stated the order was originally entered into the computer for 6:00 PM and someone changed the medication to be given at 9:00 AM and did not discontinue the 6:00 PM dose. The DON further stated the documentation showed the resident received the medication at 9:00 AM and 6:00 PM daily since 3/27/18. On 4/19/18 at 11:10 AM the facility ' s Consulting Pharmacist stated in an interview that she tried to review a resident ' s MAR when doing a medication review. The Pharmacist further stated she saw the resident on 3/29/18 and 4/17/18 and she missed that the Rosuvastatin was being given twice a day. The Pharmacist stated she guessed she trusted the nurses to discontinue a medication in the computer when a medication was re-entered with a new time. On 4/19/18 at 4:25 PM the Director of Nursing stated in an interview she would expect the pharmacist to pick up on irregularities during her medication review and report them to her. On 4/19/18 at 4:34 PM the Administrator stated in an interview she expected the pharmacist to have	F 756	months. The results of the audits will be forwarded to the QAPI committee monthly for three months for review and recommendations. Pharmacy Consultant and the Director of Nursing will be responsible for implementing the acceptable plan of correction.	

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F 756	Continued From page 12 identified the double dosing of the medication for Resident #43.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff and nurse practitioner interviews the facility failed to discontinue a medication order on the Medication Administration Record when the medication was entered to be given at a different time that resulted in an excessive dose of the medication for 1 of 5 residents whose medications were reviewed (Resident #43).	F 757	The nurse changed the administration time of the Rosuvastatin Calcium from 6:00pm to 9:00am on 03/26/2018 and failed to discontinue the previous order for the Rosuvastatin Calcium to be given at 6:00pm.	5/4/18

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F 757	Continued From page 13 The findings included: Resident #43 was admitted to the facility on 8/26/14 and had a diagnosis of hyperlipidemia (high cholesterol). Review of the physician ' s orders revealed an order for Rosuvastatin Calcium 5mg (milligrams) by mouth daily for hyperlipidemia. Review of the March 2018 electronic Medication Administration Record (MAR) revealed an entry for Rosuvastatin Calcium 5mg to be given at 6:00 PM and was documented as administered to the resident for the month of March. There was an entry on the MAR for Rosuvastatin Calcium 5mg to be given at 9:00 AM daily with a start date of 3/26/18. The first dose was documented as given on 3/27/18 and given for the rest of the month of March. The April 2018 electronic MAR contained an entry for Rosuvastatin Calcium 5mg to be given at 9:00 AM. There was a second entry on the MAR for the Rosuvastatin Calcium 5mg to be given at 6:00 PM. The MAR showed documentation that both doses of the medication had been administered to the resident during the month of April. An interview was conducted with the Director of Nursing (DON) on 4/18/18 at 2:52 PM. The DON stated the order was originally entered into the computer for 6:00 PM and someone changed the medication to be given at 9:00 AM and did not discontinue the 6:00 PM dose. The DON further stated the documentation showed the resident received the medication at 9:00 AM and 6:00 PM. The DON was unable to provide the name of the staff member who changed the order in the	F 757	The Quality Assurance Nurse discontinued the 6am dose of Rosuvastatin Calcium on 4/18/2018 and received an order to continue the medication at 9:00pm starting 04/19/2018. The AHT software utilized by the facility provides an error message/validation warning to alert nurses that the resident has an active order for a drug and the opportunity to make corrections (discontinue any previous/duplicate order). The Quality Assurance Nurse and Director of Nurses provided inservice training to 100% of nurses on 04/20/2018 on the error message and the process for making corrections to the order to prevent duplicate medications/excessive dose. All new hire nurses will be trained to the error message and the process for making corrections to the order to prevent duplicate medications/excessive dose. The Director of Nursing and Quality Assurance Nurse will conduct an audit of the monthly physician orders for duplicate medications/excessive dose monthly times 3 months. The results will be forwarded to the QAPI committee monthly for three months for review and recommendations. The Director of Nursing and the Quality Assurance Nurse will be responsible for implementing the acceptable plan of correction.	

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F 757	Continued From page 14 computer. On 4/19/18 at 11:53 AM the Nurse Practitioner stated in an interview that the medication was a low dose and there was no harm to the resident.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, 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	F 758		5/6/18

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F 758	Continued From page 15 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 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacist interviews, the facility failed to address a gradual dose reduction of an antipsychotic medication as required for 1 of 4 residents reviewed for antipsychotic medications (Resident #43). The findings included: Resident #43 was admitted to the facility on 9/5/17 and had a diagnosis of Parkinson ' s disease. Review of physician ' s orders revealed the resident was admitted to the facility with an order for Nuplazid 17mg (milligrams) twice a day. Nuplazid is an antipsychotic medication used to treat delusions and hallucinations in patients with Parkinson ' s disease. Review of the medical record revealed no information that a gradual dose reduction (GDR)	F 758	The pharmacist failed to identify Nuplazid as an antipsychotic drug and as a result, did not recommend a Gradual Dose Reduction. The First Data Bank software used by the pharmacy "list the medication drug classification as unclassified, an atypical antipsychotic, Code 99 none of the above." First Data Bank does not identify Nuplazid as a antipsychotic. As a result, the contracting pharmacy must manually change the drug classification for their use. The Nurse Practitioner had ordered a Neurology Consult for Resident #43 on 04/11/2018. An appointment was scheduled for 04/23/2018. The wife rescheduled the appointment for	

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F 758	Continued From page 16 had been requested by the pharmacist or addressed by the physician in the facility. The facility ' s Consulting Pharmacist stated in an interview on 4/19/18 at 11:10 AM that technically she should have requested a GDR for the Nuplazid but the resident was on a low dose of the medication and was stable on the drug so she did not request a GDR. On 4/19/18 at 4:25 PM the Director of Nursing stated in an interview she would expect the pharmacist to alert the physician to address a GDR of an antipsychotic medication. On 4/19/18 at 4:34 PM the Administrator stated in an interview she would expect the pharmacist to make the physician aware of the need for a GDR of an antipsychotic medication.	F 758	04/30/2018. The resident was seen by Neurology on 04/30/2018. No reduction to Nuplzaid was recommended at this time. The Nurse Practitioner declined a Gradual Dose Reduction on 04/27/2018 as Resident #43 is receiving the only dose of Nuplazid - 17mg bid. In order to reduce, the medication would need to be discontinued. The Nurse Practitioner referred to Neurology for GDR and management of medications. The pharmacy consultant completed a 100% audit of psychotropic drugs to include Nuplazid on 05/06/2018. Recommendations for Gradual Dose Reductions will be forwarded to the physician for review. Results of the reviews will be forwarded to the QAPI committee monthly times 3 months for review and recommendation. Pharmacy Consultant/Director of Nursing will be responsible for implementing the acceptable plan of correction.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the dumpster free of leaks for 1 of 1 dumpsters observed.	F 814	The Environmental Services Director and Dietary Manager failed to observe the dumpster for leaking. The outside contractor was notified of the	4/27/18

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F 814	Continued From page 17 During the initial kitchen tour on 4/16/18 at 9:38 AM the dumpster area was observed. The right rear corner of the dumpster was observed to have a 6 inch by 4 inch puddle of gray sludge. 3 fingers of gray liquid spillage was observed that flowed from the sludge. One liquid finger was 12 inches long, the second liquid finger was 24 inches long and the third liquid finger was 36 inches long. On 4/17/18 at 1:38 PM the dumpster area and leakage was observed to be in the same condition. On 4/19/18 at 1:50 PM the right rear corner of the dumpster was observed to have a 6 inch by 4 inch puddle of gray sludge. In an interview on 4/19/18 at 1:50 PM the Certified Dietary Manager stated that she was not aware of any leak and they did not want the dumpster to leak. She revealed she would tell the Maintenance Man immediately and he would contact the dumpster company to have it replaced. On 4/19/18 the Administrator revealed they were not aware the dumpster had a leak. She revealed they would call the company and have it replaced.	F 814	leaking on April 19, 2018 by the Environmental Services Director. The contractor repaired the dumpster on the morning of April 20, 2018. On April 24, 2018, the Administrator re-trained the Environmental Services Director, Floor Techs and Dietary Manager to observe and recognize any leaks/damage to the dumpster. On observation of any leaks/damage to the dumpster, the Environmental Services Director will notify the dumpster contractor of the need to repair/replace the dumpster immediately. The Environmental Services Director or Floor Tech will observe the dumpster weekly during daily and preventive maintenance rounds for leaks/damage. The results will be recorded on a newly created Dumpster QA Audit Tool. The results will be reviewed by the Administrator and Environmental Services Director weekly for one month. The Administrator will be forward the observations/audits to the QAPI committee monthly for review and recommendations times one month. The Environmental Services Director will record observation on the Dumpster QA Audit Tool weekly for one month and then monthly as part of the facility Preventive Maintenance Program.	

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F 814	Continued From page 18	F 814	Administrator/Environmental Services Director will be responsible for implementing the acceptable plan of correction.	