STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

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E 000	Initial Comments An unannounced Recertification survey was conducted on 1/22/19 through 1/25/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #4UVW11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 1/22/19 through 1/25/19. Immediate Jeopardy was identified at: CFR 483.12 at tag F 600 at a scope and severity J CFR 483.25 at tag F 689 at a scope and severity J Tags F 600 and F689 constituted Substandard Quality of Care Immediate Jeopardy began on 4/9/18 and was removed on 1/25/19. An extended survey was conducted. The Statement of Deficiencies was amended on 2/25/19 at tag F689 and F600. The Statement of Deficiencies was amended on 2/28/19 at tag F550 and F580.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550		2/27/19

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

Electronically Signed | 02/18/2019

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F 550	Continued From page 1 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews, the facility failed to return a resident to bed on request and a staff member told the	F 550	F550: Resident Rights Element One: " Resident number 51 will be assisted	

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F 550	Continued From page 2 resident she was not a "baby" (Resident #51) and failed to prevent an incident where a nursing assist (NA) was rude to a resident request for a snack (Resident #69) for 2 of 2 residents reviewed for dignity and respect. The findings included: 1) Resident #51 was admitted to the facility on 10/19/18 with diagnoses that included: Schizoaffective disorder, Bipolar depression, history of stroke, anxiety disorder, diabetes mellitus, Hypertension and Osteoarthritis. A review of the active care plan dated 11/16/18 revealed a goal that the resident will express satisfaction that her daily routines and preferences are accommodated by the staff. One of the interventions was it was important for the resident to take a nap whenever she wanted. The most recent comprehensive MDS (Minimum Data Set) coded as a significant change assessment and dated 11/17/18 revealed the resident was cognitively intact, alert and oriented, able to make needs known and understand others. She required limited to extensive assistance of one to two staff members for Activities of Daily Living (ADL's) except for supervision for meals. She was assessed as having an unsteady balance during transfers and walking and is incontinent of bowel and bladder. A review of the facility Initial Allegation Report dated 12/4/18, investigation and statements, revealed on 12/1/18 Resident #51 reported she had wanted to lie down before an activity and Nurse Aide #12 (NA) placed her bed in the highest position after he was told she didn't want	F 550	to bed on request by certified nursing assistant or nurses. Staff involved no longer employed at facility as of 12/14/19. Resident number 69 was given milk as requested by another staff member. Staff involved no longer employed at facility as of 12/14/19. Element Two: " Administrator met with resident council on 1/31/19 and reviewed survey findings and asked patients to notify nurse, nursing supervisor, unit manager, Director of Nursing, Administrator or any Department Head of concerns to include mistreatment or abuse. Administrator asked that they report concerns immediately so concerns can be addressed quickly. An interview with 100% of interviewable residents on mistreatment or abuse was complete by the Unit Managers, on 2/8/19 with no concerns identified since survey. Element Three: " Resident council agenda has topic of discussion of mistreatment and/abuse added and will be reviewed monthly in resident council meeting by the Activity Director or the Activity Assistant. " Education Provided to all staff on Resident Rights and Abuse/Neglect , and included dignity and respect. This education was provided by the Unit Managers on 2/20/19. 99% of staff have been trained, the remaining will not work	

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F 550	Continued From page 3 a male to provide her personal care, so she could not go back to bed, and Nurse #8 unplugged her bed, so she could not lower it. The NA and nurse were suspended pending the outcome of the investigation and later terminated. On 1/22/19 at 9:15am an interview was attempted with Resident #51 who stated that she didn't want to discuss the incident. An interview was completed on 1/24/19 at 11:30am with NA #11 who was familiar with the resident. She stated that it was common for Resident #51 to lie back down after breakfast until activities started. She explained that she assisted the resident to stand and pivot when transferring back to bed after meals. NA #11 added that she had not witnessed any changes in the resident's mood or behavior since the incident occurred. During an interview with Resident #25 on 1/24/19 at 2:00pm, he stated that on the day of the alleged incident he had seen Resident #51 sitting in doorway and had visualized the bed in a very high position. He went on to say that he overheard NA #12 say to the resident "shut up all that noise, you aint' no baby". Resident #10 was interviewed on 1/24/19 at 2:30pm. She stated that on the day of the alleged incident she saw Resident #51 sitting in her doorway and overheard NA #12 being very disrespectful to the resident. She couldn't recall what was said but stated that she interrupted NA #12 while he was eating breakfast in the 300-hall dining room and told him that he needed to be more patient, to which he responded, "she can do what she wants to do". She stated that on the	F 550	until they receive the education. This education included agency staff. Element Four: " Monitoring and Quality Assurance: the Unit Manager, Nursing Supervisor, Director of Nursing, Staff Development Coordinator, or Minimum Data Nurse will interview ten interviewable residents per week regarding mistreatment or abuse, including dignity and respect for four weeks, monthly for three months and quarterly for three quarters. Non-interviewable residents will be monitored through department head rounds to ensure residents being treated with dignity and respect. Results of audits will be reviewed in monthly Quality Assurance Performance Improvement meeting by the Director of Nursing. All concerns of mistreatment or abuse will be investigated as soon as facility is made aware of situation. The Director of Nursing, Social Worker or Unit Manager will investigate concerns. Alleged perpetrator will be suspended during the investigation and facility will follow discipline process as indicated. Any required reporting will be completed by the Director of Nursing, Unit Manager, or Staff Development Coordinator. All Abuse Allegations and Resident Rights Concerns will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for on-going compliance.	

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F 550	Continued From page 4	F 550		

day of the alleged incident she had visualized the bed in a very high position when she went past her room.

During a phone interview with Nurse #8 on 1/24/19 at 4:41pm, she explained Resident #51 had told NA #12 that she didn't want him to provide her personal care and she advised NA #12 to get a female to provide the care and stated, "I had another resident that was actively dying so I went to that room and didn't check to see who provided her personal care after that. She denied overhearing the resident crying or any disrespectful conversation from NA #12. "A little later I went by her room and saw that she was trying to reach for the bed remote. I assisted her to sit down in her wheelchair but before I could lower the bed back down, a staff member came in to get me for another resident. When I left the room, I unplugged the bed, so she wouldn't fall. I came right back, plugged in the bed and lowered it".

On 1/24/19 at 4:51pm a phone call was placed to Nurse # 9 who was working on the day of alleged incident. A message was left for a return call. A return call was not received from Nurse #9.

A phone interview was completed with NA #13 on 1/24/19 at 4:51pm. She stated that she had started working at the facility on that weekend and had not witnessed any of the alleged incident.

NA #12 was interviewed by phone on 1/24/19 at 5:00pm. He stated that he had worked at the facility for about 4 to 5 years and denied that he left the bed in the high position. He added that third shift had gotten the resident up and left the

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F 550	Continued From page 5	F 550		

bed in the high position and stated, "that bed was up like that and the nurse told me to leave it up, so she couldn't get back in bed". He confirmed that the resident liked to lay down after meals until activities started and was unable to explain why the resident was not placed back to bed when asked as this was her normal behavior.

An interview was conducted on 1/25/19 at 9:00am with Unit Manager #2. She stated that she had not seen any adverse changes to the resident's mood or behavior since the incident in December.

On 1/25/19 at 6:10pm an interview occurred with the Administrator and Director of Nursing, who stated it was their expectation for all residents be treated with dignity and respect.
2)Resident #69 was admitted 12/28/18 with cumulative diagnoses of Altered Mental Status, Malnutrition, Bacteremia (bacteria in the blood stream), pressure ulcer, Depression and Post Traumatic Stress Disorder.

Resident #69's admission Minimum Data Set (MDS) dated 1/4/19 indicated he was cognitively intact and exhibited no behaviors.

Review of Resident #69's care plan dated 1/4/19 indicated he at nutritional risk and was to be offered snacks and encourage fluid intake.

Review of the Facility Reported Incident indicated on 1/2/19 at 3:00 AM, Resident #69 requested some ice cream. NA #8 stated "the kitchen is closed." He then asked for milk and NA #8 replied, "the kitchen is closed." NA #8 stated she had other residents to care for and for Resident #69 to stop calling for her. NA #8 was

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F 550	Continued From page 6	F 550		

terminated.

In an interview on 1/22/19 at 11:00 AM, Resident #69 stated he woke up during the night and asked NA #8 for some milk. He stated the aide was rude and told him there wasn't any milk and that the kitchen was closed. Resident #69 stated another aide came in and gave him some milk. The next morning the Administrator came in and talked to him about the incident. He stated he understood that they fired the aide and he was happy with the outcome. Resident #69 reported no emotional distress.

In a telephone interview on 1/25/19 at 10:50 AM, Nurse #6 recalled working the night on 1/2/19. She stated she became aware that NA #8 told Resident #69 there was no milk or ice cream. She stated she removed NA #8 from Resident #69's assignment and told another aide to take him some milk. She stated apparently there was no ice cream in the nourishment refrigerator. Nurse #6 stated she went in a checked-on Resident #69 and he did not appear upset and was happy to have gotten milk. She stated NA #8 was an agency aide and the facility terminated her employment regarding this incident.

Attempts to speak with NA #8 were unsuccessful.

In an interview on 1/25/19 at 5:50 PM, the Administrator and Director of Nursing (DON) stated that NA #8 was immediately reassigned and suspended pending the outcome of their investigation. The Administrator stated NA #8 was terminated. The Administrator and DON stated it was their expectation that Resident #69 be treated with respect and NA #8 should have given Resident #69 milk if there was no ice cream or

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F 550	Continued From page 7 looked in the other nourishment room for ice cream.	F 550		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other	F 565		2/27/19

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F 565	Continued From page 8 residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with residents and staff, the facility failed to resolve the repeat concern reported during Resident Council meetings for 2 of 2 consecutive months related to water temperatures in resident care areas being too cold. The findings included: Review of the monthly Resident Council meeting minutes dated 11/30/18 indicated the residents expressed a concern related to water temperatures being cold. These minutes indicated the facility was working on getting a plumber and ordering supplies to address the issue. Review of the monthly Resident Council meeting minutes dated 12/27/18 indicated a follow up of the previous month ' s (11/30/18) concern related to water temperatures. This follow up stated that water issues were still going on and that the Maintenance Director is waiting to receive parts he ordered to fix the problem. The Activities Director was present at the meeting. A Resident Council meeting was conducted on 1/23/19 at 2:00 PM with 16 alert and oriented residents who were active participants in the facility's Resident Council. The residents reported that they had a repeat concern over the past couple of months with the water temperatures not being warm enough. They reported that one day this week they had no hot water at all on 2 of the 4 units. They indicated the Maintenance Director was aware of the issue and	F 565	F565: Response to Resident Council: Element One: Resident council meeting was held on 1/31/19 facilitated by the Activity Director and the Assistant Activity Director. Residents asked for or consented for the Dietary Manager, the Maintenance Director and the Administrator to attend. The Administrator discussed concerns from resident council and the process and how they were addressed. (The process will be that the concerns from Resident Council will be written on individual IDT Response forms, and the appropriate department head will provide written documentation of their follow up to address the concern, which will be shared at the following Resident Council Meeting). The Administrator explained the concerns were placed in the minutes, placed on a concern form and given to the Department Head who oversees that area of concern. • The Cold Water has been addressed and corrected by the Maintenance Director on 1/31/19, by his installation of a new Mixing Valve. Prior to 1/31/19 the maintenance director would adjust temperatures daily based on his daily water temp checks per protocol. Element Two: • All residents have potential to be affected. Resident Council Minutes and Grievance logs reviewed by Administrator to ensure no other outstanding concerns	

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F 565	Continued From page 9 they were told it was being addressed. The meeting attendees all stated that the issue with the water temperatures had not been resolved. An interview was conducted with the Activities Director on 1/23/19 at 2:25 PM following the Resident Council meeting. She confirmed she was aware that the residents had repeated concerns with the water temperatures being too cold. She stated that the Maintenance Director was aware of the issue and she believed he was working on fixing the problem. An interview was conducted with the Maintenance Director on 1/25/19 at 9:30 AM. He stated that he was aware of the Resident Council ' s repeat concern related to water temperatures not being warm enough. He revealed that the facility had a problem with maintaining water temperatures within the desired 100 degrees Fahrenheit (F) and 116 degrees (F). He further revealed that this issue had been going on since October 2018. He stated he had to shut off the hot water on 2 of the 4 units earlier this week due to extremely low temperatures (53 degrees F). The Maintenance Director reported that the problem was with the mixing valve, explaining that this was what ultimately regulated the temperature of the water. He stated that he tried to fix the problem by adjusting the mixing valve, replacing parts, and disassembling the parts for cleaning and then reassembling them. He revealed that these efforts had not resolved the problem and that he had just replaced the entire mixing valve on 1 of 2 zones in the facility on 1/24/19. He stated he was unsure if the mixing valve for the other zone of the facility was going to be completely replaced.	F 565	that needed to be addressed. Element Three: • Education provided to the Inter Disciplinary Team (IDT = Administrator, Director of Nursing, Social Services, Activities Director, Dietary, Maintenance, Admissions Director and Business Office Manager) by the Administrator related to prompt resolution to Grievance and Concerns, including follow up to Resident Council. Reviewed the Resident Council IDT Response Forms that will be implemented. This education was completed on 2/21/19. Element Four: • Administrator will review all Concerns/Grievances and Resident Council Minutes monthly to ensure prompt resolution to concerns. Results of these reviews will be brought before the Quality Assurance and Performance Improvement Committee monthly, by the Administrator, with the QAPI Committee responsible for on-going compliance.	

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F 565	Continued From page 10 An interview was conducted with the Administrator on 1/25/19 at 6:10 PM. She stated that she had been the Administrator at the facility for less than a month. She indicated that she had been made aware of an issue with the regulation of water temperatures within the facility, but she was unaware that it was discussed at the Resident Council meetings. She stated that she expected concerns discussed at the Resident Council meetings to be addressed and resolved. She additionally stated that she expected issues related to the regulation of water temperatures to be addressed as soon as possible.	F 565		
F 580 SS=H	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		2/27/19

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F 580	Continued From page 11 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, physician, Dietitian and Nurse Practitioner (NP), the facility failed to provide same day notification to the medical provider of a resident's unsupervised exit from the facility (Resident #48), failed to notify the medical provider of repeated medication refusals and increased behaviors (Resident #16), failed to notify the medical provider of a resident's unintended weight loss (Resident #18); failed to notify the physician of behaviors, expressions of feeling unloved and that nobody cared (Resident	F 580	F580: Notification of Change: Element One: " The Director of Nursing verified notification of elopement that occurred in April 2018 and May 2018, for Resident # 48 with the Physician and RP on 2/12/19. Patient # 16 with medication refusals, increased behaviors, and weight loss physician and RP were notified on 2/12/19 by the Director of Nursing. Resident #18 weights and weight loss was reported to the physician and RP on 2/12/19 by the	

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F 580	Continued From page 12 #69) for 4 of 4 residents reviewed for physician notification. The findings included: 1. Resident #18 was admitted to the facility on 1/31/02 and diagnoses were traumatic brain injury and stroke. Review of Resident #18's weight record revealed in September 2018 the resident weighed 178 pounds. A review of Resident #18 ' s Dietary note dated 9/20/18 revealed the resident had experienced a significant weight loss, and a house supplement three times a day was recommended. Resident #18 had a physician order dated 9/23/18 for house supplement three times a day. A review of Resident #18 ' s care plan revealed a focus initiated on 9/23/18 that identified the resident as being at risk for nutrition/hydration alteration related to cognitive impairment and hemiplegia and significant weight loss. The goal was adequate intake to prevent significant weight change or skin breakdown, interventions were house supplement, 12 ounces of beer each day as requested, regular liberalized diet with extra chocolate milk, offer alternatives and snacks, and monitor intake and weight. A review of Resident #18 ' s physician progress note dated 11/2/18 revealed documentation that the resident was not evaluated for nor mention of weight loss. A review of Resident #18 ' s annual Minimum	F 580	Director of Nursing. Resident number 69 mood and behavior concerns were reported to the physician and responsible party on 1/24/19 by the Social Services Director. Element Two: " 100% audit was conducted of patient Medication Records for the last 30 days, for medication refusals and notification of the Physician by the Unit Manager on 1/28/19. An audit of resident□s behaviors for the past 30 days was completed to ensure that Physician and Responsible Party were notified. 100% audit was complete for all current patients with mental illness/psychiatric diagnosis and behaviors was made by the Social Services Director and physician and Responsible Party was notified. An 100% audit was completed of all Elopements in the last 4 months to ensure that the RP and Physician were notified timely, by the Director of Nursing on 1/28/19 . 100% Audit was completed for Weight Loss in the last 30 days to ensure that Physician and RP had been notified. All discrepancies had appropriate notification made to RPs and MDs accordingly. These audits were completed by the Administrator on 2/5/19. Element Three: " Education was completed with nursing staff, by the Unit Manager, on 2/20/19, regarding Procedure for Notification of Physician and Responsible Party of Changes in condition to include: Elopements, Behaviors, Medication Refusals and Weight Loss. Education	

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F 580	Continued From page 13 Data Set dated 11/5/18 revealed the resident had clear speech and usually understands and understood. The resident had severely impaired cognition. The resident required extensive assistance of 2 staff for bed mobility and of 1 staff for all other activities of daily living including eating. The resident ' s active diagnoses were hyperlipidemia, stroke, anxiety, depression, schizophrenia, impulse disorder, and non-Alzheimer's dementia. The resident received a therapeutic diet and did not indicate significant weight loss. The resident ' s weight was 163 pounds. The nutrition care assessment area was triggered and documented as addressed in the care plan. Care plan was not changed at this time. Review of the resident ' s weight record revealed the resident lost a total of 15 pounds (or 8.4 percent body weight of his body weight) from September 2018 to January 2019. Review of the resident ' s medical record revealed there were no dietician notes documented in the record between 09/20/18 to 1/11/19. A review of Resident #18 ' s dietician notes dated 1/11/19 revealed the resident had significant weight loss of 16% over the past 6 months. No new interventions were recommended. The resident ' s needs were probably being met. The dietician will update the resident ' s care plan. The resident ' s diet was liberal with ice cream. Further review of the medical record revealed no nutritional interventions were implemented from 9/11/18 to 1/23/19, to stabilize the resident ' s weight or to prevent further weight loss. On 1/24/19 at 11:30 am an interview was	F 580	included FT, PT and agency personnel. Currently 99% of staff have been educated, those remaining will not work until they receive the education. Element Four: " Unit Managers will review/audit resident□s weights weekly to ensure that any significant changes in weight will be reported to the Physician and Responsible Party timely Unit Managers will review/audit Medication Administration records 5 X week for 4 weeks and then weekly thereafter, to ensure that medication refusals and behaviors are promptly reported to the Physician and Responsible Party. Social Service Director will review all residents with behaviors, psychiatric diagnosis/mental illness weekly for physician and responsible party notification. Director of Nursing and Administrator will review any and all future Elopement Events to ensure that the physician and responsible party are notified timely. The results of these audits will be reported to the Quality Assurance and Performance Improvement Committee monthly, by the Director of Nursing, with the Administrator and QAPI Team responsible for ongoing compliance.	

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conducted with the Dietician who stated that she was aware of Resident #18's weight loss over time and of 16.1% over the past 6 months 1/11/19. The resident ' s weights were not consistently done each month. The resident had house supplement three times a day added on 9/13/18. The resident has had a steady weight loss with a known decrease in intake over the past month. The Dietician stated that the resident was at nutrition deficit risk and was discussed at the weekly meeting with nursing staff and management over the past 2 months. The Dietician stated that since the resident was taking his house supplement and continued to lose weight there should have been additional intervention. The resident is currently at his lowest weight since admission to the facility. The Dietician stated that the resident ' s physician was not informed.

On 1/25/19 at 4:55 pm an interview was conducted with the Director of Nursing who stated she expected the Dietician to follow and address weight loss and to inform the physician of significant weight loss.

On 1/25/19 at 5:20 pm an interview was conducted with Resident #18 ' s physician who stated he was not made aware of the resident ' s significant weight loss and that adding Loxapine would not be appropriate to improve appetite and weight gain. The physician felt the dietician should have addressed the resident ' s weight loss with new, appropriate weight gain interventions. The physician felt with additional weigh loss intervention the weight loss could have been avoided.

2. Resident #16 was admitted to the facility on

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9/19/13 with diagnoses aphasia, hemiplegia, stroke, and depression.

A review of Resident #16 ' s quarterly Minimum Data Set dated 11/1/18 revealed documentation that the resident was sometimes understood and sometimes understands. Cognition was intact. The resident required total dependence for all transfers including toileting, and extensive assistance for bathing and dressing. The resident ' s active diagnoses were aphasia, non-Alzheimer's dementia, hemiplegia, and depression. The resident received scheduled pain management.

A review of Resident #16 ' s care plan dated 11/14/18 revealed the resident had goals and interventions for self-care deficit, verbal behaviors, poor impulse control, communication deficit, pain, and was at risk for psychotropic medication complication (intervention was to inform the physician of changes in mental status and functional level and to monitor for continued need for medication related to mood and behavior).

Nurses' note dated 12/10/18 refused all meds "makes me sick" (Nurse #9).

A review of the resident ' s nurses ' notes from 6/1/18 to 1/24/19 revealed there was no documentation that the physician or nurse practitioner was informed of the resident ' s medication refusal and/or increased behaviors

A review of the physician and nurse practitioner communication book for timeframe 6/1/18 to 1/24/19, which was stored at the nurses ' station, revealed there was no communication to the

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medical staff that the resident had frequently refused his medication, had increased behaviors and frequently refused personal care.

A review of the resident ' s October 2018 medication administration record (MAR) revealed out of 31 days the resident refused the following medication:

Amitiza twice a day refused on 15 occasions
Aspirin once a day refused on 9 occasions
Atorvastatin once a day refused on 20 occasions
Depakote three times a day refused on 20 occasions
Flomax twice a day refused on 22 occasions
Flonase once a day refused on 15 occasions
Lisinopril once a day refused on 20 occasions
Plavix once a day refused on 20 occasions
Proscar once a day refused on 20 occasions
Zoloft once a day refused on 20 occasions
Trazadone once a day refused on 18 occasions

A review of the resident ' s November 2018 MAR revealed out of 30 days the resident refused the following medication:

Amitiza twice a day refused on 20 occasions
Aspirin once a day refused on 18 occasions
Atorvastatin once a day refused on 20 occasions
Depakote three times a day refused on 36 occasions
Flomax twice a day refused on 26 occasions
Flonase once a day refused on 11 occasions
Metoprolol twice a day refused on 27 occasions
Plavix once a day refused on 22 occasions
Proscar once a day refused on 18 occasions
Zoloft once a day refused on 17 occasions
Trazadone once a day refused on 17 occasions

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A review of Resident #16 ' s physician progress note dated 11/2/18 revealed the resident was seen and no new issues were identified. The resident was compliant with medication. The plan was to continue with current medication.

A review of the resident ' s December 2018 MAR revealed out of 31 days the resident refused the following medication:

Amitiza twice a day refused on 17 occasions
Aspirin once a day refused on 13 occasions
Atorvastatin once a day refused on 8 occasions
Depakote three times a day refused on 20 occasions
Flomax twice a day refused on 21 occasions
Flonase once a day refused on 4 occasions
Lisinopril refused on 8 occasions
Metoprolol twice a day refused on 19 occasions
Norvasc 5 mg once a day refused on 13 occasions
Plavix once a day refused on 8 occasions
Proscar once a day refused on 18 occasions
Zoloft once a day refused on 17 occasions
Trazadone once a day refused on 17 occasions

A review of the resident ' s January 2019 MAR revealed out of 24 days the resident refused the following medication:

Amitiza twice a day refused on 28 occasions
Aspirin once a day refused on 11 occasions
Atorvastatin once a day refused on 21 occasions
Depakote three times a day refused on 42 occasions
Flomax twice a day refused on 31 occasions
Flonase once a day refused on 15 occasions
Lisinopril refused on 19 occasions
Metoprolol twice a day refused on 27 occasions

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Norvasc 5 mg once a day refused on 13 occasions
Plavix once a day refused on 19 occasions
Proscar once a day refused on 19 occasions
Zoloft once a day refused on 19 occasions
Trazadone once a day refused on 19 occasions

On 1/24/19 at 10:10 am an observation was done of the resident who was lying in his bed with his eyes closed. The resident ' s hair appeared slick and his nails were long and dirty. The resident had a low voice tone and was oriented to self and situation.

On 1/24/19 at 10:10 am an interview was conducted with Resident #16 who stated that he wanted his nails cleaned. The resident voice no concerns. The resident stated that he took his medication this morning.

On 1/25/19 at 9:30 am an interview was conducted with Nurse Assistant (NA) #14 who stated she was familiar and assigned to Resident #16. The resident had a history of refusing care and verbal behaviors. NA #14 commented that lately his refusal of care had increased. NA #14 commented that he accepted morning care and it was noted that the resident ' s nails were long and dirty. NA #14 went back to take care of the resident ' s nails and he refused, the nurse was informed, and the nurse was also unable to intervene.

On 1/25/19 at 10:40 am an interview was conducted with Nurse #11 who stated that she was regularly day shift assigned to Resident #16. Nurse #11 commented that the resident had lately more frequently refused care and his medication. The nurse would try and return to offer care but

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had continued to decline the care. Nurse #11 stated that she was aware that the resident had refused multiple doses of his psychotropic medication for several weeks. Nurse #11 stated that other shift nurses had reported the same. Nurse #11 stated that she had not called the physician to inform him of the resident ' s repeated, long-term refusal of his medication. Nurse #11 commented that the resident had a right to refuse. Nurse #11 agreed that the resident had increased behaviors of refusing care and increased occasions of refusing medication. Nurse #11 stated that she was aware the resident had verbal outburst of foul language recently which was considered increased behaviors. Nurse #11 agreed that the resident ' s refusal to take his psychotropic medication placed him at risk for increased behaviors and depression.

On 1/25/19 at 1:10 pm an interview was conducted with Nurse #9 who stated she was familiar with Resident #16 and frequently assigned on evening shift. Nurse #9 stated that she recalled that the resident had frequently refused his medication and had documented last month that the resident informed her the medication "made him sick." Nurse #9 did not inform the physician or nurse practitioner at that time. Nurse #9 stated that she placed a note in the physician ' s communication book stored at the nurses ' station about the resident ' s refusal. She could not remember when. Nurse #9 commented that the staff were aware of the resident ' s medication refusal and that the refusals were documented on the MAR. Nurse #9 commented that the refusals had become more frequent and this information was not provided to the Director of Nursing (DON) or the resident ' s physician.

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On 1/25/19 at 4:55 pm an interview was conducted with the DON who stated she expected staff to inform her and the resident ' s physician of medication refusal after 3 occasions and to monitor the resident ' s behavior in relation to psychotropic medication refusals.

On 1/25/19 at 5:00 pm an interview was conducted with Resident #16 ' s physician who stated he was not informed that the resident repeatedly refused his medication and had increased behaviors. The physician stated that he expected staff to inform him of any resident changes. The physician commented he would see the resident on his next visit to the facility.

3. Resident #48 was admitted to the facility on 11/28/17 with diagnoses that included altered mental status, anxiety, and insomnia.

The admission Minimum Data Set (MDS) assessment dated 12/5/17 indicated Resident #48 ' s cognition was severely impaired. He was assessed with wandering behaviors daily.

Resident #48 ' s plan of care included the focus area of the risk for elopement related to his expressed desire to leave the facility and multiple attempts made by the resident to exit the facility. Resident #48 was noted to have removed his own wanderguard. This area was initiated on 11/30/17 and revised on 12/18/17.

An incident report dated 5/16/18 completed by Nurse #2 indicated Resident #48 had an unsupervised exit from the facility. He was found outside of the facility without supervision by a facility visitor at approximately 7:15 PM. This

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incident report indicated the Nurse Practitioner (NP) was notified the following morning (5/17/18 at 7:55 AM).

A phone interview was attempted with Nurse #2 on 1/24/19 at 1:16 PM. She was unable to be reached. Nurse #2 wrote the incident report related to Resident #48 ' s 5/16/18 unsupervised exit from the facility.

A phone interview was conducted with the NP on 1/25/19 at 4:45 PM. He stated that he was not the NP at the facility at the time of the 5/16/18 unsupervised exit for Resident #48. He indicated that as a medical provider, he expected the facility to notify him or the physician as soon as possible after an incident of a resident ' s unsupervised exit from the building. He stated that the following day was not an acceptable timeframe for notification.

A phone interview was conducted with Resident #48 ' s physician/facility ' s Medical Director on 1/25/19 at 5:15 PM. He stated that he expected the facility to notify him or his NP as soon as possible after an incident of a resident ' s unsupervised exit from the building. He stated that the following day was not an acceptable timeframe for notification.

An interview was conducted with the current Administrator on 1/25/19 at 6:10 PM. She stated that she expected the physician and/or NP to be notified as soon as possible after an incident of a resident ' s unsupervised exit from the building. She indicated that the following day was not an acceptable timeframe for notification.

4. Resident #69 was admitted on 12/28/18 with

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cumulative diagnoses of Altered Mental Status, Depression and Post Traumatic Stress Disorder (PTSD).

Review of Resident #69's admission orders dated 12/28/18 indicated he was prescribed Remeron (antidepressant) every day for depression.

Resident #69's admission Minimum Data Set (MDS) dated 1/4/19 indicated he was cognitively intact, with no mood disturbance and exhibited no behaviors.

In an interview on 1/22/19 at 11:00 AM, Resident #69 stated he was diagnosed with Depression and PTSD and had a history of psychological services with medication interventions. Resident #69 started waving his arms, became tearful and stated his children had not come to see him since his admission and that made him sad. He stated he did not understand why his kids did not care about him anymore. Resident #69 went on to state he experienced "shell shock" after returning from Vietnam and it affected his first marriage that resulted in a divorce. He stated his second wife died a year ago.

Review of Resident #69's nursing notes from 12/28/18 to 1/23/19 read a nursing note dated 12/30/18 at 9:04 PM, Resident #69 was exhibited an incident of "jerking motions with arms" requiring staff to assist him with eating on several occasions, multiple occasions of Resident #69 yelling out for staff and multiple request for snacks.

During an interview on 1/23/19 at 4:45 PM, the Corporate Nurse/Former Interim Director of

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Nursing (DON) stated the Psychiatric Nurse Practitioner(PNP) was at the facility 2-3 times weekly. She stated if Resident #69 was experiencing any mood or behavior concerns, it was her expectation that he received a referral for a Psychiatric evaluation.

During an interview on 1/24/19 at 10:35 AM, the Social Worker (SW) stated she completed the cognition, mood and behaviors section on Resident #69's admission MDS dated 1/4/19 and she did not note any concerns in those areas. The SW stated that staff had not reported any cognition, mood or behaviors concerns and she did not read his nursing notes.

During an interview on 1/24/19 at 11:50 AM, the PNP stated she was asked to evaluate Resident #69 earlier this morning and that he was tearful during the evaluation and he stated he felt unloved. The PNP stated she changed his antidepressant and added a medication for insomnia and planned to continue to see Resident #69.

During an interview on 1/24/19 at 3:30 PM, Nursing Assistant (NA) #10 stated Resident #69 was very inpatient and had stated he felt unloved but he never cried in front of her. She stated she did not report how Resident #69 felt to anyone.

During an interview on 1/24/19 at 3:35 PM, Nurse #14 stated Resident #69 was "very needy and inpatient" with frequent episodes of yelling out for staff to come and feed him or bring him a snack. She stated Resident #69 can feed himself. She stated she did not report how he was feeling to anyone but documented any behaviors in his nursing notes.

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F 580	Continued From page 24 During an interview on 1/25/19 at 8:45 AM, Nurse #3 stated she had never seen Resident #69 crying, but he had expressed feelings of being upset that his kids had not come to see him and that nobody cared about him. She stated she did not report how he was feeling to anyone but documented the behaviors of Resident #3 yelling rather than using his call bell and him saying he could not feed himself insisting that staff feed him. She stated she was not aware of any reason Resident #69 could not feed himself. She stated it seemed "unusual" for him to request to be fed. During a telephone interview on 1/25/19 at 3:45 PM, Physician #2 stated he was not aware of the mood and behaviors issues exhibited by Resident #69 and he expected Resident #69 receive a Psychiatric evaluation if he was experiencing any mood or behaviors concerns. He stated Resident #69 was a "very sick man" and recently was discharged from the hospital after a very prolonged stay. During an interview on 1/25/19 at 5:50 PM, the Administrator stated it was her expectation that the staff would have identified and notified Physician #2 about his behaviors, expressions of feeling unloved and that nobody cared for a possible Psychiatric evaluation.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 600		2/27/19

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F 600	Continued From page 25 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility neglected to provide the supervision and monitoring to prevent a cognitively impaired resident who displayed wandering behaviors from 2 incidents of unsupervised exits from the facility for 1 of 1 residents (Resident #48) sampled with wandering behaviors. Resident #48 was found unsupervised outside of the facility on 4/9/18 and 5/16/18. On both occasions, Resident #48 was self-propelling his wheelchair on the sidewalk adjacent to the facility parking lot. The resident was returned inside of the facility with no injuries following both of these unsupervised exits from the facility. The facility also failed to protect Resident #51 from staff to resident abuse for 1 of 1 residents sampled for abuse. Immediate Jeopardy began on 4/9/18 when staff neglected to supervise and monitor Resident #48' s whereabouts and as a result he was found outside by Nursing Assistant #1 in his wheel chair on a side walk approximately 90 feet away from the facility ' s front door without supervision at approximately 8:00 PM. Immediate Jeopardy was removed on 1/25/19 when the facility	F 600	F600: Abuse/Neglect: Element One: " Resident # 48 has had no further Elopements. Resident # 51 has had no further abuse events. Element Two: " 100% audit was completed for all residents who are at risk for Elopement to ensure appropriate interventions and monitoring in place. This audit was completed by the Unit Managers on 1/29/19 and all were noted to have wander guard in place per protocol. " Resident Council Meeting held by Administrator on 1/31/19 reviewed abuse/neglect and resident rights. " 100% of Current Residents who are alert and oriented were interviewed by the Unit Manager, on 2/12/19 regarding Resident Rights/Abuse / Neglect without further concerns. Element Three: " All staff were educated on Elopement Prevention and Fire Drill process. " All staff were educated on	

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provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. Example #2 related to Resident #51 was cited at a scope and severity of a "D" where a plan of correction is required.

The findings included:

1. Resident #48 was admitted to the facility on 11/28/17 with diagnoses that included altered mental status, anxiety, and insomnia.

A review of Resident #48 ' s December 2017 physician ' s orders indicated a wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) was initiated on 11/30/17 due to poor safety awareness. The wanderguard was to be checked for function and placement every shift.

A nursing note dated 1/11/18 at 5:41 AM indicated Resident #48 ' s wanderguard was not on his ankle. Resident #48 ' s room was searched but was unable to be located. The resident was asked where his bracelet was, and he reported he was unable to recall what happened to it. Resident #48 was noted to have been hovering at exits and exhibiting exit seeking behaviors during the previous shift. The wanderguard was unable to be replaced as there were no additional wanderguards at the facility. The Maintenance Director was informed of the need for an

Abuse/Neglect.
" Education was completed by Unit Managers on 2/20/19, FT , PT, PRN and agency staff were included. Currently 99% of staff have received education, the remaining staff shall not work until they receive the education.
Element Four:
" Administrator and Maintenance Director will conduct facility Fire Drills that will include review of securing of the doors and accounting for the whereabouts of all residents. These drills will be conducted weekly x 4 then monthly thereafter and will encompass all three shifts. First drill scheduled for Wednesday January 30th. The doors and wander guard systems will continue to be checked routinely (daily) by the Maintenance Director, and weekend managers. The Interdisciplinary Team (Administrator, Director of Nursing, Maintenance Director) will conduct Elopement Drills , which will include observations of staff response to wander guard alarm system, weekly X 4 and then monthly thereafter, these drills will encompass all three shifts. Drill will include calling a Code Green and searching for a missing person following established protocol. The drills will include triggering the wander guard alarm to determine the appropriate response from the staff. Results of these drills will be brought before the Quality Assurance and Performance Improvement Committee for review monthly by the Administrator and/or Maintenance Director.
" Social Services will complete 10 Interviews per week X 4 weeks, then

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F 600	Continued From page 27 additional wanderguard. The physician ' s order related to Resident #48 ' s wanderguard was changed on 2/1/18 to indicate the wanderguard was to be placed on his wheelchair rather than on his right lower extremity. A nursing note dated 2/20/18 indicated Resident #48 was exit seeking and wandering the facility hallway by self-propelling his wheelchair. A nursing note dated 2/21/18 indicated Resident #48 "insisted that he needed to leave and had somewhere to go .... [he] even tried to rally other residents telling them he had a truck and they needed to leave". A Lift-Transfer-Repositioning Evaluation dated 2/28/18 for Resident #48 indicated he was able to transfer independently using a cane and wheelchair. The quarterly MDS assessment dated 3/6/18 indicated Resident #48 ' s cognition was severely impaired. He was noted with no behaviors and no wandering. Resident #48 required the supervision of 1 with bed mobility, transfers, and walking in corridor. He was assessed as requiring supervision of 2 or more for locomotion on/off unit. Resident #48 required the limited assistance of 1 with walking in room. He had no functional impairment with range of motion and he utilized a wheelchair. Review of Resident #48 ' s care plan, which was reviewed by staff on 3/18/18, contained the focus area of the risk for elopement related to Resident #48 ' s expressed desire to leave the facility and	F 600	weekly X 4 weeks and then monthly, with Alert and Oriented residents regarding potential abuse/neglect. Non-Interviewable residents will be observed through routine daily rounds by the IDT to ensure that there is no evidence of abuse/neglect. Any Negative findings will be addressed immediately. Results of these interviews will be brought before the Quality Assurance and Performance Improvement Committee by the Administrator monthly with the QAPI Committee responsible for on-going compliance.	

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multiple attempts made by the resident to exit the facility. The interventions indicated a wanderguard was in place and was to be utilized and monitored per facility protocol.

a. An incident report dated 4/9/18 completed by Nurse #1 indicated Resident #48 was found outside the facility without supervision. Nursing Assistant (NA) #1 brought Resident #48 back into the facility from the facility ' s parking lot at 8:00 PM. His wanderguard was on his wheelchair and was functioning properly at the time of the elopement. The door alarm was also functioning at the time of the elopement. Resident #48 was noted as last seen at 7:30 PM self-propelling in his wheelchair in the hallway by the dining room located near the front entrance of the facility. Resident #48 was interviewed and was unable to recall what happened. This incident report indicated a physical evaluation of Resident #48 was not completed after the incident. The report also indicated an elopement evaluation and care plan update were not completed. The summary of the interview with Resident #48 ' s assigned nurse, Nurse #1, indicated she heard the alarm sounding and she started to walk up the hall when an NA (unnamed) told her Resident #48 went out the front door. The summary of the interview with Resident #48 ' s assigned NA (unnamed) indicated she was on her break at the time of incident. The root cause/conclusion was indicated to be Resident #48 ' s confusion and his wish to go home. The corrective actions indicated that all doors were checked for functioning and all wanderguards on residents were checked for functioning with no issues identified.

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An observation was conducted with the Maintenance Director on 1/24/19 at 3:27 PM of the area where Resident #48 was found outside of the building unsupervised on 4/9/18 (as described by NA #1 during interview). This location was a cement sidewalk located directly next to the parking lot of the facility. This parking lot led to a well-traveled roadway with a speed limit of 45 miles per hour (mph). The Maintenance Director measured the distance from the facility ' s front door to Resident #48 ' s identified location and noted the distance as approximately 90 feet.

A review of the weather conditions per Weather Underground ' s website (www.wunderground.com) for Asheboro ' s weather history indicated the temperature on 4/9/18 at 7:55 PM was 52 degrees Fahrenheit (F) and there was no precipitation.

The following information was obtained from staff interviews and observations related to Resident #48 ' s unsupervised exit from the facility on 4/9/18 at approximately 8:00 PM.

- A phone interview was conducted with NA #1 on 1/24/19 at 2:37 PM. She confirmed she was the first staff to respond to the wanderguard door alarm on 4/9/18 when Resident #48 had an unsupervised exit from the building at approximately 8:00 PM. She stated she was not assigned to Resident #48 and she was unsure which NA was assigned to him at the time of the 4/9/18 incident. She reported that she was completing care for one of her residents in their room when she first heard the front door alarm. She indicated that she was working on the 400

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hall which led straight up to the front door of the facility. She revealed that the alarm was sounding for about 2 minutes when she exited her resident ' s room and proceeded up the 400-hall corridor to the front door of the facility. NA #1 stated she walked up to the front door to see why the alarm was going off and she saw that a visitor had exited the building and was in the parking lot and Resident #48 was self-propelling in his wheelchair on the sidewalk adjacent to the facility ' s parking lot. She confirmed no staff were present with Resident #48 outside of the building. She stated that she thought Resident #48 followed the visitor out of the front door of the facility. She explained that a numerical code was used to unlock the door and that facility staff and visitors were all aware of the code. She stated that after the visitor entered the code and exited the door that Resident #48 followed behind the visitor engaging the audible wanderguard alarm when he crossed the threshold of the front door. NA #1 stated she exited the building and pushed Resident #48 back into the building by wheelchair. She indicated he had no injuries. NA #1 was unable to recall what Resident #48 was wearing when he was found outside, and she was unable to recall when the door alarm ceased sounding. She reported the alarm was very loud and was easily heard from inside the resident rooms. She was unable to explain why she was the first staff to respond to it. NA #1 stated that Resident #48 was known to be an exit seeker and that he self-propelled his wheelchair throughout the facility all the time.

- A phone interview was attempted with Nurse #1 on 1/24/19 at 11:50 AM and 1:17 PM. She was unable to be reached. Nurse #1 was

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assigned to Resident #48 at the time of his 4/9/18 unsupervised exit from the facility.

- A phone interview was conducted with NA #2 on 1/25/18 at 8:20 AM. She stated that she was working on 4/9/18 at the time of Resident #48 ' s unsupervised exit from the facility. She was uncertain which NA was assigned to Resident #48 during the time of this incident, but she stated she had not thought it was her. She confirmed that she heard the front door alarm go off and that NA #1 was the first staff to respond to the alarm. She revealed that when any door alarms went off the staff were supposed to respond immediately. NA #2 was unable to explain why she had not responded to the front door alarm and why no other staff had responded to the alarm prior to NA #1 on 4/9/18 when Resident #48 exited the building unsupervised. NA #2 stated that Resident #48 was known to be an exit seeker and that he self-propelled his wheelchair throughout the facility all the time since admission through present.

- A phone interview was conducted with the facility ' s former Administrator on 1/24/19 at 3:55 PM. She stated that she was the Administrator at the time of Resident #48 ' s unsupervised exit from the facility on 4/9/18 at approximately 8:00 PM. The 4/9/18 incident report for Resident #48 was reviewed with the former Administrator. She reported that the root cause of the incident was staffs ' failure to respond immediately to the front door alarm which allowed Resident #48 to follow a visitor out of the facility and self-propel his wheelchair on the sidewalk adjacent to the parking lot of the facility. She indicated that after the incident she believed an inservice was

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conducted by the unit managers on the elopement procedure. The former Administrator stated that Resident #48 was known to be an exit seeker and that he had removed his wanderguard from his ankle on more than one occasion. She explained that one time he used a butter knife he had kept from one of his meals to remove it and another time he stretched it out until he was able to pull it off. She stated his wanderguard ' s placement was moved to his wheelchair to prevent him from removing it.

- An interview was conducted with the Corporate Nurse/former interim Director of Nursing (DON) on 1/24/19 at 2:45 PM. She indicated she was not working at the facility at the time of Resident #48 ' s unsupervised exit on 4/9/18. She stated that based on the inservice records, re-education on elopement procedures was provided to staff on 4/12/18 through 4/15/18. She revealed that the records showed 53 of the 62 staff who were employed at the facility at the time of the 4/9/18 elopement received the inservice. She confirmed all staff employed at the facility were not inserviced on the elopement procedure after Resident #48 ' s unsupervised exit on 4/9/18.

b. An incident report dated 5/16/18 completed by Nurse #2 indicated Resident #48 was found outside the facility without supervision. A facility visitor notified Dietary Aide #1 and Dietary Aide #2 that Resident #48 was outside unsupervised at 7:15 PM. Dietary Aide #1 pushed Resident #48 back into the building by wheelchair. Resident #48 was interviewed, and he stated, "I ' m going home". The incident report indicated a physical evaluation was conducted with no identified

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concerns and the care plan was updated. The summary of the interview with Resident #48 ' s assigned nurse (unnamed) indicated an active fire drill was conducted that evening and residents were assisted to their rooms. Rounds were made during the fire drill and Resident #48 was observed attempting to exit his room and was assisted back to the room on multiple occasions. Dietary staff alerted nursing staff that Resident #48 was observed sitting in his wheelchair on the sidewalk adjacent to the parking lot of the facility without supervision. The summary of the interview with Resident ' s assigned NA (unnamed) provided the same information as his assigned nurse. The root cause/conclusion indicated a fire drill was conducted and the exit doors were unlocked and Resident #48 self-propelled out of the facility. The corrective actions indicated the care plan was updated.

An observation was conducted with the Maintenance Director on 1/24/19 at 3:27 PM of the area where Resident #48 was found outside of the building unsupervised on 5/16/18 (as described by Dietary Aide #1 during interview). This location was a cement sidewalk located directly next to the parking lot of the facility. This parking lot led to a well-traveled roadway with a speed limit of 45 miles per hour. The Maintenance Director measured the distance from the front door to Resident #48 ' s identified location and noted the distance as approximately 65 feet.

A review of the weather conditions per Weather Underground ' s website (www.wunderground.com) for Asheboro ' s

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weather history indicated the temperature on 5/16/18 at 7:00 PM was 70 degrees F and there was no precipitation.

The following information was obtained from staff interviews and observations related to Resident #48 ' s unsupervised exit from the facility on 5/16/18 at approximately 7:15 PM.

- An interview was conducted with Dietary Aide #1 on 1/24/19 at 1:31 PM. She confirmed she was working on 5/16/18 at the time of Resident #48 ' s unsupervised exit from the facility. She stated that they had a fire drill at the facility that evening but she was unable to recall a specific time. She stated that after the fire drill she and Dietary Aide #2 were in the kitchen when a facility visitor knocked on the kitchen door and informed them that a resident was outside of the building. Dietary Aide #1 indicated she went into the dining room to look out the window and she saw Resident #48 self-propelling in his wheelchair on the sidewalk adjacent to the facility ' s parking lot. She reported that there was no staff outside with Resident #48. She stated that she went outside and pushed Resident #48 back into the building by wheelchair. She reported that Dietary Aide #2 went to get nursing staff to let them know Resident #48 was found outside unsupervised by a facility visitor. She stated she was unable to recall what Resident #48 was wearing at the time of the incident. Dietary Aide #1 was asked how Resident #48 got out of the building and she indicated that he must have gotten out during the fire drill when the doors to the facility were unlocked. She revealed that she had not known then and still had not known now who was

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responsible for monitoring the exit doors during a fire drill.

- A phone interview was conducted with Dietary Aide #2 on 1/24/19 at 4:04 PM. She confirmed she was working on 5/16/18 at the time of Resident #48 ' s unsupervised exit from the facility. She stated that there was a fire drill at some point that evening and after the fire drill a visitor came to the kitchen door and told her and Dietary Aide #1 that a resident was outside without supervision. She reported that Dietary Aide #1 went to get Resident #48 and she went let nursing staff know he was found outside unsupervised by a facility visitor. Dietary Aide #2 was asked how Resident #48 got out of the building and she indicated that he must have gotten out during the fire drill when the doors to the facility were unlocked. She revealed that she had not known then and still had not known now who was responsible for monitoring the exit doors during a fire drill.

- A phone interview was attempted with Nurse #2 on 1/24/19 at 1:16 PM. She was unable to be reached. Nurse #2 wrote the incident report related to Resident #48 ' s 5/16/18 unsupervised exit from the facility.

- A phone interview was conducted with NA #2 on 1/25/18 at 8:20 AM. She stated that she was working on 5/16/18 at the time of Resident #48 ' s unsupervised exit from the facility. She was uncertain which NA was assigned to Resident #48 during the time of this incident, but she stated she had not thought it was her. She confirmed that there was a fire drill that evening and that during fire drills the exit doors were unlocked and the wanderguard system was disengaged. She

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stated that Resident #48 must have gotten out when doors were unlocked and since the wanderguard system was disengaged the alarm had not gone off when he went out the door. She was asked who was supposed to monitor the exit doors during a fire drill and she stated that she thought it was dietary staffs ' responsibility.

- An interview was conducted with the Maintenance Director on 1/24/19 at 12:04 PM. He stated he had worked at the facility for over two years. The 5/16/18 incident report related to Resident #48 ' s unsupervised exit during a fire drill was reviewed with the Maintenance Director. He stated that during a fire drill all exit doors, 5 in total, were unlocked and the wanderguard system was disengaged. He indicated that staff were responsible for monitoring the exit doors throughout this time as a resident was able to leave the facility without an alarm sounding. The Maintenance Director was asked if staff education on the fire drill was provided after the 5/16/18 unsupervised exit for Resident #48. He indicated he was unable to recall when the last fire drill procedure inservice was conducted.

- A phone interview was conducted with the former Administrator on 1/24/19 at 3:55 PM. She stated that she was the Administrator at the time of Resident #48 ' s unsupervised exit from the facility on 5/16/18 at approximately 8:00 PM. The 5/16/18 incident report for Resident #48 was reviewed with the former Administrator. She revealed that an investigation into the incident had not been conducted because she knew Resident #48 exited the building during the fire drill when the wanderguard system was disengaged. The former Administrator additionally revealed that the root cause of the

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incident was staffs ' failure to monitor the exit doors during a fire drill. She indicated that after the incident she believed an inservice was conducted on the fire drill procedures. She was unable to recall who was responsible for providing this inservice and was unable to recall if all facility staff had received the inservice.

- An interview was conducted with the Corporate Nurse/former interim DON on 1/24/19 at 2:45 PM. She indicated she was not working at the facility at the time of Resident #48 ' s unsupervised exit on 5/16/18. She stated that based on the inservice records, there was no evidence staff education was provided related to the fire drill procedure after Resident #48 ' s unsupervised exit on 5/16/18.

An elopement evaluation was completed for Resident #48 on 5/17/18. Resident #48 was noted as an elopement risk related, in part, to his ability to self-propel wheelchair, history of actual elopement, history of wandering that placed him at significant risk of getting to a dangerous place, his expressed desire to leave, and exit seeking behaviors of hovering near exits and restlessness/agitation.

On 5/17/18 Resident #48 ' s care plan related to the risk for elopement was updated with the intervention of monitoring the nature and circumstances of attempted elopement and adjust care delivery appropriately.

An observation was conducted of Resident #48 on 1/22/19 at 10:05 AM. He was self-propelling his wheelchair in the hallway of his unit of the facility. His wanderguard was located on his wheelchair.

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An observation was conducted of Resident #48 on 1/23/19 at 2:00 PM. He was self-propelling his wheelchair in the hallway of his unit of the facility. His wanderguard was located his wheelchair.

On 1/24/19 a review of the facility ' s protocol for wanderguard ' s, dated 5/1/16, was conducted and indicated that wanderguard bracelets were to be inspected per the manufacturer ' s recommendations.

An interview was conducted with the Corporate Nurse/former interim DON on 1/24/19 at 2:45 PM. She stated she was aware that Resident #48 ' s wanderguard was placed on his wheelchair (initiated 2/1/18). She revealed that the manufacturer of the wanderguard had not been consulted to verify if placement on a wheelchair was in accordance with their recommendations.

A phone interview was conducted with the Product Sales Manager for the manufacturer of the facility ' s wanderguards on 1/24/19 at 5:07 PM. He indicated that their wanderguard transmitter was not recommended to be installed or strapped onto any equipment. He stated that this would apply to wheelchairs. He reported that the transmitter was to be attached directly to the resident ' s ankle or wrist to ensure proper functioning.

An interview was conducted with the current Administrator on 1/25/19 at 6:10 PM. She stated that she began working at the facility recently and she was not present for either of Resident #48 ' s unsupervised exits from the facility (4/9/18 and

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5/16/18). The Administrator indicated she was aware that Resident #48 ' s wanderguard had been placed on his wheelchair. She revealed she was not aware this placement was against the manufacturer ' s instructions. She indicated that the manufacturer should have been consulted prior to placing the wanderguard on Resident #48 ' s wheelchair on 2/1/18. She reported the wanderguard was moved to Resident #48 ' s ankle on 1/25/19 to comply with the manufacturer ' s recommendations. The Administrator indicated she expected residents known to be an elopement risk to be monitored closely to prevent an unsupervised exit. She additionally indicated she expected staff to respond immediately to a wanderguard alarm and for all exit doors to be monitored by a staff member during a fire drill and/or actual fire to prevent a resident from exiting the building without supervision. The Administrator acknowledged that the facility had not provided the necessary supervision and monitoring to prevent Resident #48 from exiting the facility unsupervised on 4/9/18 and 5/16/18. She additionally acknowledged that the facility failed to follow the manufacturer ' s instructions for wanderguard placement, failed to respond immediately to a wanderguard alarm, and failed to monitor the exit doors during a fire drill.

The Administrator and DON were notified of the Immediate Jeopardy on 1/23/18 at 5:20 PM.

On 1/25/19 at 7:23 AM the facility provided the following credible allegation of Immediate Jeopardy removal:

- The plan of correcting the specific deficiency.

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The plan should address the processes that lead to the deficiency cited;

The resident was admitted to the facility on 11/28/2017. Per the care plan initiated on admission and the Elopement Assessment dated 11/30/17, the resident was identified as elopement risk. Resident # 48 had a wander guard bracelet on his wheelchair, due to previous removal of wander guard bracelet from his ankle. Resident had previously been more independent with ambulation, however as evidenced by MDS completed shortly after this event on 4/19/18, resident did not walk in corridor, and required limited assistance of one person for locomotion on unit.

Resident # 48 wandered to the front of the facility at approximately 7:30 pm and was noted by a staff member NA (nurses ' aide) AC, to be near the front door following after another resident and a visitor.NA AC called Licensed Practical Nurse (LPN) HM to assist. Resident was found in parking lot of facility.

LPN HM, and NA AC assisted resident # 48 back inside the facility without incident or injury. There is no documented assessment of resident for this date. Physician was notified by LPN HM on 4/9/18 at 8:10 pm, and POA, Resident #48 ' s family member, was notified on 4/9/18 at 8:30 pm (as documented on Risk Event Summary Report) -All exit doors were checked and all wander guards were checked at the time of the incident and all doors and bands were found to be functioning, according to the Event Summary Report (Incident Report). Event Summary report does not indicate who completed this audit or when completed. Facility cannot locate

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documentation of follow up post this event. Education was completed for 53 staff members related to Elopement Protocol on 4/12/18 -4/15/18. Elopement Protocol Addresses response to door alarms. There were a total of 62 employees at the time of this event, including agency staff.

On 5/16/18 the facility had a fire drill conducted by the local fire department, at approximately 7:00 pm. The drill was conducted by the fire department personnel activating a pull alarm. Once the drill was completed, the alarm was silenced by the fire department personnel at an unknown time, (somewhere between 7:00 - 7:20 pm) however the fire department personnel failed to reset the system as is the normal process when fire drill is conducted by fire department, however it is the facility ' s ultimate responsibility to ensure the system is reset, this is normally completed by the Maintenance Director. The Maintenance Director reports that normally he is alerted in advance to the Fire Departments plan to conduct and onsite fire drill, but that on this occasion 5/16/18 it was a new Fire Department Personnel and he did not notify him in advance. The above-mentioned delay in reset of the system, left the centers 5 exit doors unsecured. These doors are normally wanderguarded. Staff failed to monitor the 5 unsecured exit doors during this time. Protocol calls for all doors to be monitored during a fire drill, by staff on duty at time. At 7:01pm the Fire Department called the maintenance director to notify him that they were conducting a Fire Drill, at 7:04 pm the alarm company called the maintenance director to inform him of the alarm sounding. At 7:05 pm the charge nurse on duty, (Unable to determine who

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this staff member was) called the maintenance director and informed him of drill and they did not know how to reset the alarms. Maintenance director drove into facility to reset alarm, arriving at approximately 7:30 pm at which time he reset the alarms. During this 30-minute time frame the doors were not being monitored. Staff on duty were not trained on how to reset the alarm -Staff had not previously been trained on monitoring the doors. This was an unscheduled drill completed by the local Fire Department as they routinely do in Randolph County.

During the time that the system was down, and the doors were not secure, Resident # 48 was found by the dietary aide LC, she stated that a visitor came and knocked on the kitchen door and told her a resident was outside. Kitchen staff LC noted resident # 48 outside of the facility on the sidewalk near the front entrance - approximately 65 feet from the front entrance, seated in her wheel chair. Resident # 48 was safely returned by dietary staff member LC to the center without injury or incident. LPN AA assessed resident and documented vital signs on the Risk Management Event Summary (Incident Report). The Nurse Practitioner was notified of event on 5/17 at 7:55 a.m., by LPN AA. (Which is within 24 hours of event that had no injury. Resident family member was notified of event on 5/16 at 8:00 pm by LPN AA.

Since the event on 5/16/18, Resident # 48 has had no further incidents of exiting the facility unaccompanied.

Facility is unable to locate an investigation, staff education, or monitoring post this event. Facility

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has had several leadership positions (Administrators and Directors of Nursing) turn over since 5/16/18. Therefore, there is no evidence or documentation that the dietary aide LC was interviewed post this event.

- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;

Education was initiated on 1/24/19 at 8:00 a.m. regarding policy on Neglect and covered that not following resident ' s care plan can lead to neglect. This education was conducted by the Nursing Leadership team (Supervisors, Director of Nursing, and Regional Nurse). All staff on the schedule on 1/24/19 were educated on this, no staff shall work until they receive this education. Nursing Supervisor educating night shift staff on 1/24/19 as they come on shift to ensure compliance. Nursing Supervisor also made telephone call education to multiple staff members on 1/24/19.

Education was initiated at approximately 2:00 pm on 1/23/19 by the Nursing Leadership, (Director of Nursing, Supervisors, regional nurse and Administrator) on the process for ensuring that the Fire Alarm System is reset, and doors secure after every Fire Drill. Education also included that in the event that the system cannot be reset immediately, and/or the doors cannot be secured, the staff on duty at time of drill, as stated in policy, are to monitor the exits and complete a head count and account for the whereabouts of all residents, in particular the residents at risk for Elopement. Education is at 98% for all

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employees, any staff that have not received this training will not work until they have completed the education. Education was completed on Elopement procedure beginning on 4/12 and completed on 4/15/18. Total of 62 staff members employed at time of this event. 53 were educated post event. This education included agency staff.

100% audit was completed on 1/23/19 by the nursing leadership team (Supervisors, Direct of Nursing and regional nurse) of all current residents at risk for Elopement -5 current residents at risk for Elopement. The audit included ensuring that they had secure bracelet in place, that the function and placement of bracelet is checked per protocol, and that Elopement Risk Book was up to date along with the care plans. No discrepancies noted in audit. All current at-risk residents found to have a current Elopement Assessment on file. The facility staff completed a 100% head count of all current residents on 1/23/19 at 2:00 pm to ensure all residents accounted for. This was completed by the nursing leadership team (nursing supervisors, Director of Nursing and Regional Nurse).
Elopement Assessments completed/updated for all current residents by the nursing leadership team (supervisors, Director of Nursing and regional nurse) this was initiated on 1/23/19 and will be completed on 1/24/19. No additional residents found to be at risk. Four of the 5 residents identified at risk have their wander guards on their ankles. Resident # 48 had his Wander guard on his wheel chair. Resident # 48 has had Wanderguard removed from wheel chair and place on his ankle, per manufacturer ' s recommendations. (On 1/25/19)

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- The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;

Charge nurse on 100 hall on all three shifts, will assign staff members to be responsible for monitoring the doors in the event of a fire drill/fire alarm. Licensed nurses will be educated by the nursing leadership (supervisors, Director of Nursing and Regional Nurse) that it is the responsibility of charge nurse to assign staff members each shift on the staffing assignment sheets that they will be responsible to monitor doors in the event of a fire or fire drill. Staffing assignments are reviewed by all staff on duty at the beginning of each shift.

Administrator and Maintenance Director will conduct facility Fire Drills that will include review of securing of the doors and accounting for the whereabouts of all residents. These drills will be conducted weekly x 4 then monthly thereafter and will encompass all three shifts. First drill scheduled for Wednesday January 30th. The doors and wander guard systems will continue to be checked routinely (daily) by the Maintenance Director, and weekend managers.

The Interdisciplinary Team (Administrator, Director of Nursing, Maintenance Director) will conduct Elopement Drills weekly X 4 and then monthly thereafter, these drills will encompass all three shifts. Drill will include calling a Code Green and searching for a missing person following established protocol. The drills will include triggering the wander guard alarm to

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determine the appropriate response from the staff. First drill to be held on Wednesday January 30th. All staff required to respond to alarms once they are heard.

Results of these drills will be brought before the Quality Assurance and Performance Improvement Committee for review monthly by the Administrator and/or Maintenance Director. An ADHOC QAPI Committee meeting was held on 1/24/19 at 12:00 p.m. to review the above plan. Attended by Administrator, Director of Nursing, Regional Nurse, Nursing Supervisors, Maintenance Director, nurse ' s aide and Regional Nurse.

- The title of the person responsible for implementing the acceptable plan of correction.

Allegation of compliance 1/24/19 at 1:00 pm. Center Executive Director is responsible for the implementation of this plan.

The credible allegation of Immediate Jeopardy removal was validated on 1/25/19 at 5:30 PM. Record review indicated there were 5 current residents identified as at risk for elopement. Observations of these 5 residents showed each had a wanderguard in place on their ankle or wrist as indicated by the manufacturer. Monitoring for function and placement of the wanderguard was present on the Treatment Administration Records, the Elopement Risk Book was updated, and each of the 5 residents had a care plan related to elopement risk in place. Elopement Assessments were completed/updated for 100% of the current facility residents on 1/23/19 and 1/24/19. Observations

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confirmed the exit doors and wanderguards were functioning properly. A review of inservice sign in sheets as well as staff interviews verified education was provided on 1/23/19 and 1/24/19 on neglect, elopement procedure, and the fire drill procedure.

2) Resident #51 was admitted to the facility on 10/19/18 with diagnoses that included: Schizoaffective disorder, Bipolar depression, history of stroke, anxiety disorder, diabetes mellitus, Hypertension and Osteoarthritis.

A review of the active care plan dated 11/16/18 revealed a goal that the resident would express satisfaction that her daily routines and preferences were accommodated by the staff. One of the interventions stated it was important for the resident to take a nap whenever she wanted.

The most recent comprehensive MDS (Minimum Data Set) coded as a significant change assessment and dated 11/17/18 revealed the resident was cognitively intact, alert and oriented, able to make needs known and understood others. She required limited to extensive assistance of one to two staff members for Activities of Daily Living (ADL's) except for supervision for meals. She was assessed as having an unsteady balance during transfers was incontinent of bowel and bladder.

A review of the Initial Allegation Report, investigation and statements revealed on 12/1/18 Resident #51 had wanted to lie back down in bed

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after breakfast until activities started. She reported Nurse Aide (NA) #12 raised the bed in the highest position after she had told him she didn't want a male providing personal care and stated NA #12 told her he was all she had. She further stated that Nurse #8 unplugged her bed, so she could not lower it. Both the nurse and NA were suspended pending the outcome of the investigation and terminated 12/4/18.

On 1/22/19 at 9:15am an interview was attempted with Resident #51 who stated that she didn't want to discuss the incident.

The Corporate Nurse/Former Interim DON was interviewed 1/24/19 at 8:20am. She stated that she was the one that investigated the allegation and explained that NA #12 was normally assigned to the resident and would normally get a female aide to assist with her toileting needs. She added that she had not had any complaints from the resident or other residents prior to that day regarding NA #12 being disrespectful. She further added that Nurse #8 stated she unplugged the bed because it was unsafe for the resident to try and lower it. She was unable to state why the resident was not assisted back to bed as requested that day.

An interview was completed on 1/24/19 at 11:30am with NA #11 who was familiar with the resident. She stated that it was common for Resident #51 to lie back down after breakfast until activities started. She explained that she assisted the resident to stand and pivot when transferring back to bed after meals. NA #11 added that she had not witnessed any changes in the resident's mood or behavior since the incident occurred.

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During an interview with Resident #25 on 1/24/19 at 2:00pm, he explained that he had just returned from being out of the facility and noticed that Resident #51 was sitting in her wheelchair, crying in her doorway. He stated that he went to speak to her and sent his wife to get a Diet Coke for the resident. Resident #25 stated that Resident #51 told him she wanted to go back to bed, pointed at the nurse and stated, "she told me No, raised my bed and broke it so I couldn't get back in it". He went on to say that he entered her room and saw that the bed was in the highest position, "I tried to use the control to lower it, it didn't work, and I noticed that it was unplugged". He went on to say that he overheard NA #12 say to the resident "shut up all that noise, you aint' no baby". He went to the nurse to ask why the bed was unplugged and she told him, "I raised the bed and unplugged it. She don't need to be lying in bed all the time and I want her to sit up in the chair for a while". Resident #25 stated he told the nurse the resident had every right to go back to bed when she wanted to and at that time the nurse went and plugged in the bed where it was then lowered, and the resident assisted to lie down.

Resident #10 was interviewed on 1/24/19 at 2:30pm. She stated that on the day of the alleged incident she saw Resident #51 sitting in her doorway and overheard NA #12 being very disrespectful to the resident. She couldn't recall what was said but stated that she interrupted NA #12 while he was eating breakfast in the 300-hall dining room and told him that he needed to be more patient, to which he responded, "she can do what she wants to do". She stated that on the day of the alleged incident she had visualized the bed in a very high position when she went past

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her room.

During a phone interview with Nurse #8 on 1/24/19 at 4:41pm, she explained Resident #51 had told NA #12 that she didn't want him to provide her personal care to which she then advised NA #12 to get a female to provide the care and stated, "I had another resident that was actively dying so I went to that room and didn't check to see who provided her personal care after that". She denied overhearing the resident crying or any disrespectful conversation from NA #12. She went on to say that "a little while later I went by her room and saw that she was standing by the bed, reaching for the remote. I assisted her to sit down and before I could lower the bed another staff member came and got me for another resident. When I left the room, I unplugged the bed, so she wouldn't fall. I came right back, plugged in the bed, lowered it and helped her get in the bed".

On 1/24/19 at 4:51pm a phone call was placed to Nurse # 9 who was working on the day of alleged incident. A message was left for a return call. A return call was not received from Nurse #9.

A phone interview was completed with NA #13 on 1/24/19 at 4:51pm. She stated that she had started working at the facility on that weekend and was not aware any incidences that occurred.

NA #12 was interviewed by phone on 1/24/19 at 5:00pm. He stated that he had worked at the facility for about 4 to 5 years and began the conversation explaining that he changed the resident's brief because she was on his assignment and stated "she has lied on me" referring to the resident. He denied that the

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F 600	Continued From page 51 resident requested a female aide or that he left the bed in the high position. He added that third shift had gotten the resident up and left the bed in the high position and stated, "that bed was up like that and the nurse told me to leave it up, so she couldn't get back in bed". He confirmed that the resident liked to lay down after meals until activities started and was unable to state why the resident was not placed back to bed when asked as this was her normal behavior. An interview was conducted on 1/25/19 at 9:00am with Unit Manager #2. She stated that she had not seen any adverse changes to the resident's mood or behavior since the incident in December. On 1/25/19 at 6:10pm an interview occurred with the Administrator and Director of Nursing, who stated it was their expectation for all resident's to be free from abuse of any kind.	F 600		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		2/27/19

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(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in

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completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §

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F 623	Continued From page 54 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to notify the regional Ombudsman of a hospital transfer for 2 (Resident #87 and Resident #2) of 2 sampled residents reviewed for Hospitalization. The finding included: 1. Resident #87 was admitted on 10/24/18 with a diagnosis of Coronary Artery Disease. Resident #87 admission Minimum Data Set (MDS) dated 10/31/18 indicated severe cognitive impairment with no behaviors. He was coded for extensive assistance with most of his activities of daily living (ADLs). Review of Resident #87's electronic and hard copy medical record indicated he was discharged home on 11/16/18. He was re-admitted to the facility on 12/16/18. Review of a nursing note dated 12/20/18 at 8:35 PM, Resident #87 was observed wheezing and in distress. The nursing note specified Resident #87 was transferred to the hospital on 12/20/18 and expired. In an interview on 1/25/19 at 10:30 AM, the Social Worker stated it was the responsibility of the Administrator to notify the regional Ombudsman of all resident transfers to the hospital. In an interview on 1/25/19 at 10:40 AM, the Administrator stated she was not the Administrator at the time Resident #87 was transferred to the hospital but confirmed that the Ombudsman was not notified of his transfer to	F 623	F623: Transfer/Discharge Notice: Element One: • Notice of transfer for residents # 87 and # 2 were sent to the Ombudsman by the Medical Records, on 2/12/19. Element Two: • An audit of all transfers/discharges in the last 30 days was completed by the Administrator on 2/8/19 to ensure that the Ombudsman was notified. Ombudsman had not previously been notified of transfer/discharges. Element Three: • Education was provided to the Social Service Director, Medical Records and the Admissions Team by the Administrator on 2/12/19, regarding the regulation and process for notification of transfers/discharges to the Ombudsman. Element Four: • The Administrator will audit discharge notification forms sent to the Ombudsman weekly times four weeks, monthly for three months, monthly for three months and report findings in the monthly Quality Assurance Performance Improvement meeting.	

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the hospital on 12/20/18. She stated it was her understanding it was the responsibly of the medical record clerk who went out on medical leave in November 2018 and apparently that task was not assigned to another person during the medical record clerk's absence. The Administrator stated it was her expectation that the regional Ombudsman be notified of any resident hospital transfers.
2. Resident #2 was initially admitted to the facility on 9/8/18 and most recently readmitted on 12/20/18 with diagnoses that included bipolar disorder. The admission Minimum Data Set (MDS) assessment dated 9/18/18 indicated Resident #2' s cognition was intact.

A review of the Resident #2's medical record indicated he was transferred to the hospital and discharged from the facility on 12/19/18. The record revealed no documentation that the Ombudsman was notified in writing the date and the reason for Resident #2 ' s transfer to the hospital. Resident #2 was readmitted to the facility on 12/20/18.

An interview was conducted with the Social Worker on 1/25/19 at 10:30 AM. She was asked who was responsible for notifying the Regional Ombudsman of any residents who had been transferred or discharged from the facility. She stated that this was the responsibility of the Administrator.

An interview was conducted with the Administrator on 1/25/19 at 10:40 AM. She indicated that it was the Medical Records Director (MRD) who was responsible for notifying the Regional Ombudsman of transfers and/or discharges. She reported that the MRD had been

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F 623	Continued From page 56 out of the facility since November 2018 on leave. The Administrator revealed that since the MRD was not at that facility during the time of Resident #2 ' s transfer to the hospital that the Regional Ombudsman was not notified of his transfer. She additionally revealed that the Regional Ombudsman notifications had not been made for any transfers or discharges since the Medical Records Director went on leave.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to complete a Significant Change in Status Assessment (SCSA) for a resident with significant weight loss. (Resident #28). The findings included: Resident #28 was admitted to the facility on 12/28/16 with diagnoses that included dementia, dysphagia (difficulty swallowing), seizure disorder,	F 637	F637: Completion of Assessment after Significant Change: Element One: • Minimum Data Set (MDS) Correction was not made for resident # 28 regarding weight loss due to resident expiring prior to completion. Element Two: • All current residents with weight loss in the last 30 days were reviewed to ensure that a Significant Change	2/27/19

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F 637	Continued From page 57 diabetes mellitus and chronic obstructive pulmonary disease. A review of the resident's weights revealed the following: 202 pounds on 11/20/18 179.5 pounds on 11/28/18 170 pounds on 1/3/19 which was a weight loss of 15.84% A review of the Quarterly Minimum Data Set (MDS) dated 11/26/18 revealed the resident had severe cognitive impairment. She received extensive to total assistance for all ADL's to include meals. She did not have any weight loss concerns and received a mechanically altered diet. A review of the resident's most recent comprehensive MDS coded as an annual assessment and dated 1/3/19 revealed the resident had severe cognitive impairment. She received extensive to total assistance for all Activities of Daily Living (ADL's) to include meals. She was coded with a weight loss of 5% or more in the last month or a loss of 10% or more in the past 6 months, received a mechanically altered diet and had no dental concerns. Resident #28's active care plan dated 1/16/19 included the focus area of a nutritional risk with recent decline and significant weight loss over 6 months. An interview occurred on 1/25/19 at 5:30pm with the Corporate Nurse/Former Interim Director of Nursing and Unit Manager #2, as the MDS Coordinator was not available. Both parties reviewed Resident #28's medical record and	F 637	Assessment was completed accordingly, audit completed by Director of Nursing, no other significant change MDS for weight loss were noted. Element Three: • MDS Nurses (2) were educated by the Regional MDS Consultant regarding the requirements for completing a Significant Change MDS. This education was completed on 2/22/19. Element Four: • Director of Nursing will monitor residents for significant weight loss monthly, by review of weight documentation in Point Click Care, and ensure that MDS Team is aware and schedules a Significant Change MDS accordingly. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee by the Director of Nursing monthly with the QAPI Committee responsible for on-going compliance.	

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F 637	Continued From page 58 agreed that a SCSA should have been completed after the weight loss had been identified. During an interview with the Director of Nursing on 1/25/19 at 6:10pm, she stated that it was her expectation for SCSA's to be completed correctly.	F 637		
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, observation, and staff and resident interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of pain (Resident #20), diagnosis (Resident #18), behavior (Resident #48), and tobacco use (Resident #81) for 4 of 25 residents reviewed for MDS accuracy. Findings included: 1. Resident #20 was admitted to the facility on 12/2/17 with diagnoses of diabetes and arthritis. A review of Resident #20 ' s significant change Minimum Data Set (MDS) dated 10/31/18 revealed the resident had unclear speech, usually understood or understands, had an intact cognition with no behaviors. The resident required extensive assistance of 2 for bed mobility and 1 for all other activities of daily living. The resident ' s active diagnoses were arthritis, non-Alzheimer's dementia, after care for post-surgical orthopedic procedure, absence of	F 641	F641: Accuracy of Assessments: Element One: • MDS Nurse completed Corrections were for residents # 20, #18, # 48 and # 81. These corrections were made and submitted between 1/25 and 2/20/19. Element Two: • Assessments completed in the last 30 days were reviewed to ensure that all appropriate Diagnosis's were coded. Review also included ensuring that pain, behaviors, and tobacco use were appropriately coded. The above audits were completed by Regional Nurse on or before 2/26/19 with any exceptions having an MDS correction made by the MDS nurse. Element Three: • Education was provided to the MDS nurses by the Regional MDS Consultant regarding accurately coding of MDS to include review of Diagnosis, pain, behaviors and smoking history. This	2/27/19

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F 641	Continued From page 59 left toe (5th), and contracture of the left knee. The resident had scheduled pain medication (as needed pain medication was answered "no"). A review of the resident ' s medication administration record (MAR) for the 7-day, look-back period of the MDS dated 10/31/18 revealed Resident #20 received as needed pain medication in addition to scheduled. A review of Resident #20 ' s care plan dated 11/14/18 revealed goals and interventions for at risk for fall, pain (medication), and requested palliative care. On 1/25/19 at 10:40 am an interview was conducted with Nurse #11 who stated that she was regularly assigned day shift to Resident #20. Nurse #11 stated that the resident had arthritis and toe amputation pain and required scheduled and as needed medication for his pain. Nurse #11 commented that if the MAR was documented with a nurses ' signature that medication was given then she gave the medication as ordered. On 1/25/19 at 2:00 pm an interview was conducted with the MDS Nurse who stated she reviewed Resident #20 ' s significant change MDS dated 10/31/18 and the October MAR and the answer "no" for as needed pain medication, Section "J" was incorrect and she would correct the MDS. On 1/25/19 at 4:55 pm an interview was conducted with the DON who stated she expected the MDS Nurse to accurately code the MDS. 2.	F 641	education was completed on 2/22/19. Element Four: • Director of Nursing will audit 5 MDS's per week to ensure accurate coding of Diagnosis, Pain, Behaviors and Tobacco Use X 4 weeks then monthly thereafter. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing with the QAPI Committee responsible for on-going compliance.	

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Resident #18 was admitted to the facility on 1/31/02.

A review of Resident #18 ' s annual MDS dated 11/5/18 revealed the resident had clear speech usually understands and understood. The resident had a severely impaired cognition. The resident required extensive assist of 2 for bed mobility, of 1 for all other activities of daily living. The resident ' s active diagnoses were hyperlipidemia, stroke, non-Alzheimer's dementia, and morbid obesity.

A review of Resident #18 ' s Dietician notes dated 1/11/19 revealed the resident had significant weight loss over the past 6 months.

On 1/24/19 at 11:30 am an interview was conducted with the Dietician who stated that she was aware of the resident's weight loss of 16.1% over the past 6 months. The Dietician stated that the resident did not have the diagnosis of obesity.

On 1/23/19 at 9:30 am an observation was done of Resident #18 who was traveling freely around the facility in his power scooter. The resident had garbled speech and was rarely understood. The resident had verbal behaviors toward staff and visitors. The resident was of thin stature in his body and cheek bones were pronounced in his face.

On 1/25/19 at 2:00 pm an interview was conducted with the MDS Coordinator who stated that on the annual MDS dated 1/11/19 Section "I" active diagnosis of obesity was not a current diagnosis and would correct the error.

On 1/25/19 at 4:55 pm an interview was

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conducted with the DON who stated she expected the MDS Nurse to accurately code the MDS.
3. Resident #48 was admitted to the facility on 11/28/17 with diagnoses that included altered mental status, anxiety, and insomnia.

The quarterly Minimum Data Set (MDS) assessment dated 10/2/18 indicated Resident #48' s cognition was severely impaired. He was assessed with verbal behaviors on 1 to 3 days, no rejection of care, and no wandering behavior.

The annual MDS assessment dated 12/5/18 indicated Resident #48 ' s cognition was severely impaired. Section E, the Behavior Section, indicated Resident #48 had no behaviors, no rejection of care, and no wandering. Question E1100 asked, "How does resident ' s current behavior status, care rejection, or wandering compare to prior assessment?" This question was answered with N/A indicating that there were no prior MDS assessments for comparison. Section E of this MDS was completed by the Social Worker (SW).

A review of the progress notes during the 12/5/18 MDS look back period (11/29/18 through 12/5/18) revealed the following:
- A nursing note dated 11/29/18 indicated Resident #48 refused care.
- A nursing note dated 12/3/18 indicated Resident #48 refused care multiple times and was combative.
- A nursing note dated 12/5/18 indicated Resident #48 was kicking at other residents ' wheelchairs, was verbally aggressive toward staff, and refused care.
- A SW note dated 12/5/18 indicated Resident

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#48 had no new behaviors during the MDS look back period. He was noted to continue with verbal behaviors directed toward staff, refusals of care, and wandering daily. The SW also indicated that Resident #48 continued with the behavior of hoarding items in his room.

An interview was conducted with the SW on 1/24/19 at 3:49 PM. She stated that she reviewed the nursing notes and her observations to code Section E of the MDS assessments. She confirmed she completed Section E of Resident #48 ' s 12/5/18 MDS assessment. This section of Resident #48 ' s MDS that indicated he had no behaviors, no rejection of care, no wandering, and no prior MDS assessments for behavioral comparison was reviewed with the SW. The progress notes for Resident #48 during the 12/5/18 MDS look back period (11/29/18 through 12/5/18) were reviewed with the SW. She revealed that Resident #48 ' s behaviors, rejection of care, and wandering were not new behaviors, so she had not coded them. The SW additionally revealed that she coded question E1100 incorrectly as Resident #48 had multiple previous MDS assessments.

An interview was conducted with the Administrator on 1/25/19 at 6:10 PM. She stated her expectation was for the MDS to be coded accurately.

4. Resident #81 was admitted 12/18/18 with cumulative diagnosis of Peripheral Vascular Disease, Nicotine Dependence and Sepsis (blood infection).

Review of Resident #81's care plan initiated 12/19/18 did not include a care plan for smoking.

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Resident #81's admission Minimum Data Set (MDS) dated 12/25/18 indicated he was cognitively intact and exhibited no behaviors. He was coded as no tobacco use.

Review of an electronic Smoking Assessment completed 12/26/18 indicated Resident #81 was deemed a safe, independent smoker.

In an interview on 1/22/19 at 11:39 AM, Resident #81 stated he was a smoker and he went outside frequently to smoke. There were no observed smoking articles in his room. He stated he kept his smoking items secured in a drawer.

In an observation on 1/22/19 at 4:03 PM, Resident #81 was observed outside smoking in the smoking area.

In an interview on 1/23/19 at 10:40 AM, Nurse #3 stated Resident #81 was identified on admission as a safe smoker. She stated he frequently went outside to smoke.

In an interview on 1/24/19 at 3:20 PM, Nursing Assistant (NA) #10 stated Resident #81 was an independent smoker. She stated he spent a lot of time outside in the smoking area.

In a telephone interview on 1/25/19 at 2:00 PM the MDS Nurse stated section J-Health Conditions of the admission MDS dated 12/25/18 auto populated when completing a comprehensive MDS. She stated she worked remotely and did not visualize Resident #81 in the preparation of his MDS. The MDS Nurse stated she would not know Resident #81 was a smoker unless she observed him or if she had noted the

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F 641	Continued From page 64 Smoking Assessment completed on 12/26/18. In an interview on 1/25/19 at 5:50 PM, the Administrator and the Director of Nursing (DON) stated it was their expectation that the MDS dated 12/25/18 was coded accurately for Resident #81 to include his tobacco use.	F 641		
F 656 SS=E	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)-	F 656		2/27/19

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F 656	Continued From page 65 (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 review, observation,resident interview, staff interview, and Product Manager interview, the facility failed to develop comprehensive care plans (Residents #16, #25, #28, #34, #36, #69, #75, and #81) and failed to implement care plans (Residents #1, #2, #48, and #52) for 12 of 25 sampled residents. The findings included: 1. Resident #48 was admitted to the facility on 11/28/17 with diagnoses that included altered mental status, anxiety, and insomnia. A review of Resident #48' s December 2017 physician ' s orders indicated a wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) was initiated on 11/30/17 due to poor safety awareness. The admission Minimum Data Set (MDS) assessment dated 12/5/17 indicated Resident #48 ' s cognition was severely impaired. He was	F 656	F656: Comprehensive Care Plans: Development: Element One: • Resident # 16 care plan was updated to reflect medication refusals and behaviors. Resident # 25 care plan was updated to reflect edema / weight monitoring. Resident # 28 Care plan was updated to include oxygen use/respiratory symptoms. Resident # 34 care plan was updated to reflect diagnosis of diabetes. Resident # 69 care plan was updated to include use of psychotropic medications. Resident # 75 care plan was updated to include oxygen and respiratory symptoms. Resident # 81 care plan was updated to reflect smoking status. • These care plan updates were completed by the Unit Managers on 2/18/19 Implementation of care plan: Element One: Resident # 1 had fall mat discontinued	

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F 656	Continued From page 66 assessed with wandering behaviors daily. The behavioral symptoms Care Area Assessment (CAA) for the 12/5/17 MDS indicated Resident #48 was confused at times, impulsive, and determined to leave the facility. Resident #48 ' s plan of care included the focus area of the risk for elopement related to his expressed desire to leave the facility and multiple attempts made by the resident to exit the facility. Resident #48 was noted to have removed his own wanderguard. This focus area was initiated on 11/30/17 and revised on 12/18/17. The interventions indicated a wanderguard was in place and was to be utilized and monitored per facility protocol (initiated 11/30/17). A physician ' s order dated 1/23/18 clarified the placement of Resident #48 ' s wanderguard indicating it was to be on his right lower extremity. The wanderguard was to be checked for function and placement every shift. The physician ' s order related to Resident #48 ' s wanderguard was changed on 2/1/18 to indicate the wanderguard was to be placed on his wheelchair rather than on his right lower extremity. The wanderguard was to be checked for function and placement every shift. An incident report dated 4/9/18 indicated Resident #48 had an unsupervised exit from the facility. He was found outside of the facility without supervision by staff at approximately 8:00 PM. Resident #48 ' s wanderguard was in place on his wheelchair at the time of this unsupervised exit.	F 656	and resolved from care plan. Resident # 2 and # 52 have Behavior Monitoring in place per care plan. Resident # 48 has Wander Guard monitoring per care plan. Element Two: • An audit was completed for all current residents with medication refusals, daily weights, oxygen use, diagnosis of Diabetes, psychotropic medication use and smoking to ensure that these areas were addressed on their care plans. These audits were completed by the Unit Managers, Director of Nursing and Regional Nurse with appropriate care plan updates as indicated. • An Audit was completed for all residents with fall mat interventions to ensure that they are in place plan of care. • An audit was completed for all residents with Wander Guards to ensure that they are in place per the plan of care. This Audit was completed by the Unit Managers, all care plans in place. Element Three: • Education was provided to the Nurses and IDT on completion of care plans to include: medication refusals, daily weights, oxygen use, psychotropic med use, and smoking. This education was completed by The Unit Managers and Regional Nurse 2/22/19. Education included FT,PT, PRN and agency staff. Currently 99% of staff have been educated, any staff who have not received education will not work until they complete education. • Education was also completed with	

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F 656	Continued From page 67 An incident report dated 5/16/18 indicated Resident #48 had an unsupervised exit from the facility. He was found outside of the facility without supervision by a facility visitor at approximately 7:15 PM. Resident #48 ' s wanderguard was in place on his wheelchair at the time of this unsupervised exit. A review of Resident #48 ' s medical record on 1/23/19 indicated the 2/1/18 physician ' s order for the wanderguard to Resident #48 ' s wheelchair with its function and placement to be checked every shift continued to be an active order. An observation was conducted of Resident #48 on 1/23/19 at 2:00 PM. He was self-propelling his wheelchair in the hallway of his unit of the facility. Resident #48 ' s wanderguard was located on his wheelchair. A review of the facility ' s protocol for wanderguard ' s, dated 5/1/16, indicated that wanderguard bracelets were to be inspected per the manufacturer ' s recommendations. A phone interview was conducted with the Product Sales Manager for the manufacturer of the facility ' s wanderguards on 1/24/19 at 5:07 PM. He indicated that their wanderguard transmitter was not recommended to be installed or strapped onto any equipment. He stated that this would apply to wheelchairs. He reported that the transmitter was to be attached directly to the resident ' s ankle or wrist to ensure proper functioning. An interview was conducted with the Administrator on 1/25/19 at 6:10 PM. She stated that she expected care plan interventions to be	F 656	nursing staff and IDT on the implementation of care planned interventions to include fall mats, behavior monitoring and wander guards. This education was completed by the Director of Nursing on 2/22/19. Education included FT, PT , PRN and Agency staff. Currently at 99% of all staff educated, those staff remaining will not work until they complete the training. Element Four: • Care Plans will be reviewed daily in Clinical Morning Meeting to ensure that they meet resident current needs. This review will be conducted by the Director of Nursing and Unit Managers. • Unit Managers will audit residents with Fall Mats 5 X week , on varying shifts and weekends, for four weeks, then randomly thereafter, to ensure in place per care plan. • Unit Managers will audit Behavior Monitoring 5X week for four weeks, then randomly thereafter, to ensure that it is in place per care plan. • Social Service Director or Activity Director will monitor residents with Wander Guards 5X week for four weeks then randomly thereafter, to ensure that they are in place per care plan. Manager on Duty will monitor on the weekend. • Results of the above audits will be brought before the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing, with the QAPI Committee responsible for on-going compliance.	

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implemented. She additionally stated that she expected the facility ' s wanderguard protocol to be followed and for wanderguards to be utilized as recommended by the manufacturer.

2. Resident #2 was admitted to the facility on 9/8/18 and most recently readmitted on 12/20/18 with diagnoses that included bipolar disorder.

The care plan for Resident #2 included the focus area of the risk for complications related to the use of psychotropic medications. This area was initiated on 9/16/18. The interventions included, in part, monitor for side effects (initiated 9/16/18).

The admission Minimum Data Set (MDS) assessment dated 9/18/18 indicated Resident #2 ' s cognition was intact. He had verbal behaviors and rejection of care on 1 to 3 days during the MDS look back period. Resident #2 received antipsychotic medication and antidepressant medication on 7 of 7 days.

A review of Resident #2 ' s Medication Administration Records (MARs) from 9/8/18 through 1/25/19 indicated no side effect monitoring had been documented on his MARs.

An interview was conducted with Nurse #3 on 1/25/19 at 2:40 PM. She stated that the facility utilized the MAR to document side effect monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any side effects. Nurse #3 stated that the nurse who completed the admission for the resident was supposed to enter

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side effect monitoring onto the MAR for all residents who were on psychotropic medications. She indicated that this task was not always completed and that the Unit Managers (UMs) were responsible for reviewing the MAR to ensure the side effect monitoring was in place. The January 2019 MAR for Resident #2 was reviewed with Nurse #3. She confirmed that side effect monitoring was not on Resident #2 ' s MAR.

A phone interview was conducted with UM #1 on 1/25/19 at 3:01 PM. She stated that the facility utilized the MAR to document side effect monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any side effects. UM #1 stated that the nurse who completed the admission for the resident was supposed to enter side effect monitoring onto the MAR for all residents who were on psychotropic medications. She reported that she was responsible for reviewing the MARs to ensure side effect monitoring was in place for all residents on psychotropic medications. UM #1 revealed that she should have identified that Resident #2 had no side effect monitoring on his MAR. She stated that this was an oversight.

An interview was conducted with the Administrator on 1/25/19 at 6:10 PM. She stated that she expected care plan interventions to be implemented. She additionally stated that she expected side effect monitoring to be conducted for all residents on psychotropic medications.

3. Resident #81 was admitted 12/18/18 with cumulative diagnosis of Peripheral Vascular

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Disease, Nicotine Dependence and Sepsis (blood infection).

Resident #81's admission Minimum Data Set (MDS) dated 12/25/18 indicated he was cognitively intact and exhibited no behaviors.

Review of an electronic Smoking Assessment completed 12/26/18 indicated Resident #81 was deemed a safe, independent smoker.

Review of Resident #81's care plan last revised on 1/3/19 did not include a care plan for smoking.

In an interview on 1/22/19 at 11:39 AM, Resident #81 stated he was a smoker and he went outside frequently to smoke. There were no observed smoking articles in his room. He stated he kept his smoking items secured in a drawer.

In an observation on 1/22/19 at 4:03 PM, Resident #81 was observed outside smoking in the smoking area.

In an interview on 1/23/19 at 10:40 AM, Nurse #3 stated Resident #81 was identified on admission as a safe smoker. She stated he frequently went outside to smoke.

In an interview on 1/24/19 at 3:20 PM, Nursing Assistant (NA) #10 stated Resident #81 was an independent smoker. She stated he spent a lot of time outside in the smoking area.

In an interview on 1/25/19 at 1:45 PM, the Corporate Nurse/Former Interim Director of Nursing (DON) stated it was not the sole responsibility of the MDS Nurse to develop a care

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plan. She stated it was the expectation that all nurses, managers and Unit Managers could develop or implement a care plan.

In a telephone interview on 1/25/19 at 2:00 PM the MDS Nurse stated she worked remotely and did not visualize Resident #81 in the preparation of his care plan. The MDS Nurse stated she would not know to develop a smoking care plan unless she observed Resident #81 or if she had noted the Smoking Assessment completed on 12/26/18. The MDS Nurse stated it was her understanding that the Unit Manager was responsible to reviewing the care plan after she ensured that a Care Assessment Areas were addressed, and Unit Manager #1 should have care planned Resident #81 for smoking.

In a telephone interview on 1/25/19 at 3:00 PM, Unit Manager #1 stated she should have care planned Resident #81 for smoking. She stated it was an oversite.

In an interview on 1/25/19 at 5:50 PM, the Administrator and the Director of Nursing (DON) stated it was their expectation that Resident #81 have a care plan for smoking.

4. Resident #69 was admitted 12/28/18 with cumulative diagnoses of Altered Mental Status, Malnutrition, Bacteremia (bacteria in the blood stream), pressure ulcer, Depression and Post Traumatic Stress Disorder (PTSD).

Review of Resident #69's admission orders dated 12/28/18 indicated he was prescribed Remeron (antidepressant) every day for depression.

Review of Resident #69's December 2018

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Medication Administration Record (MAR) indicated he received his antidepressant daily.

Resident #69's admission Minimum Data Set (MDS) dated 1/4/19 indicated he was cognitively intact, no mood disturbance and exhibited no behaviors. He coded as having received 6 doses of an antidepressant during the look back period. The Care Area Assessment (CAA) was triggered for psychotropic medications. The CAA indicated Resident #69 would be care planned for psychotropic medications related to his Depression.

Review of Resident #69's care plan dated 1/7/19 indicated he was at risk for sadness/depression due to his diagnosis of Depression. The care plan did not include the use of psychotropic medications for his depression.

Review of Resident #69's January 2019 MAR indicated he received his antidepressant daily from 01/01/19 to 1/22/19.

In an interview on 1/22/19 at 11:00 AM, Resident #69 stated he was diagnosed with Depression and PTSD and had a history of psychological services with medication interventions. He stated he understood he was prescribed an antidepressant while at the facility.

In a telephone interview on 1/25/19 at 2:00 PM the MDS Nurse stated she worked remotely. She confirmed she completed the MDS assessment dated 1/4/19. She stated she should have care planned Resident #69 for the use of antidepressant medications and not just his diagnosis of Depression since the antidepressant can result in adverse side effects and required

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behavior/mood monitoring.

In an interview on 1/25/19 at 5:50 PM, the Administrator and the Director of Nursing (DON) stated it was their expectation that Resident #69 have a care plan for the use of psychotropic medication for Depression.

5. Resident #52 was admitted 11/28/18 with cumulative diagnoses of Cerebral Vascular Accident (CVA), Depression, Anxiety and Dementia without Behaviors.

Review of Resident #52's admission orders dated 11/28/18 indicated she was prescribed Elavil and Cymbalta (antidepressants) for Depression daily and Ativan (antianxiety) as needed for Anxiety. Her admission orders read if psychotropic medications are used, include a clinical rationale and monitor/address adverse consequences.

Review of Resident #52's admission Minimum Data Set (MDS) dated 12/5/18 indicated severe cognitive impairment and she was coded as feeling down with wandering behaviors. The MDS indicated she received antianxiety medication on 2 occasions and received antidepressants on 7 days during the look back period.

Review of Resident #52's care plan dated 12/12/18 indicated she was at risk for complications related to the use of psychotropic medications. Interventions included monitoring behaviors, mood, changes in mental status, functional stated and side effects.

Review of Resident #52's December 2018 MAR

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indicated she received her antidepressants daily and her antianxiety medication on 12 occasions. A review of Resident #52's December 2018 MAR indicated no documented side effect monitoring.

Review of Resident #52's January 2019 MAR indicated she received her antidepressants daily and her antianxiety medication on 2 occasions up until 1/3/19 when an order was written to change her antianxiety medication to scheduled 3 times daily and hold for sedation. A review of Resident #52's January 2019 MAR indicated no documented side effect monitoring.

Review of Resident #52's nursing notes from 11/28/18 to 1/23/19 included no documentation regarding monitoring of side effects of her psychotropic medications.

In an observation on 1/23/19 at 10:30 AM, Resident #52 was clothed and lying asleep across her made bed. She was easily aroused and proceed to ambulate out of her room down the hall.

In an interview on 1/24/19 at 3:20 PM, Nurse #10 stated Resident #52 was very active and wandered about the facility. Nurse #10 stated side effect monitoring for Resident #52 should be on the MAR if it was being done. Nurse #10 verified no evidence of monitoring on the December 2018 and January 2019 MAR for side effects related to Resident #52's psychotropic medications.

In another observation on 1/25/19 at 9:00 AM, Resident #52 was sitting on the side of her bed

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eating breakfast. There were no observed concerns.

In an interview on 1/25/19 at 2:40 PM, Nurse #3 stated that the facility utilized the MAR to document side effect monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any side effects. Nurse #3 stated that the nurse who completed the admission for the resident was supposed to enter side effect monitoring onto the MAR for all residents who were on psychotropic medications. She indicated that this task was not always completed and that the Unit Managers (UMs) were responsible for reviewing the MAR to ensure the side effect monitoring was in place.

In a telephone interview on 1/25/19 at 3:00 PM, UM #1 stated that the facility utilized the MAR to document side effect monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any side effects. UM #1 stated that the nurse who completed the admission for the resident was supposed to enter side effect monitoring onto the MAR for all residents who were on psychotropic medications. She reported that the Units Managers were responsible for reviewing the MARs to ensure side effect monitoring was in place for all residents on psychotropic medications and must have been an oversight.

In an interview on 1/25/19 at 5:50 PM, the Administrator and Director of Nursing (DON) stated it was their expectation that the care planned intervention of monitoring for side effects

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be documented on the MAR for any resident prescribed a psychotropic medication.

6) Resident #1 was admitted to the facility on 4/27/16 with diagnoses that included dementia, altered mental status, diabetes mellitus and heart failure.

A review of the resident's active care plan revealed there was a problem area for being at risk for falls due to impaired mobility, impaired cognition and history of falls with an intervention of a fall mat in place when the resident was in bed (initiated 12/13/17).

The annual Minimum Data Set (MDS) assessment dated 1/5/19 indicated Resident #1 was alert and oriented, had moderately impaired cognition with periods of confusion. She required extensive to total dependence from one staff member for Activities of Daily Living (ADL's) except for supervision for eating. She was assessed as having two or more falls since the last assessment.

On 1/22/19 at 9:15am an interview was completed with Resident #1, who stated that she often forgot to ask the staff for assistance with transfers.

On 1/23/19 at 2:25pm an observation revealed Resident #1 lying in her bed with no fall mat present beside her bed.

An interview was completed with Nursing Aide #11 (NA) on 1/24/19 at 2:20pm. She was unable to locate a fall mat in Resident #1's room and stated that she didn't know the resident was to have one.

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An interview was completed with Resident #1 on 1/24/19 at 2:30. She stated that when she stood her legs hurt. She was able to show how to use the call light for assistance from staff but stated that she often forgot and felt like she didn't need help. She couldn't recall a fall mat being placed next to her bed.

During an interview with Unit Manager #2 on 1/25/19 at 9:00am she confirmed that the fall mat was present on the care plan as an intervention and was unsure why it was not in the resident's room or resolved on the care plan. She added that the unit managers and nurses update and revise the care plans as needed.

On 1/25/19 at 6:10pm an interview was completed with the Administrator and Director of Nursing. They stated that it was their expectation for the care plan interventions to be implemented.

7) Resident #36 was admitted to the facility on 11/1/18 with a readmission date of 11/16/18. Her diagnoses included cerebral infarction (a stroke), vascular dementia, muscle weakness and hypertension.

The admission MDS assessment dated 11/23/18 assessed the resident as alert and oriented with periods of confusion. She received extensive to total assistance from one to two staff members for ADL's and had impairment on one side of her body.

Review of the resident's active care plan dated 12/2/18 revealed she was care planned for risk of

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falls, vision impairment and assistance required with ADL's, however bed rails were not mentioned as an intervention for enabling positioning and were present on the bed.

On 1/25/19 at 11:00am an interview was completed with Resident #36, who stated that she liked to hold onto the bed rails when the staff assisted with her personal care and could reach with her right hand to adjust self in the bed.

An interview was conducted with NA #11 on 1/25/19 at 11:05am. She stated that the resident reached for the bed rails when personal care was provided and could use her right hand to adjust self in the bed.

On 1/25/19 at 6:10pm an interview was completed with the Administrator and Director of Nursing. They stated it was their expectation for the care plan to be comprehensive and person centered.

8) Resident #34 was admitted to the facility on 11/8/18 with diagnoses that included Diabetes Mellitus, cerebral infarction (stroke) and aphasia.

A review of Resident #34's current physician orders revealed the following orders related to Diabetes Mellitus:
A) Accuchecks twice a day with Sliding Scale Insulin
B) Humalog solution 100u/ml. Inject as per sliding scale if 0 - 150 = 0 units Call MD if blood glucose is less than 70; 151 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351+ = 10 units call MD immediately for further instruction if blood glucose is greater than 400.

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The admission MDS was dated 11/15/18 and assessed the resident with cognitive impairment. She required extensive to total assistance from one to two staff members for all ADL's to include meals. She had received two days of insulin injections during the 7 day look back period.

Review of the active care plan dated 11/24/18 revealed the resident was not care planned for the risk of hyperglycemia or hypoglycemia related to the diagnosis of Diabetes Mellitus and the use of Sliding Scale Insulin.

Review of the January Medication Administration Record (MAR) showed that Resident #34 received Sliding Scale Insulin eight times from January 1 through January 25, 2019.

An interview occurred on 1/25/19 at 5:30pm with the Corporate Nurse/Former Interim Director of Nursing, as the MDS Coordinator was not available. She stated that the resident should have had a care plan for diabetes risks and the use of Sliding Scale Insulin.

On 1/25/19 at 6:10pm an interview was completed with the Administrator and Director of Nursing. They stated it was their expectation for the care plan to be comprehensive and person centered.

9) Resident #28 was admitted to the facility on 12/28/16 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), anemia, hypertension and dysphagia (difficulty swallowing).

The most recent MDS coded as an annual

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assessment and dated 1/3/19, assessed the resident with severe impaired cognition. She received extensive to total assistance of one to two staff members for all ADL's to include meals. No special treatments were identified.

A physician order dated 1/17/19 was present to start oxygen to maintain saturations greater than 93%.

Per the January 2019 MAR, oxygen was started 1/17/19 at 2 liters via nasal cannula continuously.

Resident #28 was observed with oxygen on at 2 liters via nasal cannula on 1/22/19 at 10:35am.

A review of the resident's active care plan dated 1/23/19 revealed she was care planned for the diagnosis of COPD and a desire for palliative/comfort care measures only. The use of oxygen was not present in the interventions.

An interview occurred on 1/25/19 at 5:30pm with the Corporate Nurse/Former Interim Director of Nursing, as the MDS Coordinator was not available. She stated that the use of oxygen should have been placed on the care plan and added that the unit managers and nurses updated care plans with changes and altered interventions.

On 1/25/19 at 6:10pm an interview was completed with the Administrator and Director of Nursing. They stated it was their expectation for the care plan to be comprehensive and person centered.

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10.
Resident #16 was admitted to the facility on 9/19/13 with diagnoses aphasia, hemiplegia, stroke, and depression.

A review of Resident #16 ' s quarterly Minimum Data Set dated 11/1/18 revealed documentation that the resident was sometimes understood and sometimes understands. Cognition was intact. The resident required total dependence for all transfers including toileting, and extensive assistance for bathing and dressing. The resident ' s active diagnoses were aphasia, non-Alzheimer's dementia, hemiplegia, and depression. The resident received scheduled pain management.

A review of Resident #16 ' s care plan dated 11/14/18 revealed the resident had goals and interventions for self-care deficit, verbal behaviors, poor impulse control, communication deficit, pain, and was at risk for psychotropic medication complication (intervention was to inform the physician of changes in mental status and functional level and to monitor for continued need for medication related to mood and behavior).

A review of the resident ' s November 2018 MAR revealed out of 30 days the resident refused the following medication:

Amitiza twice a day refused on 20 occasions
Aspirin once a day refused on 18 occasions

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Atorvastatin once a day refused on 20 occasions
Depakote three times a day refused on 36 occasions
Flomax twice a day refused on 26 occasions
Flonase once a day refused on 11 occasions
Metoprolol twice a day refused on 27 occasions
Plavix once a day refused on 22 occasions
Proscar once a day refused on 18 occasions
Zoloft once a day refused on 17 occasions
Trazadone once a day refused on 17 occasions

A review of the resident ' s December 2018 MAR revealed out of 31 days the resident refused the following medication:

Amitiza twice a day refused on 17 occasions
Aspirin once a day refused on 13 occasions
Atorvastatin once a day refused on 8 occasions
Depakote three times a day refused on 20 occasions
Flomax twice a day refused on 21 occasions
Flonase once a day refused on 4 occasions
Lisinopril refused on 8 occasions
Metoprolol twice a day refused on 19 occasions
Norvasc 5 mg once a day refused on 13 occasions
Plavix once a day refused on 8 occasions
Proscar once a day refused on 18 occasions
Zoloft once a day refused on 17 occasions
Trazadone once a day refused on 17 occasions

A review of the resident's January 2019 MAR revealed out of 24 days the resident refused the following medication:

Amitiza twice a day refused on 28 occasions
Aspirin once a day refused on 11 occasions
Atorvastatin once a day refused on 21 occasions
Depakote three times a day refused on 42

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occasions
Flomax twice a day refused on 31 occasions
Flonase once a day refused on 15 occasions
Lisinopril refused on 19 occasions
Metoprolol twice a day refused on 27 occasions
Norvasc 5 mg once a day refused on 13 occasions
Plavix once a day refused on 19 occasions
Proscar once a day refused on 19 occasions
Zoloft once a day refused on 19 occasions
Trazadone once a day refused on 19 occasions

On 1/25/19 at 10:40 am an interview was conducted with Nurse #11 who stated that she was regularly day-shift assigned to Resident #16. Nurse #11 commented that the resident had lately more frequently refused his medication and had increased behaviors. Nurse #11 stated that other shift nurses had reported the same. Nurse #11 was not aware if there were care plan goal(s) and interventions for medication refusal for the resident.

On 1/25/19 at 1:10 pm an interview was conducted with Nurse #9 who stated she was familiar with Resident #16 and frequently assigned to him on evening shift. Nurse #9 stated that she recalled the resident had frequently refused his medication. Nurse #9 commented that the refusals were documented on the medication administration record but could not recall if medication refusal was on the resident ' s care plan.

On 1/25/19 at 4:55 pm an interview was conducted with the DON who stated she expected staff to develop and implement the resident ' s care plans according to their needs and to make any changes.

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11.
Resident #75 was admitted to the facility on 7/23/18 with diagnoses of congestive heart failure, chronic obstructive pulmonary disease (COPD), and respiratory failure.

A review of the physician order dated 11/2/18 revealed an order for oxygen 2 liters nasal cannula continuously and to check every shift.

A review of Resident #75 ' s Medicare 60-day Minimum Data Set (MDS) dated 1/3/19 revealed the resident had adequate hearing, clear speech, was understood and understands. The resident had an intact cognition. The resident required extensive assistance of 2 staff for bed mobility and all transfers including toileting, and of 1 staff for all personal care and dressing. The active diagnoses were congestive heart failure, hypertension, COPD, and muscle wasting. The resident required continuous oxygen.

A review of Resident #75 ' s care plan dated 11/14/18 revealed an activities of daily living self-care deficit, was at risk for falls immobility, at risk for infection to wounds, at risk for nutritional deficit, received psychotropic meds, and was at risk for skin breakdown. No respiratory and oxygen administration goals and interventions were identified as being documented.

On 1/23/19 at 11:20 am an observation was done of the resident who was reclining in his bed wearing a nasal cannula. The resident was receiving oxygen via an oxygen concentrator.

On 1/25/19 at 10:40 am an interview was conducted with Nurse #11 who stated that she

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was regularly day-shift assigned to Resident #75. Nurse #11 commented that the resident had a respiratory deficit and was administered continuous oxygen. Nurse #11 was not aware if there were care plan goal(s) and interventions for respiratory and oxygen.

On 1/25/19 at 4:55 pm an interview was conducted with the DON who stated she expected staff to develop and implement the resident ' s care plans according to their needs and to make any changes.

12.

Resident #25 was admitted to the facility on 2/16/18 with diagnoses of cirrhosis of the liver, chronic pain, panic disorder, and insomnia.

A review of Resident #25 ' s quarterly Minimum Data Set (MDS) dated 11/6/18 revealed the resident had an intact cognition with no behaviors. The resident was independent with all activities of daily living. Active diagnoses were heart failure, COPD, and edema. The resident received scheduled and as needed pain medication. The resident also received diuretic medication for 7 days.

A review of Resident #25 ' s care plan created on 2/16/18 and updated on 8/17/18 revealed a focus problem for congestive heart failure and an intervention to assess the resident ' s edema.

A review of Resident #25 ' s nurses ' notes from 10/1/18 to present revealed that there was no documentation of the resident ' s lower extremity edema status. The resident had weight gain and

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diuretic administered and lower extremity weeping of fluid.

A review of Resident #25 ' s physician order dated 11/8/18 was for daily weight and to notify the physician if weight increase was greater or equal to 3-pound weight gain in 1 day or greater than or equal to 5-pound weight gain in one week. History of lower extremity edema and weeping.

Nurses note dated 1/11/19 increased lower extremity fluid weeping.

On 1/23/19 at 1:20 pm an observation was done of Resident #25 who had bilateral edema to his lower legs and his left leg had two open areas with dressings that were moist. The resident commented when the fluid leaks out of his legs his skin opens.

On 1/23/19 at 1:30 pm an interview was done of the assigned Nurse #7 who stated that she knew Resident #25 had an order for daily weights and to assess the resident ' s edema. When Nurse #7 reviewed the resident ' s weight record there were several gaps in documentation for January 2019. Nurse #7 stated that the weight record reviewed was the only place for weight documentation and if the date was left blank the weight was not done. She was not aware of the resident refusing to be weighed. Nurse #7 agreed that she weighed the resident on day shift in the morning as documented. Nurse #7 was not aware that the resident ' s daily weight order included for the physician to be notified for weight gain. Nurse #7 added to the daily weight order to document the weight amount on the medication administration record (MAR) to trigger compliance. Nurse #7 was aware that the

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F 656	Continued From page 87 resident had acquired weeping fluid of his lower legs with a history of the same from edema and was taking a daily diuretic. On 1/25/19 at 2:00 pm interview was conducted with Nurse #9 who stated she had worked at the facility for 12 years, usually on evening or night shift. Nurse #9 stated that she was very familiar with Resident #25 ' s lower extremity edema which had caused weeping fluid periodically. Nurse #9 expected day shift to weigh the resident and assess his edema if he was not ready to get out of bed at 6:00 am. Nurse #9 was not aware that the resident was not weighed each day but was aware there was a physician order to notify for weight gain and edema. On 1/25/19 at 5:10 pm an interview was conducted with Resident #25 ' s physician who stated that he expected staff to weigh the resident as ordered and inform him of weight gain, edema or any changes for potential treatment. The physician stated that he had not been informed of the resident ' s weight gain or increased edema. The physician also commented that if the weight was missed and the last weight revealed weight gain now, he would expect to be notified no matter how many days were in between. On 1/25/19 at 4:55 pm an interview was conducted with the DON who stated she expected staff to develop and implement the resident ' s care plans according to their needs and to make any changes. The resident was known to have chronic, varying edema and had an order to be weighed daily.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		2/27/19

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F 657	Continued From page 88 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff and resident interviews, the facility failed to review and revise the resident ' s care plan in the area of behaviors (Resident #25), urinary catheter (Resident #36), and elopement (Resident #48) for 3 of 25 resident care plans reviewed for revisions. The facility also failed to incorporate a Nursing Assistant in the care planning process (Residents #2 and #23) for 2 of 2 residents reviewed for	F 657	F657: Care Plan Revisions: Element One: • Care Plans for Residents # 25, # 36 and # 48 have been updated accordingly by the Unit Managers on or before 2/20/19. • Resident’s # 2 and #23 have had their Care Plans updated/revised with nurse’s aid input, by Social Services Director on	

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F 657	Continued From page 89 participation in care planning. Findings included: 1. Resident #25 was admitted to the facility on 2/16/18 with diagnoses of cirrhosis of the liver, chronic pain, panic disorder, and insomnia. A review of Resident #25 ' s quarterly Minimum Data Set (MDS) dated 11/6/18 revealed the resident had an intact cognition with no behaviors. The resident was independent with all activities of daily living. Active diagnoses were anxiety, depression, and post-traumatic stress disorder (PTSD). The resident received scheduled and as needed pain medication. The resident also received antipsychotic, hypnotic, antidepressant, antianxiety, and opioid medication for 7 days. A review of Resident #25 ' s care plan created on 2/16/18 and updated on 8/17/18 revealed a focus problem for physical behaviors related to poor impulse control with a goal to seek out staff when feeling frustrated or provoked. The interventions included: monitor medications, evaluate the circumstances of the behavior, encourage resident to seek staff support, and remove resident from the environment. The resident also had a focus problem for depression and potential complications of antidepressant medication. A review of Resident #25 ' s psychiatry progress note dated 3/16/18 revealed the resident was readmitted on 2/19/18. The note documented that the "resident had history and present of holes in his story and incongruence with incidents and events. The resident was not in the facility during	F 657	2/20/19. Element Two: • An Audit was completed for all current residents with pain, behaviors and Catheters, and those residents who have had catheters discontinued in last 30 days, have been reviewed to ensure that care plan is current and accurate. These audits were completed by the Unit Managers, on or before 2/20/19 with appropriate care plan updates as indicated. • All future care plan development will include input from Nurses Aids. Element Three: • Education was provided to licensed nurses and IDT members regarding appropriate revision of care plans. • Education was provided for the IDT/Care Plan Team (MDS, Social Serviced, Dietary, Activities, Unit Managers, and nurses aids) regarding the regulation on involving nurse's aids in the development of resident care plans. This education provided by Regional Nurse on 2/22/19. All members of the IDT/Care Plan team are full time. All members have received the training. Element Four: • Care plans will be updated in daily clinical meeting from the twenty four hour report, the Physician orders, and event reporting, by the Unit Managers.. Audits will be completed by the Director of Nursing or Unit Managers, on care plan	

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F 657	Continued From page 90 2017 because of drug-seeking behaviors. On 1/23/19 at 1:20 pm an interview was conducted with the resident who stated that at times when his medication for pain ran out sometimes there was a delay of 2 days and he did not have medication. The resident commented that another resident offered him her pain medication when his ran out. Resident #25 had no concerns and thought the resident was being kind. The incident was reported to staff. The resident then went on to say that he received pain medication from the stock and had not missed a dose when Nurse #7 entered the room. Nurse #7 redirected the resident and stated that backup pain medication was kept in facility stock and the resident would not be without medication. The resident also stated that his current medication was effective. The resident commented that he was relaxed without panic attacks or night mares and his pain was under control. On 1/23/19 at 1:30 pm an interview was conducted of the assigned day shift Nurse #7 who stated the resident was known to provide inaccurate information and that PTSD was a newer diagnosis after the resident ' s admission. The resident was also known to manipulate staff. On 1/25/19 at 9:00 am an Interview was conducted with Unit Manager #2 who stated that unit managers and nurses updated the care plan with any changes. She indicated that she was not aware that Resident #25 needed a care plan revision. On 1/25/19 at 2:00 pm an interview was conducted with evening shift Nurse #9 who stated	F 657	updates and nurse aid involvement with care plan development, weekly for four weeks, then monthly for three months, quarterly for three quarters. Results will be reviewed in the Quality Assurance and Performance Improvement Committee monthly, by the Director of Nursing , with the QAPI Committee responsible for on-going compliance.	

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she had worked at the facility for 12 years. Jennifer was very familiar with Resident #25. The resident could be manipulative and not be truthful of what he (the resident) had to state. The resident had to be redirected and informed when not honest.

On 1/25/19 at 4:55 pm an interview was conducted with the DON who stated she expected the Unit Managers and nursing staff to update the resident ' s care plan according to any changes with the resident and any resident needs.

2) Resident #36 was admitted to the facility on 11/1/18 with a readmission date of 11/16/18. Her diagnoses included cerebral infarction (a stroke), vascular dementia, muscle weakness and hypertension.

The admission Minimum Data Set (MDS) assessment dated 11/23/18 assessed the resident as alert and oriented with periods of confusion. She received extensive to total assistance from one to two staff members for ADL's and had impairment on one side of her body. She was assessed with an indwelling catheter and was incontinent of bowel.

Review of the resident's active care plan dated 12/2/18 revealed she was care planned with an indwelling urinary catheter due to urinary retention.

A review of the physician orders revealed an order dated 12/12/18 to discontinue the urinary catheter.

A review of a skilled nursing note dated 12/13/18

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revealed the urinary catheter was discontinued.

During an interview with the Unit Manager #2 on 1/25/19 at 9:00am she stated that the unit managers and nurses update and revise the care plans as needed and was unsure why the urinary catheter was not resolved after it was discontinued.

On 1/25/19 at 6:10pm an interview was completed with the Administrator and Director of Nursing. They stated it was their expectation for the care plan to be an accurate representation of the resident.

3. Resident #48 was admitted to the facility on 11/28/17 with diagnoses that included altered mental status, anxiety, and insomnia.

A review of Resident #48' s December 2017 physician ' s orders indicated a wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) was initiated on 11/30/17 due to poor safety awareness.

The admission Minimum Data Set (MDS) assessment dated 12/5/17 indicated Resident #48 ' s cognition was severely impaired. He was assessed with wandering behaviors daily.

Resident #48 ' s plan of care included the focus area of the risk for elopement related to his expressed desire to leave the facility and multiple attempts made by the resident to exit the facility. Resident #48 was noted to have removed his own wanderguard. This focus area was last revised on 12/18/17.

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An incident report dated 4/9/18 completed by Nurse #1 indicated Resident #48 had an unsupervised exit from the facility. He was found outside of the facility without supervision by Nursing Assistant (NA) #1 at approximately 8:00 PM.

An incident report dated 5/16/18 completed by Nurse #2 indicated Resident #48 had an unsupervised exit from the facility. He was found outside of the facility without supervision by a facility visitor at approximately 7:15 PM.

On 1/23/19 Resident #48 ' s active care plan was reviewed. The focus area of the care plan related to elopement had not been revised to indicate that Resident #48 had 2 actual unsupervised exits from the facility. This care plan read, in part, "[Resident #48] has made multiple attempts to exit facility".

An interview was conducted with Unit Manager (UM) #2 on 1/25/19 at 9:00 AM. She stated that the nurses and UMs were all expected to update the resident care plans as needed.

A phone interview was attempted with Nurse #1 on 1/24/19 at 11:50 AM and 1:17 PM. She was unable to be reached. Nurse #1 wrote the incident report (dated 4/9/18) and was assigned to Resident #48 at the time of his 4/9/18 unsupervised exit from the facility. Nurse #1 had not updated Resident #48 ' s care plan to indicate he had an unsupervised exit from the facility.

A phone interview was attempted with Nurse #2 on 1/24/19 at 1:16 PM. She was unable to be reached. Nurse #2 wrote the incident report

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related to Resident #48 ' s 5/16/18 unsupervised exit from the facility. Nurse #2 had not updated Resident #48 ' s care plan to indicate he had an unsupervised exit from the facility.

An interview was conducted with the Administrator on 1/25/19 at 6:10 PM. She stated that she expected care plans to be reviewed and revised with any significant changes. She indicated that Resident #48 ' s care plan related to elopement should have been revised to indicate that he had 2 unsupervised exits from the facility.

4. Resident #2 was admitted to the facility on 9/8/18 and most recently readmitted on 12/20/18 with diagnoses that included bipolar disorder.

A post admission care conference note indicated a meeting was conducted on 9/13/18 for Resident #2. There was no Nursing Assistant (NA) in attendance at the meeting.

The admission Minimum Data Set (MDS) assessment dated 9/18/18 indicated Resident #2 ' s cognition was intact.

A care plan meeting note indicated a conference was conducted on 9/19/18 for Resident #2. There was no NA in attendance at the meeting.

An interview was conducted with the Social Worker (SW) on 1/25/19 at 5:10 PM. She stated that the facility utilized care plan conferences to develop and review the care plans for all residents. She indicated she was the coordinator of these meetings. She reported that care plan conferences were held shortly after a resident ' s admission, quarterly, and as needed. She

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indicated that these conferences were supposed to be attended by all disciplines that were involved in the resident ' s care plan, including an NA that was familiar with the resident. The SW explained that it was essential for an NA to be present at the meeting because the NAs were normally the staff that were most familiar with the needs of the resident. The care plan documentation for Resident #2 that indicated an NA was not present at his 9/13/18 post admission care conference or his 9/19/18 care plan conference was reviewed with the SW. She confirmed there was no NA present at either meeting. The SW was unable to explain why an NA was not present at either meeting. She stated that she was unaware of any other method in place at the facility for an NA to participate in the development and review of care plans. She revealed that Resident #2 had a variety of care needs that would have benefited from an NAs input in the development of his care plan such as physical behaviors, rejection of care, the use of psychotropic medications, and the need for Activities of Daily Living assistance.

An interview was conducted with the Administrator on 1/25/19 at 6:10 PM. She stated she began working at the facility within the past month and she was still learning the normal processes of the facility. She indicated that she expected an NA to be incorporated into the care planning process.

5. Resident #23 was admitted to the facility on 10/26/18 with diagnoses that included bipolar disorder.

A post admission care conference note indicated

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a meeting was conducted on 10/29/18 for Resident #23. There was no Nursing Assistant (NA) in attendance at the meeting.

The admission Minimum Data Set (MDS) assessment dated 11/2/18 indicated Resident #23 ' s cognition was intact.

Record review on 1/25/19 indicated no additional care conferences had been conducted for Resident #23 after the 10/29/18 post admission care conference.

An interview was conducted with the Social Worker (SW) on 1/25/19 at 5:10 PM. She stated that the facility utilized care plan conferences to develop and review the care plans for all residents. She indicated she was the coordinator of these meetings. She reported that care plan conferences were held shortly after a resident ' s admission, quarterly, and as needed. She indicated that these conferences were supposed to be attended by all disciplines that were involved in the resident ' s care plan, including an NA that was familiar with the resident. The SW explained that it was essential for an NA to be present at the meeting because the NAs were normally the staff that were most familiar with the needs of the resident. The care plan documentation for Resident #23 that indicated an NA was not present at her 10/29/18 post admission care conference was reviewed with the SW. She confirmed there was no NA present at the meeting. The SW was unable to explain why an NA was not present at the meeting. She stated that she was unaware of any other method in place at the facility for an NA to participate in the development and review of care plans. She revealed that Resident #23 had a variety of care

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F 657	Continued From page 97 needs that would have benefited from an NAs input in the development of her care plan such as pain, the use of psychotropic medications and anticoagulant medications, and the need for Activities of Daily Living assistance. An interview was conducted with the Administrator on 1/25/19 at 6:10 PM. She stated she began working at the facility within the past month and she was still learning the normal processes of the facility. She indicated that she expected an NA to be incorporated into the care planning process.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff, resident and physician interviews, the facility failed to daily weigh and assess the resident ' s edema and follow the physician order for 1 of 1 resident reviewed for edema (Resident #25). Findings included: Resident #25 was re-admitted to the facility on 2/16/18 with diagnoses of cirrhosis of the liver, chronic pain, panic disorder, and insomnia. A review of Resident #25 ' s care plan created on 6/10/16 and updated on 2/16/18 revealed a focus problem for congestive heart failure, a goal of decreased or absence of peripheral edema, and	F 658	F658: Professional Standards: Element One: F658: Professional Standards: Element One: • Resident # 25 is having weights obtained per order. Element Two: • All current residents with orders for daily weights were reviewed to ensure that weights have been obtained per order. There was only one resident with orders for Daily Weights, and the weights were entered accordingly. This audit was completed by Unit Managers.	2/27/19

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F 658	Continued From page 98 an intervention to evaluate for edema and to notify the physician of increased edema. A focus problem of daily diuretic and the resident tended to have bilateral lower leg edema, a goal of maintain a stable weight, and an intervention to weigh the resident per policy and alert the physician to any significant loss or gain. A review of Resident #25 ' s quarterly Minimum Data Set (MDS) dated 11/6/18 revealed the resident had an intact cognition with no behaviors. The resident was independent with all activities of daily living. Active diagnoses were anxiety, depression, congestive heart failure, and post-traumatic stress disorder (PTSD). The resident received scheduled and as needed pain medication. The resident also received antipsychotic, hypnotic, antidepressant, antianxiety, opioid medication, and diuretic for 7 days. A review of Resident #25 ' s physician order dated 11/8/18 was for daily weight and to notify the physician if weight increase was greater or equal to 3-pound weight gain in 1 day or greater than or equal to 5-pound weight gain in one week. History of lower extremity edema and weeping. A review of Resident #25 ' s nurses' notes from 12/1/18 to 1/23/19 did not reveal documentation assessment of the resident's lower extremity edema nor communication with the physician regarding the resident's weight gain and edema. The following was Resident #25 ' s flow chart documented weights: 11/29/2018 6:30 am 328.7 pounds	F 658	Element Three: • Education provided to nursing staff on obtaining weights per order. This education was completed by the Unit Managers on or before 2/20/19. Education included FT, PT, PRN and agency staff. Currently at 99% of current staff educated, the remaining staff members will not work until they receive the training. Element Four: • Unit Managers will monitor all residents with orders for daily and weekly weights 5 X per week for four weeks, then weekly thereafter, to ensure that weights are obtained per order. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee by the Administrator monthly with the QAPI Committee responsible for on-going compliance.	

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12/5/2018 6:07 am 332.2 pounds
12/7/2018 5:29 am 336.2 pounds
12/12/2018 6:34 am 325.4 pounds
12/17/2018 12:53 pm 330.6 pounds
12/17/2018 1:38 pm 332.2 pounds
12/21/2018 5:34 am 330.4 pounds
12/30/2018 6:51 am 319.2 pounds
1/3/2019 6:13 am 317.2 pounds
1/9/2019 3:03 pm 319.4 pounds
1/14/2019 12:52 pm 331.4 pounds
1/17/2019 2:24 pm 335.0 pounds

A review of the physician communication book from 6/1/18 to 1/9/19 revealed there was no documented communication to the physician regarding the resident ' s weight or edema.

Nurses note dated 1/11/19 increased lower extremity fluid weeping.

On 1/23/19 at 1:20 pm an observation was done of Resident #25 who had bilateral edema to his lower legs and his left leg had two open areas with dressings that were moist. The resident commented when the fluid leaks out of his legs his skin opens.

On 1/23/19 at 1:30 pm an interview was done of the assigned Nurse #7 who stated that she knew Resident #25 had an order for daily weights. When Nurse #7 reviewed the resident ' s weight record there were several gaps in documentation for January 2019. Nurse #7 stated that the weight record reviewed was the only place for weight documentation and if the date was left blank the weight was not done. She was not aware of the resident refusing to be weighed. Nurse #7 stated that the night shift was responsible to weigh the resident early in the

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F 658	Continued From page 100	F 658		

morning and document. Nurse #7 stated that night shift had not informed her when they were not able to weigh the resident. Nurse #7 agreed that she weighed the resident on day shift in the morning as documented. Nurse #7 was not aware that the resident ' s daily weight order included for the physician to be notified for weight gain. Nurse #7 added to the daily weight order to document the weight amount on the medication administration record (MAR) to trigger compliance. Nurse #7 was aware that the resident had acquired weeping fluid of his lower legs with a history of the same from edema and was taking a daily diuretic.

On 1/25/19 at 2:00 pm interview was conducted with Nurse #9 who stated she had worked at the facility for 12 years, usually on evening or nigh shift. Nurse #9 stated that she was very familiar with Resident #25 ' s lower extremity edema which had caused weeping fluid periodically. Nurse #9 expected day shift to weigh the resident if he was not ready to get out of bed at 6:00 am. Nurse #9 was not aware that the resident was not weighed each day but was aware there was a physician order to notify for weight gain.

On 1/25/19 at 5:10 pm an interview was conducted with Resident #25 ' s physician who stated that he expected staff to weigh the resident as ordered and inform him of weight gain or any changes for potential treatment. The physician stated that he had not been informed of the resident ' s weight gain or increased edema. The physician also commented that if the weight was missed and the last weight revealed weight gain now, he would expect to be notified no matter how many days were in between. The physician also stated that increased fluid weight gain and

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F 658	Continued From page 101 edema could cause fluid weeping.	F 658		
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 observations, staff interviews and record review, the facility failed to provide nail care to a resident identified as dependent on staff for her activities of daily living (ADLs). This was for 1 (Resident 70) of 2 residents reviewed the ADLs. The findings included: Resident #70 was admitted 12/21/15 with cumulative diagnoses of Alzheimer's Disease and Contractures. Review of Resident #70 quarterly Minimum Data Set (MDS) dated 12/27/18 indicated severe cognitive impairment and exhibited no behaviors. She was coded for total assistance with all her personal hygiene. Review of Resident #70's care plan last revised 1/22/19 indicated she was dependent on staff for her ADL care to include personal hygiene. During an observation on 1/23/19 at 10:25 AM, Resident #70 was sitting in a high back wheel chair in the main dining room. She was observed with long, jagged finger nails with brown debris under her nails. During an interview on 1/24/19 at 9:20 AM,	F 677	F677: ADL Care: Element One: • Resident # 70 was provided nail care on 1/30/19, by the Unit Manager. Element Two: • 100% audit of current residents was completed by the Unit Manager, on 2/8/19, to ensure that proper nail care was provided. Any resident with nails that required cleaning or trimming was completed during the audit. Element Three: • Education was provided for nursing staff (licensed and unlicensed staff) on providing nail care routinely, this education also addressed that nail care should be completed during showers and as needed. Education completed by Unit Managers on or before 2/20/19. FT,PT, PRN and agency staff were included in education. Currently at 99% of staff educated, remaining staff members shall not work until they receive the training. Element Four:	2/27/19

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F 677	Continued From page 102 Nursing Assistant (NA) #7 and NA #9 both stated Resident #70 was dependent on staff for all ADLs. During a wound care observation on 1/24/19 at 2:10 PM with Nurse #12, Resident #70's finger nails were noted to be long, jagged with brown debris under her nails. Nurse #12 stated the aides provided nail care as needed for residents who were not diabetic. Nurse #12 confirmed Resident #70 was not diagnosed with Diabetes, but she did not notice the appearance of Resident #70's finger nails during the wound care observation. During an interview on 1/24/19 at 3:25 PM, NA #15 stated she was assigned Resident #70 for second shift. NA #15 stated Resident #70 was dependent on staff for all her ADLs. NA #15 stated Resident #70 was resistant to care on occasion, but re-approach was usually successful. NA #15 stated the aides were responsible for nail care for residents without a diagnosis of Diabetes. She stated she normally provided nail care whenever she noticed long or dirty nails for her non-diabetic residents. NA #15 stated she did not think Resident #70 had a diagnosis of Diabetes. During an observation on 1/25/19 at 9:17 AM, Resident #70 was lying in bed. Her finger nails were observed long, jagged with brown debris under her nails. During an interview on 1/25/19 at 4:30 PM, NA #16 stated Resident #70 was combative with her ADLs at times. NA #7 stated Resident #70 only receives bed baths at the request of her family. She stated Resident #70 was known to scratch	F 677	• Unit Managers will complete weekly audits of 10 random residents nail care for four weeks and then randomly thereafter. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly by Director of Nursing with the QAPI Committee responsible for on-going compliance.	

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F 677	Continued From page 103 and dig in her sacral wound causing it to bleed. NA #7 stated the brown debris was likely old blood. She stated she would provide Resident #70 nail care immediately. During an interview on 1/25/19 at 5:50 PM, the Administrator and Director of Nursing (DON) stated it was their expectation that Resident #70 receive nail care as needed especially since she was scratching her wound causing it to bleed.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(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 observations, resident and staff interviews and record review, the facility failed to clarify a pressure ulcer treatment for a newly admitted resident (Resident #69) and failed to ensure a prescribed alternating air mattress was functioning properly for 1 (Resident #69) of 3 residents reviewed for pressure ulcers. The findings included:	F 686	F686: Pressure Ulcers: Element One: • Resident # 69 had treatment order clarified on and mattress replaced on 2/8/19. Element Two: • 100% audit of all current residents with wounds was completed by the	2/27/19

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F 686	Continued From page 104 Resident #69 was admitted 12/28/18 with cumulative diagnoses of Altered Mental Status, Malnutrition, Bacteremia (bacteria in the blood stream), pressure ulcer, Depression and Post Traumatic Stress Disorder. Review of Resident #69's hospital discharge orders dated 12/28/18 read he was to have a Mepilex dressing (foam, absorbent dressing) to his sacral wound. There were no specifications as to the frequency the sacral wound dressing was to be changed. Review of a Skin Check electronic form dated 12/28/18 indicated Resident #69 was admitted with an open area to his sacrum identified a pressure with a pressure redistribution surface in place. There was no other documented description of his sacral wound. Review of a Skin Integrity Report completed on 12/28/18 by Unit Manager (UM) #1 read Resident #69 was admitted with a stage 3 pressure ulcer. The wound was described with 90% granulation (healthy tissue) with 10% slough (dead tissue) measuring 3 centimeters (cm) length by 1.5 cm width and 1.3 cm depth with a moderate amount of serosanguineous (yellowish drainage with a small amount of blood) drainage. The wound was absent of odor. The Skin Integrity Report did not indicate what if any treatment orders were in place. Review of Resident #69's admission orders dated 12/28/18 did not include any dressing change orders to his sacral wound but did include orders for intravenous antibiotics daily. Review of Resident #69's December 2018	F 686	Director of Nursing and Unit Managers to ensure that an appropriate treatment is in place. This audit was completed on 1/31/19, all orders in place accordingly. • 100% audit was completed on all current residents with an air mattress in place to ensure that they were functioning properly. This audit was completed on 2/15/19 by the unit managers, no discrepancies noted. Element Three: • Education was provided to the licensed nurses by the Director of Nursing and Unit Managers regarding obtaining treatment orders for all new admits with wounds and all new wounds timely. Education also included monitoring of air mattresses to ensure they are functioning properly. This education was completed on or before 2/20/19. FT/PT/PRN and agency staff were included in training. Currently 99% of staff have received education, remaining staff members will not work until they complete the training. Element Four: • Unit Managers will audit all residents with wound weekly x 4 weeks and then randomly thereafter to ensure that appropriate treatments are in place. • Air Mattress checks will be added to the Treatment Records, and will be audited by the Unit Managers 5 X week for four weeks, then weekly thereafter to ensure that air mattresses are monitored for proper function. Results of these audits will be brought to the Quality Assurance and Performance	

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F 686	Continued From page 105 Treatment Administration Record did not include any documented evidence of any dressing changes to his sacral wound. Review of Resident #69's care plan dated 12/28/18 indicated he had actual skin breakdown. Interventions included wound care as ordered and a pressure redistribution surface to his bed. Review of a Skin Integrity Report completed on 1/3/19 by UM #1 read Resident #69 was admitted with a stage 3 pressure ulcer. The wound was described with 90% granulation with 10% slough measuring 2.8 cm length by cm width and 1.3 cm depth with a moderate amount of serosanguineous drainage. The wound was absent of odor. The Skin Integrity Report did not indicate what if any treatment orders were in place. Resident #69's admission Minimum Data Set (MDS) dated 1/4/19 indicated he was cognitively intact and exhibited no behaviors. He was coded with one stage 3 pressure ulcer present on admission and coded for the presence of a pressure reducing mattress. Review of Resident #69's electronic Physician Orders indicated an order dated 1/6/19 which read his stage 3 sacral wound was to be cleaned with Normal Saline, the area patted dry and packed with Calcium Alginate Rope (antimicrobial wound packing designed to be absorbent) and then covered with a dry dressing daily. Review Resident #69's January 2019 TAR did not include any treatment to his sacral wound until 1/7/19 and which time, he received daily treatment as ordered on 1/6/19.	F 686	Improvement Committee monthly by the Director of Nursing, with the QAPI Committee responsible for on-going compliance.	

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Review of a Skin Integrity Report completed on 1/9/19 by UM #1 read Resident #69 was admitted with a stage 3 pressure ulcer. The wound was described with 90% granulation with 10% slough measuring 2.5 cm length by cm width and 1.3 cm depth with a moderate amount of serosanguineous drainage. The wound was absent of odor. The Skin Integrity Report did not indicate what if any treatment orders were in place.

Review of a Skin Integrity Report completed on 1/16/19 by UM #1 read Resident #69 was admitted with a stage 3 pressure ulcer. The wound was described with 80% granulation with 20% slough measuring 2.5 cm length by cm width and 1.3 cm depth with a moderate amount of serosanguineous drainage. The wound was absent of odor. The Skin Integrity Report did not indicate what if any treatment orders were in place.

During an interview on 1/22/19 at 11:00 AM, Resident #69 stated he developed a wound to his sacrum while in the hospital for an extended stay. He stated the facility had been providing wound care since his admission, but his dressing often needed to be redressed due to excessive drainage. Resident #69's alternating air mattress pump was observed to be turned off. He stated he had an appointment later in the week to see the Wound Physician and the Orthopedic Physician.

During an observation on 1/23/19 at 10:3 AM, Resident #69 was lying in bed with his alternating air mattress pump turned off.

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During a wound care observation on 1/23/19 at 2:25 PM with Nurse #3, the old dressing was observed to have a tannish colored drainage. The wound had no odor and Resident #69 stated it was not painful. There were no observed concerns related to the wound care technique or infection control practices. Surveyor asked Nurse #3 if she noticed Resident #69's alternating air mattress pump was turned off. She stated she thought she heard the pump running when she was in Resident #69's room earlier today but she could not be certain. Nurse #3 stated there was no one person designated to ensure the alternating air mattresses were functioning properly. Nurse #3 turned Resident #69's alternating air mattress pump at this time. Resident #69 stated "I was wondering why this bed was so hard."

During an interview on 1/24/19 at 4:00 PM, UM #1 stated she did the weekly wound assessment on Resident #69. She stated she spoke with Nurse #3 who regularly works with Resident #69 and Nurse #3 stated she was putting a foam dressing to his sacrum but did not document it. UM #1 stated Resident #69 was admitted after the Christmas holiday and it was difficult getting wound care clarification orders from Physician #2. UM #1 stated it was her expectation that the admitting nurse obtain wound orders of wound order clarification when a resident was admitted with a pressure ulcer.

During an interview on 1/25/19 at 8:45 AM, Nurse #3 stated UM #1 completed all the new admission skin assessments and contacted the Physician for wound care orders or order clarification. Nurse #3 stated she was not allowed to stage pressure ulcers and would not know what to say or ask the

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Physician for regarding pressure ulcer care. She stated it was her responsibility to provide the treatments as ordered and report any worsening or signs of infection to UM #1. Nurse #3 stated when Resident #69 was admitted, she was not aware of any wound care orders, so she placed a foam dressing to his sacrum until UM #1 returned from taking time off over the Christmas holiday. She stated she did not report to anyone that there were no wound care orders for Resident #69's pressure ulcer. Nurse #3 stated she was not aware of admission orders for Mepilex to his sacrum, but she had to change the foam dressing every day because of all the excessive drainage from his sacral wound. She stated it was the responsibility of UM #1 to review the hospital records and ensure the facility had all Physician orders and clarification as needed.

During another interview on 1/25/19 at 8:50 AM, Resident #69 was lying in bed with his alternating air mattress pump functioning. Resident #69 confirmed that Nurse #3 was providing wound care to his sacrum since his admission but stated the dressing often would come off in the beginning but that at improved with the change in his treatment orders. Resident #69 stated he only saw the Orthopedic Physician yesterday and was not scheduled to see the Wound Physician until next week.

During an interview on 1/25/19 at 9:40 AM, the Corporate Nurse/Former Interim Director of Nursing stated UM #1 was on vacation the week after Christmas and returned to work on 1/1/19. She stated it was her expectation that when she returned to work on 1/1/19, UM #1 should have contacted Physician #2 for clarification of Resident #69's wound care orders.

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During another telephone interview on 1/25/19 at 3:00 PM, UM #1 stated she was on vacation a few days after Christmas. She stated she only found the Mepilex order in Resident #69's hospital discharge paperwork yesterday and that it was an oversight. UM #1 stated she was working on 1/1/19 but not in the capacity of UM so she did not think to contact Physician #2 for wound care orders for Resident #69. She stated it came to her attention on 1/6/19 that Resident #69 needed clarification for the treatment to his pressure ulcer. UM #1 contact Physician #2 on 1/6/19 and obtained the current treatment prescribed.

During a telephone interview on 1/25/19 at 3:45 PM, Physician #2 stated it was his expectation that staff contact him for any resident admitted with confusing or incomplete orders to obtain clarification immediately. He stated it was his expectation that Resident #69 always receive treatments as ordered and for his alternating air mattress be in operation.

During an interview on 1/25/19 at 5:50 PM, the Administrator and Director of Nursing (DON) stated it was their expectation that Nurse #3 would have contacted Physician #2 at the time she realized there was some question about Resident #69's wound care and not wait until UM #1 returned from her time off. The Administrator and DON further stated it was their expectation that Nurse #3 would have reported to UM #1 once she returned to work that there were still some questions about Resident #69's wound care and that UM #1 would have contacted Physician #2 prior to 1/6/19 for clarification of Resident #69's wound care orders. Both the

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F 686	Continued From page 110 Administrator and the DON stated they were uncertain who was responsible for ensuring Resident #69's alternating air mattress was functioning because they both recently started their positions at the facility. The DON stated it was her expectation that the assigned nurse ensured proper function of a specialty mattress prescribed for any resident.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to provide supervision or interventions to prevent accidents for 2 of 5 sampled residents (Residents #48, and #1) reviewed for accidents. The facility failed to supervise a cognitively impaired resident who displayed wandering behaviors from exiting the facility while unsupervised (Resident #48). Resident #48 was found unsupervised outside of the facility on 4/9/18 and 5/16/18. On both occasions, Resident #48 was self-propelling his wheelchair on the sidewalk adjacent to the facility parking lot. The resident was returned inside of the facility with no injuries following both of these unsupervised exits from the facility. The facility also failed to provide planned fall risk interventions for Resident #1.	F 689	F689: Accidents/ Hazards: Element One: " Resident # 48 currently has wander guard on his ankle, and has had no further Elopements. Resident # 1 had fall matt discontinued and resolved from care plan on 2/07/19 by the Director of Nursing. Element Two: " 100% audit of all current residents who are at risk for Elopement was completed by nursing leadership to ensure that interventions were in place as ordered and care planned. This audit was completed on 1/29/19 by the Unit Managers. No discrepancies noted. " 100% audit of all current residents with Fall Matts as a fall intervention was	2/27/19

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F 689	Continued From page 111 Immediate Jeopardy began on 4/9/18 when Resident #48 was found outside by Nursing Assistant #1 in his wheel chair on a side walk approximately 90 feet away from the facility' s front door without supervision at approximately 8:00 PM. Immediate Jeopardy was removed on 1/25/19 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. Example #2 related to Resident #1 was cited at a scope and severity of a "D" where a plan of correction is required. The findings included: 1. Resident #48 was admitted to the facility on 11/28/17 with diagnoses that included altered mental status, anxiety, and insomnia. A review of Resident #48 ' s December 2017 physician ' s orders indicated a wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) was initiated on 11/30/17 due to poor safety awareness. The wanderguard was to be checked for function and placement every shift. A nursing note dated 1/11/18 at 5:41 AM indicated Resident #48 ' s wanderguard was not on his ankle. Resident #48 ' s room was searched but	F 689	completed to ensure that they were in place as indicated. This why completed by the Unit Managers and regional nurse on 2/21/19. Discrepancies corrected during audit. Element Three: " Education was provided to all staff regarding Elopement Prevention, by the Unit Managers and Director of Nursing on or before 2/20/19. FT/PT/PRN and Agency staff were included. Currently at 99% of staff educated, remaining staff shall not work until they receive the training. " Education was provided for all licensed staff regarding following fall interventions, including Fall Matts. This education was completed by the Unit Managers on or before 2/20/19, and included FT/PT/PRN and agency staff. Currently at 99% of staff educated, remaining staff will not work until they receive training. Element Four: " Director of Nursing and Nursing Leadership will audit all residents at risk for Elopement 5 X per week (to include off shifts and weekends) for four weeks and randomly thereafter, to ensure that Elopement Risk interventions are in place as indicated. " Unit Managers will audit all residents with Fall Matts 5X week for four weeks and then weekly thereafter to ensure as indicated. " Results of these audits will be brought before the Quality Assurance and	

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F 689	Continued From page 112 was unable to be located. The resident was asked where his bracelet was, and he reported he was unable to recall what happened to it. Resident #48 was noted to have been hovering at exits and exhibiting exit seeking behaviors during the previous shift. The wanderguard was unable to be replaced as there were no additional wanderguards at the facility. The Maintenance Director was informed of the need for an additional wanderguard. The physician ' s order related to Resident #48 ' s wanderguard was changed on 2/1/18 to indicate the wanderguard was to be placed on his wheelchair rather than on his right lower extremity. A nursing note dated 2/20/18 indicated Resident #48 was exit seeking and wandering the facility hallway by self-propelling his wheelchair. A nursing note dated 2/21/18 indicated Resident #48 "insisted that he needed to leave and had somewhere to go .... [he] even tried to rally other residents telling them he had a truck and they needed to leave". A Lift-Transfer-Repositioning Evaluation dated 2/28/18 for Resident #48 indicated he was able to transfer independently using a cane and wheelchair. The quarterly MDS assessment dated 3/6/18 indicated Resident #48 ' s cognition was severely impaired. He was noted with no behaviors and no wandering. Resident #48 required the supervision of 1 with bed mobility, transfers, and walking in corridor. He was assessed as requiring supervision of 2 or more for locomotion	F 689	Performance Improvement Committee monthly by the Director of Nursing with the QAPI Committee responsible for on-going compliance.	

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on/off unit. Resident #48 required the limited assistance of 1 with walking in room. He had no functional impairment with range of motion and he utilized a wheelchair.

Review of Resident #48 ' s, care plan which was reviewed by staff on 3/18/18, contained the focus area of the risk for elopement related to Resident #48 ' s expressed desire to leave the facility and multiple attempts made by the resident to exit the facility. The interventions indicated a wanderguard was in place and was to be utilized and monitored per facility protocol.

a. An incident report dated 4/9/18 completed by Nurse #1 indicated Resident #48 was found outside the facility without supervision. Nursing Assistant (NA) #1 brought Resident #48 back into the facility from the facility ' s parking lot at 8:00 PM. His wanderguard was on his wheelchair and was functioning properly at the time of the elopement. The door alarm was also functioning at the time of the elopement. Resident #48 was noted as last seen at 7:30 PM self-propelling in his wheelchair in the hallway by the dining room located near the front entrance of the facility. Resident #48 was interviewed and was unable to recall what happened. This incident report indicated a physical evaluation of Resident #48 was not completed after the incident. The report also indicated an elopement evaluation and care plan update were not completed. The summary of the interview with Resident #48 ' s assigned nurse, Nurse #1, indicated she heard the alarm sounding and she started to walk up the hall when an NA (unnamed) told her Resident #48 went out the front door. The summary of the interview with Resident #48 ' s assigned NA

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(unnamed) indicated she was on her break at the time of incident. The root cause/conclusion was indicated to be Resident #48 ' s confusion and his wish to go home. The corrective actions indicated that all doors were checked for functioning and all wanderguards on residents were checked for functioning with no issues identified.

An observation was conducted with the Maintenance Director on 1/24/19 at 3:27 PM of the area where Resident #48 was found outside of the building unsupervised on 4/9/18 (as described by NA #1 during interview). This location was a cement sidewalk located directly next to the parking lot of the facility. This parking lot led to a well-traveled roadway with a speed limit of 45 miles per hour (mph). The Maintenance Director measured the distance from the facility ' s front door to Resident #48 ' s identified location and noted the distance as approximately 90 feet.

A review of the weather conditions per Weather Underground ' s website (www.wunderground.com) for Asheboro ' s weather history indicated the temperature on 4/9/18 at 7:55 PM was 52 degrees Fahrenheit (F) and there was no precipitation.

The following information was obtained from staff interviews and observations related to Resident #48 ' s unsupervised exit from the facility on 4/9/18 at approximately 8:00 PM.

- A phone interview was conducted with NA #1

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on 1/24/19 at 2:37 PM. She confirmed she was the first staff to respond to the wanderguard door alarm on 4/9/18 when Resident #48 had an unsupervised exit from the building at approximately 8:00 PM. She stated she was not assigned to Resident #48 and she was unsure which NA was assigned to him at the time of the 4/9/18 incident. She reported that she was completing care for one of her residents in their room when she first heard the front door alarm. She indicated that she was working on the 400 hall which led straight up to the front door of the facility. She revealed that the alarm was sounding for about 2 minutes when she exited her resident ' s room and proceeded up the 400-hall corridor to the front door of the facility. NA #1 stated she walked up to the front door to see why the alarm was going off and she saw that a visitor had exited the building and was in the parking lot and Resident #48 was self-propelling in his wheelchair on the sidewalk adjacent to the facility ' s parking lot. She confirmed no staff were present with Resident #48 outside of the building. She stated that she thought Resident #48 followed the visitor out of the front door of the facility. She explained that a numerical code was used to unlock the door and that facility staff and visitors were all aware of the code. She stated that after the visitor entered the code and exited the door that Resident #48 followed behind the visitor engaging the audible wanderguard alarm when he crossed the threshold of the front door. NA #1 stated she exited the building and pushed Resident #48 back into the building by wheelchair. She indicated he had no injuries. NA #1 was unable to recall what Resident #48 was wearing when he was found outside, and she was unable to recall when the door alarm ceased sounding. She reported the alarm was very loud

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and was easily heard from inside the resident rooms. She was unable to explain why she was the first staff to respond to it. NA #1 stated that Resident #48 was known to be an exit seeker and that he self-propelled his wheelchair throughout the facility all the time.

- A phone interview was attempted with Nurse #1 on 1/24/19 at 11:50 AM and 1:17 PM. She was unable to be reached. Nurse #1 was assigned to Resident #48 at the time of his 4/9/18 unsupervised exit from the facility.

- A phone interview was conducted with NA #2 on 1/25/18 at 8:20 AM. She stated that she was working on 4/9/18 at the time of Resident #48 ' s unsupervised exit from the facility. She was uncertain which NA was assigned to Resident #48 during the time of this incident, but she stated she had not thought it was her. She confirmed that she heard the front door alarm go off and that NA #1 was the first staff to respond to the alarm. She revealed that when any door alarms went off the staff were supposed to respond immediately. NA #2 was unable to explain why she had not responded to the front door alarm and why no other staff had responded to the alarm prior to NA #1 on 4/9/18 when Resident #48 exited the building unsupervised. NA #2 stated that Resident #48 was known to be an exit seeker and that he self-propelled his wheelchair throughout the facility all the time since admission through present.

- A phone interview was conducted with the facility ' s former Administrator on 1/24/19 at 3:55 PM. She stated that she was the Administrator at

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the time of Resident #48 ' s unsupervised exit from the facility on 4/9/18 at approximately 8:00 PM. The 4/9/18 incident report for Resident #48 was reviewed with the former Administrator. She reported that the root cause of the incident was staffs ' failure to respond immediately to the front door alarm which allowed Resident #48 to follow a visitor out of the facility and self-propel his wheelchair on the sidewalk adjacent to the parking lot of the facility. She indicated that after the incident she believed an inservice was conducted by the unit managers on the elopement procedure. The former Administrator stated that Resident #48 was known to be an exit seeker and that he had removed his wanderguard from his ankle on more than one occasion. She explained that one time he used a butter knife he had kept from one of his meals to remove it and another time he stretched it out until he was able to pull it off. She stated his wanderguard ' s placement was moved to his wheelchair to prevent him from removing it.

- An interview was conducted with the Corporate Nurse/former interim Director of Nursing (DON) on 1/24/19 at 2:45 PM. She indicated she was not working at the facility at the time of Resident #48 ' s unsupervised exit on 4/9/18. She stated that based on the inservice records, re-education on elopement procedures was provided to staff on 4/12/18 through 4/15/18. She revealed that the records showed 53 of the 62 staff who were employed at the facility at the time of the 4/9/18 elopement received the inservice. She confirmed all staff employed at the facility were not inserviced on the elopement procedure after Resident #48 ' s unsupervised exit on 4/9/18.

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b. An incident report dated 5/16/18 completed by Nurse #2 indicated Resident #48 was found outside the facility without supervision. A facility visitor notified Dietary Aide #1 and Dietary Aide #2 that Resident #48 was outside unsupervised at 7:15 PM. Dietary Aide #1 pushed Resident #48 back into the building by wheelchair. Resident #48 was interviewed, and he stated, "I ' m going home". The incident report indicated a physical evaluation was conducted with no identified concerns and the care plan was updated. The summary of the interview with Resident #48 ' s assigned nurse (unnamed) indicated an active fire drill was conducted that evening and residents were assisted to their rooms. Rounds were made during the fire drill and Resident #48 was observed attempting to exit his room and was assisted back to the room on multiple occasions. Dietary staff alerted nursing staff that Resident #48 was observed sitting in his wheelchair on the sidewalk adjacent to the parking lot of the facility without supervision. The summary of the interview with Resident ' s assigned NA (unnamed) provided the same information as his assigned nurse. The root cause/conclusion indicated a fire drill was conducted and the exit doors were unlocked and Resident #48 self-propelled out of the facility. The corrective actions indicated the care plan was updated.

An observation was conducted with the Maintenance Director on 1/24/19 at 3:27 PM of the area where Resident #48 was found outside of the building unsupervised on 5/16/18 (as described by Dietary Aide #1 during interview). This location was a cement sidewalk located

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directly next to the parking lot of the facility. This parking lot led to a well-traveled roadway with a speed limit of 45 miles per hour. The Maintenance Director measured the distance from the front door to Resident #48 ' s identified location and noted the distance as approximately 65 feet.

A review of the weather conditions per Weather Underground ' s website (www.wunderground.com) for Asheboro ' s weather history indicated the temperature on 5/16/18 at 7:00 PM was 70 degrees F and there was no precipitation.

The following information was obtained from staff interviews and observations related to Resident #48 ' s unsupervised exit from the facility on 5/16/18 at approximately 7:15 PM.

- An interview was conducted with Dietary Aide #1 on 1/24/19 at 1:31 PM. She confirmed she was working on 5/16/18 at the time of Resident #48 ' s unsupervised exit from the facility. She stated that they had a fire drill at the facility that evening but she was unable to recall a specific time. She stated that after the fire drill she and Dietary Aide #2 were in the kitchen when a facility visitor knocked on the kitchen door and informed them that a resident was outside of the building. Dietary Aide #1 indicated she went into the dining room to look out the window and she saw Resident #48 self-propelling in his wheelchair on the sidewalk adjacent to the facility ' s parking lot. She reported that there was no staff outside with Resident #48. She stated that she went outside

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and pushed Resident #48 back into the building by wheelchair. She reported that Dietary Aide #2 went to get nursing staff to let them know Resident #48 was found outside unsupervised by a facility visitor. She stated she was unable to recall what Resident #48 was wearing at the time of the incident. Dietary Aide #1 was asked how Resident #48 got out of the building and she indicated that he must have gotten out during the fire drill when the doors to the facility were unlocked. She revealed that she had not known then and still had not known now who was responsible for monitoring the exit doors during a fire drill.

- A phone interview was conducted with Dietary Aide #2 on 1/24/19 at 4:04 PM. She confirmed she was working on 5/16/18 at the time of Resident #48 ' s unsupervised exit from the facility. She stated that there was a fire drill at some point that evening and after the fire drill a visitor came to the kitchen door and told her and Dietary Aide #1 that a resident was outside without supervision. She reported that Dietary Aide #1 went to get Resident #48 and she went let nursing staff know he was found outside unsupervised by a facility visitor. Dietary Aide #2 was asked how Resident #48 got out of the building and she indicated that he must have gotten out during the fire drill when the doors to the facility were unlocked. She revealed that she had not known then and still had not known now who was responsible for monitoring the exit doors during a fire drill.

- A phone interview was attempted with Nurse #2 on 1/24/19 at 1:16 PM. She was unable to be reached. Nurse #2 wrote the incident report related to Resident #48 ' s 5/16/18 unsupervised

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exit from the facility.

- A phone interview was conducted with NA #2 on 1/25/18 at 8:20 AM. She stated that she was working on 5/16/18 at the time of Resident #48 ' s unsupervised exit from the facility. She was uncertain which NA was assigned to Resident #48 during the time of this incident, but she stated she had not thought it was her. She confirmed that there was a fire drill that evening and that during fire drills the exit doors were unlocked and the wanderguard system was disengaged. She stated that Resident #48 must have gotten out when doors were unlocked and since the wanderguard system was disengaged the alarm had not gone off when he went out the door. She was asked who was supposed to monitor the exit doors during a fire drill and she stated that she thought it was dietary staffs ' responsibility.

- An interview was conducted with the Maintenance Director on 1/24/19 at 12:04 PM. He stated he had worked at the facility for over two years. The 5/16/18 incident report related to Resident #48 ' s unsupervised exit during a fire drill was reviewed with the Maintenance Director. He stated that during a fire drill all exit doors, 5 in total, were unlocked and the wanderguard system was disengaged. He indicated that staff were responsible for monitoring the exit doors throughout this time as a resident was able to leave the facility without an alarm sounding. The Maintenance Director was asked if staff education on the fire drill was provided after the 5/16/18 unsupervised exit for Resident #48. He indicated he was unable to recall when the last fire drill procedure inservice was conducted.

- A phone interview was conducted with the

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former Administrator on 1/24/19 at 3:55 PM. She stated that she was the Administrator at the time of Resident #48 ' s unsupervised exit from the facility on 5/16/18 at approximately 8:00 PM. The 5/16/18 incident report for Resident #48 was reviewed with the former Administrator. She revealed that an investigation into the incident had not been conducted because she knew Resident #48 exited the building during the fire drill when the wanderguard system was disengaged. The former Administrator additionally revealed that the root cause of the incident was staffs ' failure to monitor the exit doors during a fire drill. She indicated that after the incident she believed an inservice was conducted on the fire drill procedures. She was unable to recall who was responsible for providing this inservice and was unable to recall if all facility staff had received the inservice.

- An interview was conducted with the Corporate Nurse/former interim DON on 1/24/19 at 2:45 PM. She indicated she was not working at the facility at the time of Resident #48 ' s unsupervised exit on 5/16/18. She stated that based on the inservice records, there was no evidence staff education was provided related to the fire drill procedure after Resident #48 ' s unsupervised exit on 5/16/18.

An elopement evaluation was completed for Resident #48 on 5/17/18. Resident #48 was noted as an elopement risk related, in part, to his ability to self-propel wheelchair, history of actual elopement, history of wandering that placed him at significant risk of getting to a dangerous place, his expressed desire to leave, and exit seeking behaviors of hovering near exits and

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restlessness/agitation.

On 5/17/18 Resident #48 ' s care plan related to the risk for elopement was updated with the intervention of monitoring the nature and circumstances of attempted elopement and adjust care delivery appropriately.

An observation was conducted of Resident #48 on 1/22/19 at 10:05 AM. He was self-propelling his wheelchair in the hallway of his unit of the facility. His wanderguard was located on his wheelchair.

An observation was conducted of Resident #48 on 1/23/19 at 2:00 PM. He was self-propelling his wheelchair in the hallway of his unit of the facility. His wanderguard was located his wheelchair.

A phone interview as conducted with the Product Sales Manager for the manufacturer of the facility ' s wanderguards on 1/24/19 at 5:07 PM. He indicated that their wanderguard transmitter was not recommended to be installed or strapped onto any equipment. He stated that this would apply to wheelchairs. He reported that the transmitter was to be attached directly to the resident ' s ankle or wrist to ensure proper functioning.

An interview was conducted with NA #7 on 1/24/19 at 1:52 PM. She stated that she had worked at the facility for 8 years and was familiar with Resident #48. She reported that Resident #48 was known to have exit seeking behaviors from his admission through present. She stated that he self-propelled his wheelchair all over the building. NA #7 reported that Resident #48 made statements of wanting to get out of the facility and

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that one day he was going to leave this place. She indicated that Resident #48 had a wanderguard on his wheelchair. NA #7 revealed she was unaware that Resident #48 had two unsupervised exits from the facility. She was asked who was responsible for responding to an exit door alarm and she stated that all staff were to respond to the alarm immediately whether or not they were assigned to the resident. She was then asked who was responsible for monitoring the exit doors during a fire drill and she stated that she was unsure who was assigned this responsibility but indicated her awareness that the exit doors needed to be monitored to prevent a resident from leaving the building.

An interview was conducted with Nurse #3 on 1/24/19 at 3:34 PM. She stated that she had worked at the facility for over a year and that she regularly worked with Resident #48. She reported that Resident #48 was known to have exit seeking behaviors from his admission through present. She stated that he self-propelled his wheelchair all over the building. She reported that Resident #48 had a wanderguard on his wheelchair because he kept removing the wanderguard when it was placed on his ankle. Nurse #3 revealed she was only aware of the 5/16/18 unsupervised exit for Resident #48. She stated she had not known he had two unsupervised exits. She was asked who was responsible for responding to an exit door alarm and she stated that all staff were to respond to the alarm immediately whether or not they were assigned to the resident. Nurse #3 was then asked who was responsible for monitoring the exit doors during a fire drill and she stated that she was unsure who was assigned this

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responsibility but indicated her awareness that the exit doors needed to be monitored to prevent a resident from leaving the building.

An interview was conducted with the current Administrator on 1/25/19 at 6:10 PM. She stated that she began working at the facility recently and she was not present for either of Resident #48 ' s unsupervised exits from the facility (4/9/18 and 5/16/18). The Administrator indicated she was aware that Resident #48 ' s wanderguard had been placed on his wheelchair. She revealed she was not aware this placement was against the manufacturer ' s instructions. She reported the wanderguard was moved to Resident #48 ' s ankle on 1/25/19 to comply with the manufacturer ' s recommendations. The Administrator indicated she expected residents known to be an elopement risk to be monitored closely to prevent an unsupervised exit. She additionally indicated she expected staff to respond immediately to a wanderguard alarm and for all exit doors to be monitored by a staff member during a fire drill and/or actual fire to prevent a resident from exiting the building without supervision.

The Administrator and DON were notified of the Immediate Jeopardy on 1/23/18 at 5:20 PM.

On 1/25/19 at 7:23 AM the facility provided the following credible allegation of Immediate Jeopardy removal:

- The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;

The resident was admitted to the facility on

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11/28/2017. Per the care plan initiated on admission and the Elopement Assessment dated 11/30/17, the resident was identified as elopement risk. Resident # 48 had a wander guard bracelet on his wheelchair, due to previous removal of wander guard bracelet from his ankle. Resident had previously been more independent with ambulation, however as evidenced by MDS completed shortly after this event on 4/19/18, resident did not walk in corridor, and required limited assistance of one person for locomotion on unit.

On 4/9/18, Resident # 48 wandered to the front of the facility at approximately 7:30 pm and was noted by a staff member NA (nurses ' aide) AC, to be near the front door following after another resident and a visitor. NA AC called Licensed Practical Nurse (LPN) HM to assist. Resident was found in parking lot of facility.

LPN HM, and NA AC assisted resident # 48 back inside the facility without incident or injury. There is no documented assessment of resident for this date. Physician was notified by LPN HM on 4/9/18 at 8:10 pm, and POA, Resident #48 ' s family member, was notified on 4/9/18 at 8:30 pm (as documented on Risk Event Summary Report) -All exit doors were checked and all wander guards were checked at the time of the incident and all doors and bands were found to be functioning, according to the Event Summary Report (Incident Report). Event Summary report does not indicate who completed this audit or when completed. Facility cannot locate documentation of follow up post this event. Education was completed for 53 staff members related to Elopement Protocol on 4/12/18 -4/15/18. Elopement Protocol Addresses

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response to door alarms. There was a total of 62 employees at the time of this event, including agency staff.

On 5/16/18 the facility had a fire drill conducted by the local fire department, at approximately 7:00 pm. The drill was conducted by the fire department personnel activating a pull alarm. Once the drill was completed, the alarm was silenced by the fire department personnel at an unknown time, (somewhere between 7:00 - 7:20 pm) however the fire department personnel failed to reset the system as is the normal process when fire drill is conducted by fire department, however it is the facility ' s ultimate responsibility to ensure the system is reset, this is normally completed by the Maintenance Director. The Maintenance Director reports that normally he is alerted in advance to the Fire Department ' s plan to conduct an onsite fire drill, but that on this occasion 5/16/18 it was a new Fire Department Personnel and he did not notify him in advance. The above mentioned delay in reset of the system, left the centers 5 exit doors unsecured. These doors are normally wanderguarded. Staff failed to monitor the 5 unsecured exit doors during this time. Protocol calls for all doors to be monitored during a fire drill, by staff on duty. At 7:01pm the Fire Department called the maintenance director to notify him that they were conducting a Fire Drill, at 7:04 pm the alarm company called the maintenance director to inform him of the alarm sounding. At 7:05 pm the charge nurse on duty (Unable to determine who this staff member was) called the maintenance director and informed him of drill and they did not know how to reset the alarms. Maintenance director drove into facility to reset alarm, arriving at approximately 7:30 pm at which time he reset

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the alarms. During this 30 minute time frame the doors were not being monitored. Staff on duty were not trained on how to reset the alarm -Staff had not previously been trained on monitoring the doors. This was an unscheduled drill completed by the local Fire Department as they routinely do in Randolph County.

During the time that the system was down and the doors were not secure, Resident # 48 was found by the dietary aide LC, she stated that a visitor came and knocked on the kitchen door and told her a resident was outside. Kitchen staff LC noted resident # 48 outside of the facility on the sidewalk near the front entrance - approximately 65 feet from the front entrance, seated in her wheel chair. Resident # 48 was safely returned by dietary staff member LC to the center without injury or incident. LPN AA assessed resident and documented vital signs on the Risk Management Event Summary (Incident Report). The Nurse Practitioner was notified of event on 5/17/18 at 7:55 a.m., by LPN AA. (Which is within 24 hours of event that had no injury. Resident sister was notified of event on 5/16/18 at 8:00 pm by LPN AA.

Since the event on 5/16/18, Resident # 48 has had no further incidents of exiting the facility unaccompanied.

Facility is unable to locate an investigation, staff education, or monitoring post this event. Facility has had several leadership positions (Administrators and Directors of Nursing) turn over since 5/16/18. Therefore, there is no evidence or documentation that the dietary aide LC was interviewed post this event.

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F 689	Continued From page 129 - The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Education was initiated at approximately 2:00 pm on 1/23/19 by the Nursing Leadership, (Director of Nursing, Supervisors, regional nurse and Administrator) on the process for ensuring that the Fire Alarm System is reset and doors secure after every Fire Drill. Education also included that in the event that the system cannot be reset immediately and/or the doors cannot be secured, the staff on duty at time of drill, as stated in policy, are to monitor the exits and complete a head count and account for the whereabouts of all residents, in particular the residents at risk for Elopement. Education is at 98% for all employees, any staff that have not received this training will not work until they have completed the education. Education was completed on Elopement procedure beginning on 4/12/18 and completed on 4/15/18. Total of 62 staff members employed at time of this event. 53 were educated post event. This education included agency staff. 100% audit was completed on 1/23/19 by the nursing leadership team (Supervisors, Direct of Nursing and regional nurse) of all current residents at risk for Elopement - 5 current residents at risk for Elopement. The audit included ensuring that they had secure bracelet in place, that the function and placement of bracelet is checked per protocol, and that Elopement Risk Book was up to date along with the care plans. No discrepancies noted in audit. All current at risk residents found to have a current Elopement Assessment on file. The facility staff completed a 100% head count of all current residents on 1/23/19 at 2:00 pm to ensure all residents	F 689		

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accounted for. This was completed by the nursing leadership team (nursing supervisors, Director of Nursing and Regional Nurse).

Elopement Assessments completed/updated for all current residents by the nursing leadership team (supervisors, Director of Nursing and regional nurse) this was initiated on 1/23/19 and will be completed on 1/24/19. No additional residents found to be at risk. Four of the 5 residents identified at risk have their wander guards on their ankles. Resident # 48 had his Wander guard on his wheel chair. Resident # 48 has had Wanderguard removed from wheel chair and place on his ankle, per manufacturer ' s recommendations (on 1/25/19)

- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;

Charge nurse on 100 hall on all three shifts, will assign staff members to be responsible for monitoring the doors in the event of a fire drill/fire alarm. Licensed nurses will be educated by the nursing leadership (supervisors, Director of Nursing and Regional Nurse) that it is the responsibility of charge nurse to assign staff members each shift on the staffing assignment sheets that they will be responsible to monitor doors in the event of a fire or fire drill. Staffing assignments are reviewed by all staff on duty at the beginning of each shift.

Administrator and Maintenance Director will conduct facility Fire Drills that will include review of securing of the doors and accounting for the

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whereabouts of all residents. These drills will be conducted weekly x 4 then monthly thereafter and will encompass all three shifts. First drill scheduled for Wednesday, January 30, 2019. The doors and wander guard systems will continue to be checked routinely (daily) by the Maintenance Director, and weekend managers.

The Interdisciplinary Team (Administrator, Director of Nursing, Maintenance Director) will conduct Elopement Drills weekly X 4 and then monthly thereafter, these drills will encompass all three shifts. Drill will include calling a Code Green and searching for a missing person following established protocol. The drills will include triggering the wander guard alarm to determine the appropriate response from the staff. The first drill will be held on Wednesday, January 30, 2019. All staff are responsible to respond to alarms soon as they are heard.

Results of these drills will be brought before the Quality Assurance and Performance Improvement Committee for review monthly by the Administrator and/or Maintenance Director. An ADHOC QAPI Committee meeting was held on 1/24/19 at 12:00 p.m. to review the above plan. Attended by Administrator, Director of Nursing, Regional Nurse, Nursing Supervisors, Maintenance Director, nurse ' s aide and Regional Nurse.

- The title of the person responsible for implementing the acceptable plan of correction.

Center Executive Director is responsible for the implementation of this plan.

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The credible allegation of Immediate Jeopardy removal was validated on 1/25/19 at 5:30 PM. Record review indicated there were 5 current residents identified as at risk for elopement. Observations of these 5 residents showed each had a wanderguard in place on their ankle or wrist as indicated by the manufacturer. Monitoring for function and placement of the wanderguard was present on the Treatment Administration Records, the Elopement Risk Book was updated, and each of the 5 residents had a care plan related to elopement risk in place. Elopement Assessments were completed/updated for 100% of the current facility residents on 1/23/19 and 1/24/19. Observations confirmed the exit doors and wanderguards were functioning properly. A review of inservice sign in sheets as well as staff interviews verified education was provided on 1/23/19 and 1/24/19 on the elopement procedure and the fire drill procedure.

2) Resident #1 was admitted to the facility on 4/27/16 with diagnoses that included dementia, altered mental status, diabetes mellitus and heart failure. Resident #1 was moderately cognitively impaired with periods of confusion, but was interviewable.

A record review revealed the following falls from near her bed:

A) On 9/10/18 at 4:24pm Resident #1 was found on the floor beside her bed facing the wheelchair (WC). She stated that she was standing from the WC. The WC brakes were locked but the resident was bare footed.

B) On 11/20/18 at 6:00pm Resident #1 was found sitting upright beside her bed and in front of the WC on the floor. She stated that she was leaning over to pick up a tissue by her feet and

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slipped out of the WC. It was noted the resident does not ask for assistance.

C) On 12/17/18 at 2:00pm, Resident #1 was found sitting on the floor. She stated that she was transferring to the bed from the WC. Staff reminded her to use the call light when assistance was needed.

D) On 12/28/18 at 11am Resident #1 was found on the floor next to her bed. She stated, "I did not want to sit on the bed and I wanted to do my nails, so I slid down the WC into the floor".

A review of the active care plan revealed a problem for risk for falls related to impaired mobility, impaired cognition and history of falls. Interventions included encourage non slipper socks when not wearing shoes, fall mat in place when resident in bed (initiated on 12/13/17), place resident's belongings and clothing within reach while resident is in bed, remind to use call light and ask for assistance, staff to try and anticipate needs of resident and roommate, utilize low bed, place call light within reach, maintain a clutter free environment in the resident's room and consistent furniture arrangement. Interventions updated on 6/20/18 included assure all lights are dimmed to resident's preference at the time of going to bed to prevent resident from self-transferring and on 7/11/18 check the resident frequently throughout shift when in bed as she frequently attempts to self-transfer.

The annual Minimum Data Set (MDS) assessment dated 1/5/19 indicated Resident #1's cognition was alert and oriented with periods of confusion. She required extensive to total dependence from one staff member for Activities of Daily Living (ADL's) except for supervision for eating. She was assessed as having two or more

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falls since the last assessment.

On 1/22/19 at 9:15am an interview was completed with Resident #1, who stated that she often forgot to ask the staff for assistance with transfers.

An interview occurred with Nurse #6 on 1/23/19 at 11:40am who stated that Resident #1 got up frequently unassisted either trying to get in the bed or assisting her roommate to the bathroom. She explained the staff constantly encouraged her to call for assistance and performed frequent checks. She added that the resident preferred to stay in her room except for meals.

On 1/23/19 at 11:50am Nurse Aide #11 (NA) stated that Resident #1 attempted to transfer self frequently and often tried to assist her roommate to the bathroom. She stated that staff redirected as needed and provided frequent checks as she preferred to stay in her room except for meals.

On 1/23/19 at 2:25pm an observation revealed Resident #1 lying in her bed with no fall mat present beside her bed.

The Corporate Nurse/Former Interim Director of Nursing was interviewed on 1/24/19 at 8:30am. She explained that all falls were reviewed in the interdisciplinary team morning meeting. She added that Resident #1 had poor safety awareness and continued to attempt unassisted transfers despite interventions felt to be appropriate that had been put into place. She was unable to state why the fall mat was not in the resident's room or if it should have been resolved on the care plan.

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F 689	Continued From page 135 An interview was completed with NA #11 on 1/24/19 at 2:20pm. She was unable to locate a fall mat in Resident #1's room and stated that she didn't know the resident was to have one. An interview was completed with Resident #1 on 1/24/19 at 2:30. She stated that when she stood her legs hurt. She was able to show how to use the call light for assistance from staff but stated that she often forgot and felt like she didn't need help. During an interview with the Unit Manager #2 on 1/25/19 at 9:00am she stated that the resident was noncompliant with unassisted transfers despite redirection and cues and would often try to assist her roommate. She confirmed that the fall mat was present on the care plan and stated that it was initiated on 12/13/17. She was unable to state why the fall mat was not in the resident's room or resolved on the care plan. On 1/25/19 at 6:10pm an interview was completed with the Administrator and Director of Nursing. They stated that it was their expectation for safety interventions to be in place according to the care plan.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(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-	F 692		2/27/19

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F 692	Continued From page 136 §483.25(g)(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; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(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 record review, observations, and staff and Physician interviews, the facility failed to monitor weight loss, prevent continued weight loss and evaluate existing interventions for weight loss for 1 of 5 residents reviewed for nutrition (Resident #18). Resident #18 experienced an unintended 15-pound (8.4 percent) weight loss during a four month period as a result of no interventions being implemented by the facility to prevent him from losing weight. Findings included: Resident #18 was admitted to the facility on 1/31/02 and diagnoses were traumatic brain injury and stroke. Review of Resident #18 ' s weight record revealed the following weights: May 2018: 206 pounds August 2018: 194 pounds September 2018: 178 pounds A review of Resident #18 ' s Dietary note dated	F 692	F692: Nutrition/Hydration: Element One: • Resident # 18 was seen and assessed by Registered Dietician on 2/13 with new interventions recommended and implemented. Recommendations that were implemented were weekly weights, and house cup icecream with lunch and dinner. Nurse Practioner also had Advanced Care Planning discussion with resident and his family. No further interventions desired. Element Two: • All current residents who have had weight loss in the last 30 days have been reviewed and assessed by the Registered Dietician for appropriate interventions, on 2/25/19 with implementation of new recommendations for all residents with weight loss. Element Three: • Education was provided to the Registered Dietician by the Regional	

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F 692	Continued From page 137 9/20/18 revealed the resident had experienced a significant weight loss, and a house supplement three times a day was recommended. Resident #18 had a physician order dated 9/23/18 for house supplement three times a day. A review of Resident #18 ' s care plan revealed a focus initiated on 9/23/18 that identified the resident as being at risk for nutrition/hydration alteration related to cognitive impairment and hemiplegia and significant weight loss. The goal was adequate intake to prevent significant weight change or skin breakdown, interventions were house supplement, 12 ounces of beer each day as requested, regular liberalized diet with extra chocolate milk, offer alternatives and snacks, and monitor intake and weight. A review of Resident #18 ' s physician progress note dated 11/2/18 revealed documentation that the resident was not evaluated for nor mention of weight loss. A review of Resident #18 ' s annual Minimum Data Set dated 11/5/18 revealed the resident had clear speech and usually understands and understood. The resident had severely impaired cognition. The resident required extensive assistance of 2 staff for bed mobility and of 1 staff for all other activities of daily living including eating. The resident ' s active diagnoses were hyperlipidemia, stroke, anxiety, depression, schizophrenia, impulse disorder, and non-Alzheimer's dementia. The resident received a therapeutic diet and did not indicate significant weight loss. The resident ' s weight was 163 pounds. The nutrition care assessment area was triggered and documented as addressed in the	F 692	Nurse and the Regional Dietary Manager on ensuring that all significant weight loss is addressed with new interventions. This education was completed on 2/20/19. • Education was provided by the Regional Nurse regarding ensuring weight loss is addressed timely. This education was completed on 2/21/19. Element Four: • Resident's weights will be obtained per order. Reweights will be obtained for a weight variance of 5 pounds per policy. Residents with weight loss or weight gain of 5% will be reviewed in the customer at risk meeting weekly by the interdisciplinary team, with appropriate registered dietician referrals as indicated made by the Unit Managers/Director of Nursing or charge nurses. • Audits of weights will be completed by the Unit Managers, weekly for four weeks, monthly for three months, monthly for three quarters Results of audits will be reviewed in monthly Quality Assurance meeting by the unit manager or director of nursing.	

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care plan. Care plan was not changed at this time.

Review of Resident #18 ' s November and December 2018 and January 2019 medication administration record (MAR) revealed documentation that the resident received and consumed his house supplement three times a day and rarely refused.

Review of Resident #18 ' s weight record revealed the following weights:
November 2018: 172 pounds
December 2018: weight not obtained
January 2019: 163 pounds

Review of the resident ' s weight record revealed the resident lost a total of 15 pounds (or 8.4 percent body weight of his body weight) from September 2018 to January 2019. Review of the resident ' s medical record revealed there were no dietician notes documented in the record between 09/20/18 to 1/11/19.

A review of Resident #18 ' s dietician notes dated 1/11/19 revealed the resident had significant weight loss of 16% over the past 6 months. No new interventions were recommended. The resident ' s needs were probably being met. The dietician will update the resident ' s care plan. The resident ' s diet was liberal with ice cream.

Resident #18 had a physician order for Loxapine 10 mg at bedtime dated 1/16/19 for schizoaffective disorder.

Further review of the medical record revealed no nutritional interventions were implemented from 9/11/18 to 1/23/19, to stabilize the resident ' s

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weight or to prevent further weight loss.

On 1/23/19 at 9:30 am an observation was done of Resident #18 who was traveling freely around the facility in his power scooter. The resident had garbled speech and was rarely understood. The resident was of thin stature in his body and his cheek bones were pronounced.

An observation was done on 1/24/19 at 12:00 pm of Resident #18's lunch in the main dining room which revealed the resident had consumed 1/4 of his beer and 25% of his meal with assistance and then wanted to smoke. Staff was observed to encourage the resident to eat. No other food or nutritional supplement options were offered or asked of preference to the resident by staff.

On 1/23/19 at 1:30 pm an interview was done of the assigned Nurse #7 who stated that she knew Resident #18 had an order for monthly weights. When Nurse #7 reviewed the resident ' s weight record there was no weight documented in June, July, and October of 2018. Nurse #7 stated that the weight record reviewed was the only place for weight documentation and if the date was left blank the weight was not done. She was not aware of the resident refusing to be weighed. Nurse #7 stated that the night shift was responsible to weigh the resident early in the morning and document. Nurse #7 stated that night shift had not informed her when they were not able to weigh the resident.

On 1/24/19 at 11:30 am an interview was conducted with the Dietician who stated that she was aware of Resident #18's weight loss over time and of 16.1% over the past 6 months 1/11/19. The resident ' s weights were not

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consistently done each month. The resident had house supplement three times a day added on 9/13/18. The resident has had a steady weight loss with a known decrease in intake over the past month. The resident was known to decline his food intake and asked for his "chocolate" house supplement. The medication Loxapine was restarted 1/16/19 in hope that would improve the resident's appetite and compliance with intake because the weight loss began after the Loxapine (anti-psychotic) was discontinued last summer. A recent intervention of his 1 daily beer was changed from dinner to lunch. The Dietitian stated that the facility has magic cup frozen desert supplement and protein supplement, but these were not considered. The resident's intake has been approximately 25-75%. The resident had been taking his supplement three times a day per nursing. The Dietician stated that the resident was at nutrition deficit risk and was discussed at the weekly meeting with nursing staff and management over the past 2 months. The Dietician stated that since the resident was taking his house supplement and continued to lose weight there should have been additional intervention. The resident is currently at his lowest weight since admission to the facility. The Dietician stated that the resident ' s physician was not informed. The Dietician stated that Loxapine was not an appetite stimulator, it was an anti-psychotic. The Dietician also commented that she should have addressed the continued weight loss with a second nutritional supplement and that the care plan goal was not met.

On 1/25/19 at 1:50 pm an interview was conducted with Nursing Assistant #19 (NA) who was familiar with Resident #18 and stated that the resident will eat 100% of food ordered in; he does

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F 692	Continued From page 141 not eat in-facility meals very well. Food ordered in was occasional. The resident was offered ice cream and chocolate milk. The resident received a supplement from the nurse. The resident does not like the meal-substitution sandwiches. Facility staff were aware that the resident's appetite had declined over the past three months. The NA stated the resident usually ate about 25% of his meal and required minimal assistance. On 1/25/19 at 4:00 pm an interview with the night shift nurse was attempted and was unsuccessful. On 1/25/19 at 4:55 pm an interview was conducted with the Director of Nursing who stated she expected the dietician to follow and address weight loss and to inform the physician of significant weight loss. On 1/25/19 at 5:20 pm an interview was conducted with Resident #18 ' s physician who stated he was not made aware of the resident ' s significant weight loss and that adding Loxapine would not be appropriate to improve appetite and weight gain. The physician felt the dietician should have addressed the resident ' s weight loss with new, appropriate weight gain interventions. The physician felt with additional weigh loss intervention the weight loss could have been avoided.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		2/27/19

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F 695	Continued From page 142 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed store a reusable nebulizer mask in accordance with professional standards of practice (Resident #28) and failed to follow the physician order for oxygen administration (Resident #75) for 2 of 2 residents reviewed for respiratory. The findings included: 1) Resident #28 was admitted to the facility on 12/28/16 with diagnoses that included: Chronic Obstructive Pulmonary Disease, Diabetes Mellitus and dysphagia (difficulty swallowing). A review of the physician orders revealed an order dated 11/2/18 for Albuterol Sulfate Nebulization Solution, inhale 1 vial every 12 hours prn (as needed) cough or dyspnea (difficulty breathing). The most recent comprehensive MDS (Minimum Data Set) coded as an annual assessment and dated 1/3/19 revealed the resident with severe cognitive impairments. She was coded as needing extensive to total assistance from one to two staff members for all Activities of Daily Living (ADL's). An observation on 1/22/19 at 10:35AM revealed a nebulizer mask in the windowsill, undated and not bagged.	F 695	F695: Respiratory: F695: Respiratory: Element One: • Resident # 28's nebulizer mask was placed in a bag on 2/4/19 by the Director of Nursing. And is currently stored appropriately. Resident # 75 oxygen was set for two liters as ordered by Physician, and is currently maintained at the ordered flow rate. Element Two: • 100% Audit was completed for all current residents with Nebulizer and Oxygen orders to ensure proper storage of supplies/equipment. This audit was completed on 1/29/19 by the unit managers all discrepancies were corrected upon finding. An audit of Oxygen flow rate set per order was completed on 2/21/19 by the Director of Nursing. No discrepancies noted. Element Three: • Education provided to all Nursing Staff regarding Respiratory Care and Treatment to include proper storage of Respiratory Equipment/Supplies and following physician's ordered Oxygen Flow Rates. Education completed on or before 2/20/19 by the Unit Managers. Education included FT/PT/PRN and agency staff. Currently at 99% of staff educated, those remaining will not work until they are trained.	

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F 695	Continued From page 143 On 1/23/19 at 8:25AM the nebulizer mask was observed lying in window sill of resident #28's room with no date and unbagged. An observation on 1/24/19 at 11:25AM revealed the nebulizer mask lying in resident's windowsill, undated and unbagged. On 1/24/19 at 11:45AM an interview was conducted with Nurse #7 who stated that the nebulizer mask should be stored in a bag after each use. On 1/24/19 at 12:00PM an interview was conducted with the Corporate Nurse/Former Interim Director of Nursing and current Director of Nursing, who were made aware that the nebulizer mask was sitting in Resident #28's windowsill with no date and unbagged. They stated it would be corrected at that time. An observation was made on 1/25/19 at 8:40AM revealing the nebulizer mask sitting in the resident's windowsill, undated and unbagged. In an interview on 1/25/19 at 6:10pm, the Director of Nursing stated it was her expectation for the nebulizer mask to be kept in the bag when not in use. 2. Resident #75 was admitted to the facility on 7/23/18 with diagnoses of congestive heart failure, chronic obstructive pulmonary disease (COPD), and respiratory failure. A review of Resident #75 ' s Medicare 60-day Minimum Data Set (MDS) dated 1/3/19 revealed the resident had adequate hearing, clear speech, was understood and understands. The resident had an intact cognition. The resident required	F 695	Element Four: • Unit Managers and Department Heads will monitor Nebulizer Equipment/Supplies storage daily (on varying shifts and weekends) for four weeks, then randomly thereafter. • Unit Managers will monitor Oxygen Flow Rate 5 X per week (on varying shifts and weekends) for four weeks to ensure appropriately set on ordered flow rate. • Results of these audits will be reviewed at the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing, with the QAPI Committee responsible for on-going compliance.	

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extensive assistance of 2 staff for bed mobility and all transfers including toileting, and of 1 staff for all personal care and dressing. The active diagnoses were congestive heart failure, hypertension, COPD, and muscle wasting. The resident required continuous oxygen.

A review of the physician order dated 11/2/18 revealed an order for oxygen 2 liters nasal cannula continuously and to check every shift.

A review of the physician order dated 11/5/18 revealed an order to check the oxygen saturation every shift and taper (change liter flow) to maintain oxygen saturation >90%.

A review of Resident #75 ' s January 2019 medication administration record revealed the resident ' s documented oxygen saturation was checked each shift and recorded as >95%. The oxygen flow rate was not documented.

A review of Resident #75 ' s record for the month of January 2019 revealed there was no documentation of the oxygen flow rate.

On 1/23/19 at 11:20 am an observation was done of the resident who was reclining in his bed wearing a nasal cannula. The resident was receiving oxygen via an oxygen concentrator and the flow rate was 2.5 liters/hour. The oxygen flow rate meter would require observation from horizontal level (bend over) and not from standing level to have the correct flow rate. Oxygen saturation for this morning was 96%.

On 1/24/19 at 9:20 am an observation was done of the resident who was reclining in his bed wearing a nasal cannula. The resident was

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receiving oxygen via an oxygen concentrator and the flow rate was 3 liters/hour. Oxygen saturation was 95% this morning.

On 1/24/19 at 2:40 pm an observation was done of the resident who was reclining in his bed wearing a nasal cannula. The resident was receiving oxygen via an oxygen concentrator and the flow rate was 3 liters/hour.

On 1/25/19 at 10:40 am an observation was done of the resident who was reclining in his bed wearing a nasal cannula. The resident was receiving oxygen via an oxygen concentrator and the flow rate was 3 liters/hour. Nurse #11 observed the oxygen flow rate meter from a horizontal level and commented that it was at 3 liters and was supposed to be at 2 liters. The resident ' s oxygen saturation was 96% this morning.

On 1/25/19 at 10:40 am an interview was conducted with Resident #75 who stated that he required continuous oxygen and the liter flow rate was 2 liters/hour. The resident also commented that his COPD was significant, and he required nebulizer treatment four times a day.

On 1/25/19 at 10:45 am an interview was conducted with Nurse #11 who stated that she was regularly assigned to Resident #75 on the day shift. Nurse #11 commented that the resident had a respiratory deficit and was administered continuous oxygen. Nurse #11 stated that the resident had a physician order for 2 liters of continuous oxygen. Nurse #11 stated that she did not check the oxygen flow rate this morning during medication administration and that she had not received in report from the prior nursing

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F 695	Continued From page 146 shift that the resident had a low pulse oximetry and required an increase in the oxygen flow rate. Nurse #11 stated that she was assigned to the resident this week and had not checked the flow rate (she assumed it was set at 2 liters as ordered). Nurse #11 stated that the resident had an order to increase the oxygen flow rate if his pulse oximetry went below 90%. The resident would not need additional oxygen if he was 90% or above. The resident was at 96% oxygen saturation this morning. The resident had COPD and cannot have increased oxygen unless necessary according to the physician order. On 1/25/19 at 4:00 pm an interview was attempted with the night shift nurse but was unsuccessful. On 1/25/19 at 4:55 pm an interview was conducted with the DON who stated she expected staff to follow the resident ' s physician orders and if there is a deviation from the order to notify the management and/or physician.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of	F 700		2/27/19

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F 700	Continued From page 147 bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to complete the bedrail assessment prior to use for 3 of 3 residents (Residents #36, #51 and #18). The findings included: 1) Resident #36 was admitted to the facility on 11/1/18 with a readmission date of 11/16/18. Her diagnoses included cerebral infarction (a stroke), vascular dementia, muscle weakness and hypertension. The admission Minimum Data Set (MDS) assessment dated 11/23/18, assessed the resident as alert and oriented with periods of confusion. She received extensive to total assistance from one to two staff members for Activities of Daily Living (ADL's) and had impairment to one side of her body. No falls were coded during the look back period and the bed rails were not coded as a restraint. Review of the resident's active care plan dated 12/2/18 revealed there was a problem area for the risk of falls, vision impairment and requiring assistance with ADL's, however bed rails were	F 700	F700: Bed Rails Element One: • Bed Rail Assessments were completed for residents # 36, #51 and # 18. These were completed on 2/12/19 by the Unit Manager. Element Two: • 100% of current residents were audited to ensure that their Bed Rail Assessments were accurate and complete. This audit was completed between 2/6 and 2/8/19 by the Unit Manager. Corrections made as indicated. Element Three: • Education was provided to the Licensed Nursing Staff by the Director of Nursing and Unit Managers on how to complete the Bed Rail Assessment accurately and completely. This education was completed on or before 2/20/19 by the Unit Managers. FT/PT/PRN and agency staff were included. Currently at 99% of staff educated. Remaining staff will not work until they receive training. Element Four: • Unit Managers and Director of	

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F 700	Continued From page 148 not mentioned as an intervention for enabling positioning. Review of the bed rail evaluation dated 11/21/18 revealed the staff member did not complete the evaluation in its entirety to include; checking for gaps between the head or foot board and mattress, other alternatives attempted prior to the use of bed rails, the benefit for the bed rails, observation of the resident using the bed rails and other risk factors. On 1/25/19 at 11:00am an interview was completed with Resident #36, who stated that she liked to hold onto the bed rails when the staff assisted her with personal care and was able to reach with her right hand to adjust self in the bed. An interview was conducted with NA #11 on 1/25/19 at 11:05am. She stated that the resident reached for the bed rails when personal care was provided and used her right hand to adjust self when in the bed. During an interview with the Corporate Nurse/Former Interim Director of Nursing on 1/25/19 at 12:00pm, she stated that the nurses or unit managers completed the bed rail assessments on admission and quarterly. She reviewed the bed rail evaluation dated 11/21/18 and confirmed that the evaluation was incomplete. An interview was attempted with the Unit Manager on 1/25/19 at 5:00pm but was unsuccessful. On 1/25/19 at 6:10pm an interview was completed with the Administrator and Director of	F 700	Nursing will audit all new admission and routine Bed Rail Assessments to ensure that they are accurate and complete. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing, with the QAPI Committee responsible for on-going compliance	

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F 700	Continued From page 149	F 700		

Nursing. They stated it was their expectation for the bed rail assessments to be completed accurately and completely prior to the use of bed rails.

2) Resident #51 was admitted to the facility on 10/19/18 with diagnoses that included: Schizoaffective disorder, Bipolar depression, history of stroke, anxiety disorder, diabetes mellitus, Hypertension and Osteoarthritis.

The most recent comprehensive MDS (Minimum Data Set) coded as a significant change assessment and dated 11/17/18, revealed the resident was alert and oriented, able to make needs known and understood others. She required limited to extensive assistance of one to two staff members for Activities of Daily Living (ADL's) except for supervision of meals. She was assessed as having an unsteady balance during transfers and was incontinent of bowel and bladder. No falls were coded during the look back period and the bed rails were not coded as a restraint.

A review of the active care plan dated 11/26/18 revealed a problem area of assistance required with ADL's and an intervention of bed rails used as an enabler.

Review of the undated and unsigned bed rail evaluation revealed the resident was to have quarter bed rails to aide in safe transfers. The staff did not complete the evaluation in its entirety to include; checking for gaps between the head or foot board and mattress and other alternatives attempted prior to the use of bed rails.

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On 1/22/19 at 9:15am an observation was made of Resident #51, who was alert and oriented, using the bed rail with her right hand to reposition self in the bed.

An interview was conducted with NA #11 on 1/25/19 at 11:05am. She stated that the resident could use the bed rails to reposition self when in bed and holds onto them when personal care is being rendered.

During an interview with the Corporate Nurse/Former Interim Director of Nursing on 1/25/19 at 12:00pm, she stated that the nurses or unit managers completed the bed rail assessments on admission and quarterly.

On 1/25/19 at 3:47pm the Corporate Nurse/Former Interim Director of Nursing reviewed the bed rail evaluation that was undated and not signed by a staff member, and confirmed the evaluation was incomplete.

An interview was attempted with the Unit Manager on 1/25/19 at 5:00pm but was unsuccessful.

On 1/25/19 at 6:10pm an interview was completed with the Administrator and Director of Nursing. They stated it was their expectation for the bed rail assessments to be completed accurately and completely prior to use.
3. Resident #18 was admitted to the facility on 1/31/02 with diagnoses of total brain injury, stroke, and hemiplegia.

A review of Resident #18 ' s physician order dated 10/3/17 revealed ¼ bed rails used as an enabler for turning and repositioning in bed.

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A review of Resident #18 ' s annual minimum data set (MDS) dated 11/5/18 revealed the resident had clear speech, usually understands and understood. The resident had a severely impaired cognition. The resident required extensive assistance of 2 staff for bed mobility, of 1 staff for all other activities of daily living. Restraint was answered "no."

A review of Resident #18 ' s care plan dated 11/18/16 and revised on 1/19/19 revealed a focus for required extensive assistance to total assistance with bed mobility. The goal was that needs will be anticipated and met, and intervention included the use of bed rails as an enabler (initiated on 12/24/17).

A review of Resident #18 ' s Bed Rail Evaluation form dated 12/5/18 revealed the form was partially completed. Risk factor evaluation and check for zones of entrapment were blank on the form. Nurse #16 completed the form.

A review of Resident #18 ' s Consent for Side Rail form dated 12/5/18 revealed the resident signed for consent.

On 1/23/19 at 9:30 am an observation was done of Resident #18 who was traveling freely around the facility in his power scooter. The resident had garbled speech and was rarely understood. An observation of the resident ' s bed revealed 1/3 size bilateral bed rails were in place. The mattress and bed rail were appropriately fitted, and no space was identified.

On 1/24/19 at 8:10 am an observation was done of Resident #18 who was in bed and assisted in

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F 700	Continued From page 152 transfer to his scooter. There were 1/3 size bilateral side rails in use. The resident ' s use of the bed rail as an enabler was not observed. No bruising was noted on the resident ' s arms. Due to hemiplegia the resident had use of one arm/hand. On 1/25/19 at 1:50 pm an interview was conducted with Nursing Assistant #19 (NA) who was familiar with Resident #18 and stated that the resident occasionally used the side rail when turning for personal care. The resident was able to hold on with his one hand on his body ' s usable side (the resident was not able to use one side of his body due to stroke). On 1/25/18 at 3:50 pm an interview was conducted with Nurse #16 who stated she completed Resident #18 ' s Bed Rail Evaluation form dated 12/5/18. Nurse #16 stated that not all areas were completed because that was what she thought was required by the facility and what all the other nurse staff were completing. Nurse #16 was not aware that a bed rail assessment was not complete if the Bed Rail Evaluation form had blank areas (not assessed). Alternatives to side rails were not attempted. On 1/25/19 at 4:55 pm an interview was conducted with the Director of Nursing who stated she expected the staff to complete the entire Bed Rail Evaluation form as required for safe use and decision making.	F 700		
F 742 SS=G	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure	F 742		2/27/19

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F 742	Continued From page 153 that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff, resident, psychiatric and facility nurse practitioners, and physician interviews, the facility failed to provide timely, necessary psychiatric services (Residents #16 and #2) and failed to provide a psychiatric evaluation (Resident #69) for 3 of 5 residents reviewed for unnecessary medication. Findings included: 1. Resident #69 was admitted 12/28/18 with cumulative diagnoses of Altered Mental Status, Depression and Post Traumatic Stress Disorder (PTSD). Review of Resident #69's admission orders dated 12/28/18 indicated he was prescribed Remeron (antidepressant) every day for depression. Resident #69's admission Minimum Data Set (MDS) dated 1/4/19 indicated he was cognitively intact, no mood disturbance and exhibited no behaviors. He was coded for supervision with eating. He coded as having received 6 doses of an antidepressant during the look back period. The Care Area Assessment (CAA) was triggered for psychotropic medications. The CAA indicated	F 742	F742: Mental/Psychological Concerns: Element One: " Resident # 16, #2 and # 69 have all been seen and evaluated by Mental Health Professionals. These residents were seen by Mental Health Professionals between 2/18 and 2/25/19. Element Two: " 100% audit of all current residents with Mental Illness/Psych Diagnosis, and behaviors was completed to ensure appropriate referrals and consultations with Mental Health Professionals was completed as indicated. This audit was completed by the Unit Managers on or before 2/20/19 with appropriate referrals made as indicated. Element Three: " Education was provided to the Social Service Director and Nursing Leadership by the Regional Nurse regarding the regulation for ensuring timely, necessary psychiatric services for residents with Psychiatric Diagnosis, Mental Illness and behaviors. Completed on 2/22/19.	

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F 742	Continued From page 154 Resident #69 would be care planned for psychotropic medications related to his Depression. Review of Resident #69's care plan dated 1/7/19 indicated he was at risk for sadness/depression due to his diagnosis of Depression. In an interview on 1/22/19 at 11:00 AM, Resident #69 stated he was diagnosed with Depression and PTSD and had a history of psychological services with medication interventions. Resident #69 started waving his arms, became tearful and stated his children had not come to see his since his admission and that made him sad. He stated he did not understand why his kids did not care about him anymore. Resident #69 went on the state he experienced "shell shock" after returning from Vietnam and it affected his first marriage that resulted in a divorce. He stated his second wife died a year ago. Review of Resident #69's nursing notes from 12/28/18 to 1/23/19 read a nursing note dated 12/30/18 at 9:04 PM, Resident #69 was exhibited an incident of "jerking motions with arms" requiring staff to assist him with eating on several occasions, multiple occasions of Resident #69 yelling out for staff and multiple request for snacks. During an interview on 1/23/19 at 4:45 PM, the Corporate Nurse/Former Interim Director of Nursing (DON) stated the Psychiatric Nurse Practitioner(PNP) was at the facility 2-3 times weekly. She stated if Resident #69 was experiencing any mood or behavior concerns, it was her expectation that he received a referral for a Psychiatric evaluation.	F 742	Element Four: " Director of Nursing and Social Service Director will review all residents with behaviors and new admission residents with psychiatric diagnosis/mental illness weekly to ensure that appropriate, timely psychiatric referrals and consults are obtained. Results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee monthly by the Social Service Director and/or Director of Nursing, with the QAPI Committee responsible for on-going compliance.	

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During an interview on 1/24/19 at 10:35 AM, the Social Worker (SW) stated she completed the cognition, mood and behaviors section on Resident #69's admission MDS dated 1/4/19 and she did not note and concerns in those areas. The SW stated that staff had not reported any cognition, mood or behaviors concerns and she did not read his nursing notes.

During an interview on 1/24/19 at 11:50 AM, the PNP stated she was asked to evaluate Resident #69 earlier this morning and that he was tearful during the evaluation and he stated he felt unloved. The PNP stated she changed his antidepressant and added a medication for insomnia and planned to continue to see Resident #69.

During an interview on 1/24/19 at 3:30 PM, Nursing Assistant (NA) #10 stated Resident #69 was very inpatient and had stated he felt unloved but he never cried in front of her. She stated she did not report how Resident #69 felt to anyone.

During an interview on 1/24/19 at 3:35 PM, Nurse #14 stated Resident #69 was "very needy and inpatient" with frequent episodes of yelling out for staff to come and fed him or bring him a snack. She stated Resident #69 can feed himself. She stated she did not report how he was feeling to anyone but documented any behaviors in his nursing notes.

During an interview on 1/25/19 at 8:45 AM, Nurse #3 stated she had never seen Resident #69 crying, but he had expressed feelings of being upset that his kids had not come to see him and that nobody cared about him. She stated she did

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not report how he was feeling to anyone but documented the behaviors of Resident #3 yelling rather than using his call bell and him saying he could not feed himself insisting that staff feed him. She stated she was not aware of any reason Resident #69 could not feed himself. She stated it seemed "unusual" for him to request to be fed.

During a telephone interview on 1/25/19 at 3:45 PM, Physician #2 stated he was not aware of the mood and behaviors issues exhibited by Resident #69 and he expected Resident #69 receive a Psychiatric evaluation if he was experiencing any mood or behaviors concerns. He stated Resident #69 was a "very sick man" and recently was discharged from the hospital after a very prolonged stay.

During an interview on 1/25/19 at 5:50 PM, the Administrator stated it was her expectation that the staff would have identified and notified Physician #2 about his behaviors, expressions of feeling unloved and that nobody cared for a possible Psychiatric evaluation.

2. Resident #2 was admitted to the facility on 9/8/18 and most recently readmitted on 12/20/18 with diagnoses that included bipolar disorder and dementia.

The comprehensive care plan for Resident #2 was initiated on 9/12/18 by the Social Worker (SW) and included, in part, the focus area of a Preadmission Screening and Resident Review (PASARR) level 2 related to his diagnosis of bipolar disorder. The intervention was for a referral to the PASARR authority for evaluation/reevaluation as needed. This

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A psychotherapy note dated 9/14/18 indicated an initial visit was made with Resident #2. This note indicated that psychotherapy was to be continued with Resident #2 as needed.

Resident #2' s care plan was updated on 9/16/18 with the initiation of a focus area for risk of complications related to the use of psychotropic medications. The interventions included, in part, monitor for side effects.

The admission Minimum Data Set (MDS) assessment dated 9/18/18 indicated Resident #2 had a PASARR level 2 related to serious mental illness. His cognition was assessed as intact and he had no reported issues with his mood. Resident #2 had verbal behaviors and rejection of care on 1 to 3 days during the MDS look back period. He received antipsychotic medication and antidepressant medication on 7 of 7 days.

Resident #2 ' s care plan was updated on 9/19/18 with the addition of a focus area for the potential for physical behaviors related to ineffective coping. The interventions included, in part, monitor the nature and circumstances of the physical behaviors.

Resident #2 ' s care plan was updated on 9/27/18 by the SW with the initiation of the focus area for exhibiting/or at risk for distressed/fluctuating mood symptoms related to anxiety/fear. The interventions included, in part, monitor for signs/symptoms of worsening anxiety/fear and monitor for signs and symptoms of worsening anger/agitation.

A Nurse Practitioner note dated 10/3/18 indicated

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Resident #2 reported feeling anxious.

A physician ' s order for Resident #2 dated 10/12/18 indicated a referral for psychotherapy related to anxiety. This order was handwritten by the physician on a hard copy physician ' s order form.

An NP note dated 10/26/18 indicated Resident #2 reported feeling anxious. The NP indicated Resident #2 was referred for psychotherapy.

An NP note dated 11/21/18 indicated Resident #2 again reported feeling anxious. The NP note indicated she was going to refer Resident #2 for an evaluation with the Psychiatric Nurse Practitioner (PNP).

A physician ' s order for Resident #2 dated 11/21/18 indicated a referral to the PNP related to anxiety. This order was located in two locations: (1) hard copy physician ' s order form that was handwritten by the physician and (2) an electronic order entered by Nurse #13.

A review of the medical record revealed Resident #2 was not seen by the PNP for an initial psychiatric evaluation after the 11/21/18 physician ' s order until 12/17/18 (26 days later) and he was not seen for psychotherapy after the 10/12/18 physician ' s order until 1/9/19 (79 days later).

An interview was conducted with the SW on 1/25/19 at 3:42 PM. The SW indicated she was familiar with Resident #2 and was aware he had a level 2 PASRR, was on psychotropic medications, exhibited behaviors, distressed mood, anxiety, and fear. She was asked what her

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responsibilities were for ensuring a resident with the previously mentioned mental health and behavioral issues received appropriate psychiatric services. The SW stated that she was not involved with the referral process for psychiatric services. She explained that she thought the nurses on the halls placed any psychiatric referrals in a hard copy book located at the nurse ' s station. She was asked if she had any knowledge of what psychiatric services Resident #2 had received. She reported that Resident #2 had a psychotherapy visit shortly after his admission and she thought he had seen the PNP as well. She was unable to explain why Resident #2 had not been seen for psychotherapy after the initial visit (9/14/18) until 1/9/19. She was additionally unable to explain why Resident #2 ' s initial psychiatric evaluation with the PNP (12/17/18) was conducted over 3 months after his admission (9/8/18).

An interview was conducted with Nurse #13 on 1/25/19 at 3:45 PM. She stated that the hall nurses placed referrals for psychiatric services in a hard copy book. She indicated this was the only way for the psychiatric provider to know what residents they were supposed to see. The electronic order dated 11/21/18 for a referral to the PNP for Resident #2 was reviewed with Nurse #13. She confirmed that she had entered this electronic order. She revealed she was unable to recall if she placed this referral into the hard copy book for the psychiatric provider.

An interview was conducted with the Corporate Nurse/former interim Director of Nursing (DON) on 1/25/19 at 3:42 PM. Resident #2 ' s 10/12/18 physician ' s order for psychotherapy that had not

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been obtained until 1/9/19 as well the was 11/21/18 physician ' s order for a psychiatric evaluation that had not been obtained until 12/17/18 were reviewed with the Corporate Nurse/former interim DON. She was unable to explain why there was a delay in the obtainment of both psychotherapy and a psychiatric evaluation for Resident #2.

A phone interview was conducted with the NP on 1/25/19 at 4:45 PM. He stated he just began working at the facility in mid-December 2018 on an interim basis as the other NP was out on leave. He indicated that as a medical provider, he expected referrals for psychotherapy and psychiatric evaluation by the PNP to be obtained within a business week.

A phone interview was conducted with Resident #2 ' s physician/facility ' s Medical Director on 1/25/19 at 5:15 PM. He stated that he expected referrals for psychotherapy to be obtained within 1 week and referrals for psychiatric evaluation by the PNP to be obtained within 2 weeks. Resident #2 ' s 10/12/18 physician ' s order for psychotherapy that had not been obtained until 1/9/19 as well as the 11/21/18 physician ' s order for a psychiatric evaluation by the PNP that had not been obtained until 12/17/18 were reviewed with the physician. He indicated he was unaware that there was a delay with the obtainment of these referrals for Resident #2 and revealed this had not met his expectations.

An interview was conducted with the current Administrator on 1/25/19 at 6:10 PM. She stated it was her expectation that orders for psychiatric services to be obtained within 1 to 2 weeks if routine and as soon as possible for emergent

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needs.
3. Resident #16 was admitted to the facility on 9/19/13 with diagnoses aphasia, stroke, and depression.

A review of Resident #16 ' s quarterly Minimum Data Set dated 11/1/18 revealed documentation that the resident was sometimes understood and sometimes understands. Cognition was intact. The resident required total dependence for all transfers including toileting, and extensive assistance for bathing and dressing. The resident ' s active diagnoses were aphasia, non-Alzheimer's dementia, hemiplegia, and depression. The resident received scheduled pain management.

A review of Resident #16 ' s care plan dated 11/14/18 revealed the resident had goals and interventions for self-care deficit, verbal behaviors, poor impulse control, communication deficit, pain, and was at risk for psychotropic medication complication (intervention was to inform the physician of changes in mental status and functional level and to monitor for continued need for medication related to mood and behavior).

A review of the resident ' s nurses ' notes from 6/1/18 to 1/24/19 revealed there was no documentation that the physician or nurse practitioner was informed of the resident ' s medication refusal and/or increased behaviors

A review of the physician and nurse practitioner communication book for timeframe 6/1/18 to 1/24/19, which was stored at the nurses ' station, revealed there was no communication to the medical staff that the resident had frequently

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refused his medication and had increased behaviors.

On 1/24/19 at 10:10 am an interview was conducted with Resident #16 who stated he "had not seen the doctor in a long time." The resident voiced no concerns.

On 1/25/19 at 9:30 am an interview was conducted with Nurse Assistant (NA) #14 who stated she was familiar and assigned to Resident #16. The resident had a history of refusing care and verbal behaviors. NA #14 commented that lately his refusal of care and behaviors had increased.

On 1/25/19 at 10:40 am an interview was conducted with Nurse #11 who stated that she was regularly day-shift assigned to Resident #16. Nurse #11 commented that the resident had lately more frequently refused his medication and had increased verbal behaviors with refusal of care. Nurse #11 agreed that the resident ' s refusal to take his psychotropic medication placed him at risk for increased behaviors and depression. Nurse #11 was not aware that the psychiatric service had not seen the resident since July of 2018.

On 01/25/19 at 3:10 pm an interview was conducted with the facility psychiatric nurse practitioner (PNP) who stated she saw Resident #16 months ago and has not seen him since returning to the facility recently. The PNP had planned on continuing services for the resident but her psychiatric services were suspended for several months. The PNP had increased the resident ' s Zoloft for depression in June 2018 and would have seen the resident July 2018 if the

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F 742	Continued From page 163 services were not suspended. The PNP stated that since return she had seen the urgent residents first and those placed in her communication book at the nurses' station. The PNP stated she had not had time to see Resident #16 since she returned to the facility a couple of months ago. The PNP also stated that staff had not informed her verbally or in writing that Resident #16 had refused his medication, including psychotropic medication, and had increased behaviors. The PNP could not recall the dates of psychiatric services suspension and requested the time frame be obtained from Administration. On 1/25/19 at 4:30 pm an interview was conducted with the Administrator who stated that the psychiatric nurse practitioner services were suspended for several months but could not provide the exact dates and did not know why there was a suspension. The Administrator was new to the facility and was not present during the suspension. On 1/25/19 at 5:00 pm an interview was conducted with Resident #16 ' s physician who stated he was not informed that the resident repeatedly refused his medication and had increased behaviors and that the psychiatric nurse practitioner had not evaluated the resident since July 2018. The physician stated he expected to be informed by staff if a resident needed and had not received psychiatric care. The physician commented he would see the resident on his next visit to the facility.	F 742		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		2/27/19

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F 756	Continued From page 164 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 756		

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F 756	Continued From page 165 Based on record review, observation, and interviews with staff, Pharmacy Consultant, Nurse Practitioner, and Physician, the Pharmacy Consultant failed to act on irregularities in a resident's medication orders which included and possible drug interactions and side effects, the use of 3 antidepressants and antidepressant prescribed for Dementia without behaviors This was for 1 (Resident #52) of 6 residents reviewed for unnecessary medications. The Pharmacy Consultant also failed to identify and address the lack of behavior monitoring and side effect monitoring for residents on psychotropic medications for 3 of 6 residents reviewed for unnecessary medications (Residents #52 and #69 and #2). The findings included: 1. Resident #52 was admitted 11/28/18 with cumulative diagnoses of Cerebral Vascular Accident (CVA), Depression, Anxiety and Dementia without Behaviors. There was no evidence of a diagnosis of pain. Review of Resident #52's admission orders dated 11/28/18 indicated she was prescribed Elavil (antidepressant) and Cymbalta (antidepressant) for Depression daily and Ativan (antianxiety) as needed for Anxiety. Resident #52 was also prescribed Ultram (non-narcotic pain medication) every 8 hours for pain. Her admission orders read if psychotropic medications are used, include a clinical rationale and monitor/address adverse consequences. Review of an automated electronic Medication Administration Record (MAR) progress note dated 11/28/18 read as follows: Ultram has triggered for drug to drug interaction with	F 756	F756: Drug Regimen Review: Element One: • Resident # 52 medication orders for ultram, Elavil, and Cymbalta use and associated drug interactions were discussed with physician on 2/11/19 The Physician titrated medications. The diagnosis for the use of Remeron was added on 2/9/19 by Unit Manager as stated by the Psychiatric Nurse a practitioner to use for sleep. Residents Medication administration record was updated with monitoring for side effects for psychological medications by the Unit Manager by 2/12/19. • Behavior and Side Effect monitoring is in place for residents # 52, # 69, and # 2. Element Two: • 100% Review of all current residents Pharmacy Alerts for potential Drug to Drug interactions was completed by the Director of Nursing to ensure that all were addressed with Pharmacy and Physician timely and appropriately with order clarification as indicated. This audit was completed on or before 2/20/19, with orders clarified accordingly. • An audit was completed by the Unit Managers on all residents on psychotropic medications to ensure that Behavior and Side Effect Monitoring was in place. This audit was completed by the Unit Managers on or before 2/20/19 with behavior/side effect sheets completed accordingly. Element Three: • Education was provided to the	

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F 756	Continued From page 166 Cymbalta with a severity score of severe. Side effects included agitation, altered consciousness, ataxia (loss of muscle control), myoclonus (twitching, jerking or seizures), overactive reflexes and shivering. Ultram also triggered for drug to drug interaction with Elavil with a severity score of severe. Side effects included Serotonin Syndrome (High body temperature, agitation, increased reflexes, tremor, sweating, dilated pupils and diarrhea). Review of Resident #52's admission Minimum Data Set (MDS) dated 12/5/18 indicated severe cognitive impairment and she was coded as feeling down with wandering behaviors. The MDS indicated she received antianxiety medication on 2 occasions and received antidepressants on 7 days during the look back period. She was coded as experiencing pain and on a schedule pain medication regime. Resident #52 was coded as taking Opioids (narcotic pain medication) 7 days during the look back period. Review of Resident #52's care plan dated 12/12/18 indicated she was at risk for complications related to the use of psychotropic medications. Interventions included monitoring for side effects. The care plan did not indicate any potential side effects or behaviors to be monitored. Review of a Consultant Pharmacist note dated 12/13/18 at 2:41 PM, read a medications regimen review was performed. See report for comments/recommendations. Review of a Pharmacy Consultant Report dated 12/13/18 only addressed the use of Resident	F 756	Nursing Leadership Team by the Regional Nurse on reviewing the Pharmacy Alerts daily in the Clinical Morning Meeting to ensure they are addressed timely with Pharmacy and Physician. This was completed on 2/21/19. • Education was provided to the licensed nurses on addressing pharmacy alerts timely. This education was completed on or before 2/25/19 by the Unit Managers and Regional Nurse. • Administrator met with Consultant Pharmacist to review expectations on following up on Behavior and Side Effect Monitoring, and identifying irregularities, during routine visits. This education completed on or before 2/26/19. Element Four: • Director of Nursing and Unit Managers will review the Point Click Care Dashboard daily as part of the Clinical Morning Meeting, to include review of Pharmacy Alerts related to potential Drug to Drug Interactions and ensure that Physician is notified and addresses timely. • Unit Managers will audit psychoactive medications for new orders and new admissions daily in Clinical Morning Meeting to ensure that Behavior and Side Effect monitoring are put in place. • Results of these reviews will be brought before the Quality Assurance and Performance Improvement Committee Monthly by the Director of Nursing, with the QAPI Committee responsible for on-going compliance.	

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#52's as needed order for Ativan needing a stop date since the order was greater than 14 days.

Review of a Psychiatric Progress note dated 12/17/18 read as follows: Continue Cymbalta daily which was likely chosen to target neuropathic pain and discontinue Elavil as it is on the Beers List (Criteria for potentially inappropriate medication use in in older adults to assist healthcare professional's improve the safety of prescribing medications for older adults) of potentially harmful drugs in the elderly due to potential side effects of urinary retention, Arrhythmias (irregular heart rhythm), constipation and confusion. The note also read the Responsible Party does not want Elavil discontinued because it helps with pain.

Review of Resident #52's Physician Orders indicated she was prescribed Remeron (antidepressant) daily for Dementia without Behaviors on 12/18/18.

Review of an automated electronic MAR progress note dated 12/18/18 read as follows: Elavil has triggered for drug to drug interaction with Cymbalta with a severity score of moderate. Side effects Serotonin Syndrome. Elavil has triggered for a drug to drug interaction with Ultram with a severity score of severe. Side effects included Serotonin Syndrome. Elavil has triggered for a drug to drug interaction with Clonidine (antihypertensive) with a severity score of moderate with Elavil reducing the effects of Clonidine.

Review of Resident #52's December 2018 MAR indicated she received her antidepressants daily and her antianxiety medication on 12 occasions.

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A review of Resident #52's December 2018 MAR indicated no listed side effects to be monitored.

Review of Resident #52's January 2019 MAR indicated she received her antidepressants daily and her antianxiety medication on 2 occasions up until 1/3/19 when an order was written to change her antianxiety medication to scheduled 3 times daily and hold for sedation. A review of Resident #52's January 2019 MAR indicated no listed side effects to be monitored.

Review of Resident #52's nursing notes from 11/28/18 to 1/23/19 included no documentation regarding monitoring of side effects of her psychotropic medications but did reveal that Resident #52 was experiencing wandering, confusion and "anxiety".

In an observation on 1/23/19 at 10:30 AM, Resident #52 was clothed and lying asleep across her made bed. She was easily aroused and proceed to ambulate out of her room down the hall.

Review of a Drug Regime Review (DRR) completed by the Consultant Pharmacist dated 1/23/19 at 2:49 PM read a medication regime review was performed with no irregularities found.

During an interview on 1/24/19 at 11:50 AM, the Psychiatric Nurse Practitioner (PNP) stated she noted that the Elavil was on the Beer's List for possible adverse side effects. She stated she recalled speaking with the Responsible Party (RP) for Resident #52 and tried to discontinue the Elavil, but the RP refused since the Elavil was used to treat Resident #52' pain. She stated she tried to explain the risk associated with taking the

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medications prescribed but the RP still refused. The PNP stated that Cymbalta and Elavil can be used to treat neuropathic pain but confirmed that both the medications were documented as prescribed for depression. The PNP stated if a psychotropic medication was ordered for anything other than a psychiatric illness, it falls to the medical team to address. She stated she ordered the additional medication, Remeron which was an antidepressant for sleep and she was uncertain why the orders read for Dementia without Behaviors which was not a clinical indication for Remeron. The PNP stated it was her expectation that the facility monitored for side effects of Resident #52' medication.

During an interview on 1/24/19 at 3:20 PM, Nurse #10 stated Resident #52 was very active and wandered about the facility. Nurse #10 stated side effect monitoring for Resident #52 should be on the MAR if it was being done. Nurse #10 verified no evidence of side effect monitoring on the December 2018 and January 2019 MAR related to Resident #52's psychotropic medications. She stated she wrote a nursing note for any behaviors she observed.

In another observation on 1/25/19 at 9:00 AM, Resident #52 was sitting on the side of her bed eating breakfast. There were no observed concerns.

During an interview on 1/25/19 at 2:40 PM, Nurse #3 stated that the facility utilized the MAR to document side effect monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any side effects. Nurse #3 stated that the nurse who completed

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the admission, was supposed to enter side effect monitoring onto the MAR for all residents who were on psychotropic medications. She indicated that this task was not always completed and that the Unit Managers (UMs) were responsible for reviewing the MAR to ensure the side effect monitoring was in place.

During a telephone interview on 1/25/19 at 3:00 PM, UM #1 stated that the facility utilized the MAR to document side effect monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any side effects. UM #1 stated that the nurse who completed the admission, was supposed to enter ide effect monitoring onto the MAR for all residents who were on psychotropic medications. She reported that the Units Managers were responsible for reviewing the MARs to ensure side effect monitoring was in place for all residents on psychotropic medications and it must have been an oversight.

During an interview with the Pharmacy Consultant on 1/25/19 at 4:01 PM, he stated that he completed the monthly DRRs at the facility. He stated it was abnormal for a resident to be prescribed 3 different antidepressants, but it was possible some of the antidepressants were prescribed to treat pain. He confirmed the prescribed indication was depression and no diagnosis of pain. The Consultant Pharmacist stated the progress notes dated 11/28/18 and 12/18/18 were automatically generated when Resident #52's medication orders were entered into the computer system. He stated it alerts the

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pharmacy and the facility of possible adverse side effects of drug interactions. He was unable to provide any evidence that the pharmacy contacted the facility for clarification. The Pharmacy Consultant further stated the Dementia without Behaviors was not a clinical indication for the use of Remeron. When asked if he reviewed the medical records to ensure the facility had identified potential side effects for residents receiving psychotropic medications during his monthly DRRs, he said he did not. The Pharmacy Consultant was unable to explain how he was able to ascertain if the prescribed psychotropic medication resulted in any side effects for Resident #52.

During a telephone interview on 1/25/18 at 5:10 PM, the Medical Director (MD) stated Elavil was not an antidepressant normally used the elderly residents due to potential adverse side effects and other drug interactions. He stated apparently Resident #52 was taking these medications at home and when she was discharged from the hospital, her home medications were resumed. The MD stated it was his expectation that the pharmacy and Pharmacy Consultant identified duplication of medications, incorrect clinical indications for use of a medication and notify the facility of residents taking medications with high risk of adverse side effects in combination with other medications. He stated he would be at the facility on 1/26/19 to "wean" Resident #52 off some of those medications, especially the Elavil due to concerns with interactions with other medications. The MD stated it was his expectation that side effect monitoring was completed for residents prescribed psychotropic

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medications.

During an interview on 1/25/19 at 5:50 PM, the Administrator stated it was her expectation that the Pharmacy Consultant and pharmacy to identify and address potential drug interactions immediately for clarification with the prescriber and note medication concerns during his monthly DRR. She stated it was her expectation that the Consultant Pharmacist address the lack of side effect monitoring for any resident on psychotropic medications during his monthly DRR.

2. Resident #69 was admitted 12/28/18 with cumulative diagnoses of Altered Mental Status, Malnutrition, Bacteremia (bacteria in the blood stream), pressure ulcer, Depression and Post Traumatic Stress Disorder (PTSD).

Review of Resident #69's admission orders dated 12/28/18 indicated he was prescribed Remeron (antidepressant) every day for depression. His admission orders read if psychotropic medications are used, include a clinical rationale and monitor/address adverse consequences.

Review of Resident #69's December 2018 Medication Administration Record (MAR) indicated he received his antidepressant daily. A review of Resident #69's December 2018 MAR indicated no listed targeted behaviors to be monitored.

Resident #69's admission Minimum Data Set (MDS) dated 1/4/19 indicated he was cognitively intact, no mood disturbance and exhibited no

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behaviors. He coded as having received 6 doses of an antidepressant during the look back period. The Care Area Assessment (CAA) was triggered for psychotropic medications. The CAA indicated Resident #69 would be care planned for psychotropic medications related to his Depression.

Review of Resident #69's care plan dated 1/7/19 indicated he was at risk for sadness/depression due to his diagnosis of Depression. The care plan did not include the use of psychotropic medications for his depression.

Review of Resident #69's January 2019 MAR indicated he received his antidepressant daily from 01/01/19 to 1/22/19. A review of Resident #69's January 2019 MAR indicated no listed targeted behaviors to be monitored.

Review of a Drug Regime Review (DRR) completed by the Consultant Pharmacist dated 1/21/19 at 2:41 PM read a medication regime review was performed with no irregularities found.

In an interview on 1/22/19 at 11:00 AM, Resident #69 stated he was diagnosed with Depression and PTSD and had a history of psychological services with medication interventions. He stated he understood he was prescribed an antidepressant while at the facility. Resident #69 started waving his arms, became tearful and stated his children had not come to see his since his admission and that made him sad. He stated he did not understand why his kids did not care about him anymore. Resident #69 went on the state he experienced "shell shock" after returning from Vietnam and it affected his first marriage that resulted in a divorce. He stated his second

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wife died a year ago.

Review of Resident #69's nursing notes from 12/28/18 to 1/23/19 indicated Resident #69 exhibited an incident of "jerking motions with arms", several instances staff assisted him with eating, multiple occasions of Resident #69 yelling out for staff and multiple request for snacks.

During an interview on 1/24/19 at 3:35 PM, Nurse #14 stated Resident #69 was "very needy and inpatient" with frequent episodes of yelling out for staff to come and fed him or bring him a snack. She stated Resident #69 can feed himself.

During an interview on 1/25/19 at 2:40 PM, Nurse #3 stated that the facility utilized the MAR to document targeted behavior for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any behaviors. Nurse #3 stated that the nurse who completed the admission, was supposed to enter the targeted behavior monitoring onto the MAR for all residents who were on psychotropic medications. She indicated that this task was not always completed and that the Unit Managers (UMs) were responsible for reviewing the MAR to ensure the behavior monitoring was in place. Nurse #3 stated Resident #69 exhibited episodes of yelling for staff, asking staff to feed him, being upset that his kids did not come to see and that nobody cared.

During a telephone interview on 1/25/19 at 3:00 PM, UM #1 stated that the facility utilized the MAR to document targeted behavior monitoring for all residents on psychotropic medications.

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She reported that each shift the nurse was supposed to document on the MAR if the resident had any behaviors. UM #1 stated that the nurse who completed the admission, was supposed to enter targeted behavior monitoring onto the MAR for all residents who were on psychotropic medications. She reported that the Units Managers were responsible for reviewing the MARs to ensure target behaviors monitoring was in place for all residents on psychotropic medications and it must have been an oversight.

During an interview with the Pharmacy Consultant on 1/25/19 at 4:01 PM, he stated that he completed the monthly DRRs at the facility. When asked if he reviewed the medical records to ensure the facility had identified monitoring targeted behaviors for residents receiving psychotropic medications during his monthly DRRs, he said he did not. He further revealed he was not sure where the facility documented behaviors. The Pharmacy Consultant was unable to explain how he was able to ascertain if the prescribed psychotropic medication was effective for the targeted behaviors.

During a telephone interview on 1/25/19 at 3:45 PM, Physician #2 stated it was expectation that the Consultant Pharmacist review the medical record for behavior monitoring and the medication effectiveness for Resident #69. He stated Resident #69 was a "very sick man" and recently was discharged from the hospital after a very prolonged stay.

During an interview on 1/25/19 at 5:50 PM, the

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Administrator stated it was her expectation the facility identified and monitored targeted behaviors for residents prescribed psychotropic medications. She further stated she expected the Pharmacy Consultant to address the lack of behavior monitoring for any resident on psychotropic medications during his monthly DRR.

3. Resident #2 was admitted to the facility on 9/8/18 and most recently readmitted on 12/20/18 with diagnoses that included bipolar disorder.

The care plan for Resident #2, initiated on 9/16/18, included the focus area of the risk for complications related to the use of psychotropic medications. The interventions included, in part, monitor for side effects (initiated 9/16/18).

The admission Minimum Data Set (MDS) assessment dated 9/18/18 indicated Resident #2 ' s cognition was intact. He had verbal behaviors and rejection of care on 1 to 3 days during the MDS assessment period. Resident #2 received antipsychotic medication and antidepressant medication on 7 of 7 days during the assessment period. The psychotropic drug use Care Area Assessment (CAA) for the 9/18/18 MDS indicated Resident #2 was at risk for side effects and/or reactions to psychotropic medications.

A review of Resident #2 ' s September 2018 physician ' s orders and Medication Administration Record (MAR) indicated he received the following psychotropic medications: Seroquel (antipsychotic medication), Trazodone (antidepressant medication), and Lexapro (antidepressant medication). There were no target behaviors identified, no behavior

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monitoring, and no side effect monitoring documented on this MAR for the psychotropic medications in use for Resident #2.

A review of Resident #2 ' s October 2018 physician ' s orders and MAR indicated he received the following psychotropic medications: Seroquel, Lexapro, Trazodone, and Buspar (antianxiety medication). There were no target behaviors identified, no behavior monitoring, and no side effect monitoring documented on this MAR for the psychotropic medications in use for Resident #2.

A review of Resident #2 ' s November 2018 physician ' s orders and MAR indicated he received the following psychotropic medications: Seroquel, Lexapro, Trazodone, Buspar, Amitriptyline (antidepressant medication) and Cymbalta (antidepressant medication). There were no target behaviors identified, no behavior monitoring, and no side effect monitoring documented on this MAR for the psychotropic medications in use for Resident #2.

A review of Resident #2 ' s December 2018 physician ' s orders and MAR indicated he received the following psychotropic medications: Seroquel, Buspar, Amitriptyline, Cymbalta, and Remeron (antidepressant medication). There were no target behaviors identified, no behavior monitoring, and no side effect monitoring documented on this MAR for the psychotropic medications in use for Resident #2.

A review of Resident #2 ' s physician ' s orders and MAR for 1/1/19 through 1/24/19 indicated he received the following psychotropic medications: Seroquel, Buspar, Amitriptyline, Cymbalta and

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Remeron. There were no target behaviors identified, no behavior monitoring, and no side effect monitoring documented on this MAR for the psychotropic medications in use for Resident #2.

The monthly Drug Regimen Reviews (DRRs) completed by the Pharmacy Consultant from 9/18/18 through 1/24/19 revealed no identification of the lack of behavior monitoring and side effect monitoring for Resident #2.
An observation was conducted of Resident #2 on 1/22/19 at 9:30 AM. Resident #2 was alert and was seated in a wheelchair. There were no signs or symptoms of behaviors noted.

An interview was conducted with the Pharmacy Consultant on 1/25/19 at 4:01 PM. He stated that he completed the monthly DRRs at the facility. He was asked if he reviewed the medical records to ensure the facility had identified target behaviors, monitored these behaviors, and monitored for potential side effects for residents receiving psychotropic medications during his monthly DRRs. The Pharmacy Consultant revealed he had not reviewed behavior monitoring or side effect monitoring during his monthly DRR. He further revealed he was not sure where the facility documented their behavior monitoring and side effect monitoring. The Pharmacy Consultant was unable to explain how he was able to ascertain if the prescribed psychotropic medications were effective for managing target behaviors and if the resident exhibited any potential side effects.

A phone interview was conducted with Resident #2 ' s physician/facility ' s Medical Director on 1/25/19 at 5:15 PM.
He stated it was his expectation that target

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F 756	Continued From page 179 behaviors were identified and that behavior monitoring, and side effect monitoring were completed for the use of psychotropic medications. The physician explained that Resident #2 was on multiple psychotropic medications and it was essential to have target behaviors identified and behavior monitoring conducted on those target behaviors in order to determine if the medications were effective. He further explained that the use of psychotropic medications, particularly antipsychotic medications, required close monitoring for the presence of side effects as these medications had to potential to cause serious and harmful adverse consequences. An interview was conducted with the current Administrator on 1/25/19 at 6:10 PM. She stated it was her expectation that target behaviors were identified and that behavior monitoring, and side effect monitoring were completed for the use of psychotropic medications. She further stated she expected the Pharmacy Consultant to identify and address the lack of behavior monitoring and side effect monitoring for any resident on psychotropic medications during his monthly DRR.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		2/27/19

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F 758	Continued From page 180 (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 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:	F 758		

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F 758	Continued From page 181 Based on record review, observation, and interviews with staff, Pharmacy Consultant, Nurse Practitioner, and Physician, the facility failed to act on irregularities in a resident's medication orders regarding possible drug interactions and side effects, the use of 3 antidepressants and an antidepressant prescribed for Dementia without behaviors This was for 1 (Resident #52) of 6 residents reviewed for unnecessary medications. The facility also failed to identify and address the lack of behavior monitoring and side effect monitoring for residents on psychotropic medications for 3 of 6 residents reviewed for unnecessary medications (Residents #52 and #69 and #2). The findings included 1. Resident #52 was admitted 11/28/18 with cumulative diagnoses of Cerebral Vascular Accident (CVA), Depression, Anxiety and Dementia without Behaviors. There was no evidence of a diagnosis of pain. Review of Resident #52's admission orders dated 11/28/18 indicated she was prescribed Elavil (antidepressant) and Cymbalta (antidepressant) for Depression daily and Ativan (antianxiety) as needed for Anxiety. Resident #52 was also prescribed Ultram (non-narcotic pain medication) every 8 hours for pain. Her admission orders read if psychotropic medications are used, include a clinical rationale and monitor/address adverse consequences. Review of an automated electronic Medication Administration Record (MAR) progress note dated 11/28/18 read as follows: Ultram has triggered for drug to drug interaction with Cymbalta with a severity score of severe. Side	F 758	F758: Unnecessary Meds: Element One: • Resident # 52 medication orders for Ultram, Elavil, and Cymbalta use and associated drug interactions were reviewed and addressed by the physician on 2/11/19 . • Behavior and Side Effect Monitoring was put into place for residents # 52, # 69 and # 2, on 2/01/19. Element Two: • 100% Review of all current residents Pharmacy Alerts for potential Drug to Drug interactions was completed by the Director of Nursing to ensure that all were addressed with Pharmacy and Physician timely and appropriately with order clarification as indicated. Was completed by Unit Managers on or before 2/26/19, with appropriate interventions by Physician as indicated. • 100% audit of all current residents on Psychotropic medications was completed to ensure that they all have Behavior and Side Effect Monitoring in place. This was completed on or before 2/20/19 by the Unit Managers. Any discrepancies had Behavior and Side Effect Monitoring put in place immediately. Element Three: • Education was provided to the licensed nurses on addressing pharmacy alerts timely. • Education was provided to Licensed Nurses on ensuring that all residents on Psychotropic Drugs are monitored for specific behaviors to warrant the ongoing	

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F 758	Continued From page 182 effects included agitation, altered consciousness, ataxia (loss of muscle control), myoclonus (twitching, jerking or seizures), overactive reflexes and shivering. Ultram also triggered for drug to drug interaction with Elavil with a severity score of severe. Side effects included Serotonin Syndrome (High body temperature, agitation, increased reflexes, tremor, sweating, dilated pupils and diarrhea). Review of Resident #52's admission Minimum Data Set (MDS) dated 12/5/18 indicated severe cognitive impairment and she was coded as feeling down with wandering behaviors. The MDS indicated she received antianxiety medication on 2 occasions and received antidepressants on 7 days during the look back period. She was coded as experiencing pain and on a schedule pain medication regime. Resident #52 was coded as taking Opioids (narcotic pain medication) 7 days during the look back period. Review of Resident #52's care plan dated 12/12/18 indicated she was at risk for complications related to the use of psychotropic medications. Interventions included monitoring for side effects. The care plan did not indicate any potential side effects or behaviors to be monitored. Review of a Consultant Pharmacist note dated 12/13/18 at 2:41 PM, read a medications regimen review was performed. See report for comments/recommendations. Review of a Pharmacy Consultant Report dated 12/13/18 only addressed the use of Resident #52's as needed order for Ativan needing a stop	F 758	use of these medications. This education was completed by the Unit Managers on or before 2/20/19. Education included FT/PT/PRN and agency staff. Currently at 99% of staff have been educated, remaining staff will not work until they receive training. Element Four: • Director of Nursing and Unit Managers will review the Point Click Care Dashboard daily as part of the Clinical Morning Meeting, to include review of Pharmacy Alerts related to potential Drug to Drug Interactions and ensure that Physician is notified and addresses timely. • Unit Managers will audit Behavior and Side Effect Monitoring Documentation 3 X's per week for four weeks, then weekly X four weeks then randomly thereafter. • Results of the above audits will be brought before the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing, with the QAPI Committee responsible for on-going compliance.	

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date since the order was greater than 14 days.

Review of a Psychiatric Progress note dated 12/17/18 read as follows: Continue Cymbalta daily which was likely chosen to target neuropathic pain and discontinue Elavil as it is on the Beers List (Criteria for potentially inappropriate medication use in in older adults to assist healthcare professional's improve the safety of prescribing medications for older adults) of potentially harmful drugs in the elderly due to potential side effects of urinary retention, Arrhythmias (irregular heart rhythm), constipation and confusion. The note also read the Responsible Party does not want Elavil discontinued because it helps with pain.

Review of Resident #52's Physician Orders indicated she was prescribed Remeron (antidepressant) daily for Dementia without Behaviors on 12/18/18.

Review of an automated electronic MAR progress note dated 12/18/18 read as follows: Elavil has triggered for drug to drug interaction with Cymbalta with a severity score of moderate. Side effects Serotonin Syndrome. Elavil has triggered for a drug to drug interaction with Ultram with a severity score of severe. Side effects included Serotonin Syndrome. Elavil has triggered for a drug to drug interaction with Clonidine (antihypertensive) with a severity score of moderate with Elavil reducing the effects of Clonidine.

Review of Resident #52's December 2018 MAR indicated she received her antidepressants daily and her antianxiety medication on 12 occasions. A review of Resident #52's December 2018 MAR

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indicated no listed side effects to be monitored.

Review of Resident #52's January 2019 MAR indicated she received her antidepressants daily and her antianxiety medication on 2 occasions up until 1/3/19 when an order was written to change her antianxiety medication to scheduled 3 times daily and hold for sedation. A review of Resident #52's January 2019 MAR indicated no listed side effects to be monitored.

Review of Resident #52's nursing notes from 11/28/18 to 1/23/19 included no documentation regarding monitoring of side effects of her psychotropic medications but did reveal that Resident #52 was experiencing wandering, confusion and "anxiety".

In an observation on 1/23/19 at 10:30 AM, Resident #52 was clothed and lying asleep across her made bed. She was easily aroused and proceed to ambulate out of her room down the hall.

Review of a Drug Regime Review (DRR) completed by the Consultant Pharmacist dated 1/23/19 at 2:49 PM read a medication regime review was performed with no irregularities found.

During an interview on 1/24/19 at 11:50 AM, the Psychiatric Nurse Practitioner (PNP) stated she noted that the Elavil was on the Beer's List for possible adverse side effects. She stated she recalled speaking with the Responsible Party (RP) for Resident #52 and tried to discontinue the Elavil, but the RP refused since the Elavil was used to treat Resident #52' pain. She stated she tried to explain the risk associated with taking the

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medications prescribed but the RP still refused. She was unable to recall if she discussed her concerns related to the use of Elavil with the facility or Medical Director. She stated she ordered the additional medication, Remeron which was an antidepressant for sleep and she was uncertain why the orders read for Dementia without Behaviors which was not a clinical indication for Remeron. The PNP stated it was her expectation that the facility monitored for side effects of Resident #52' medication.

During an interview on 1/24/19 at 3:20 PM, Nurse #10 stated Resident #52 was very active and wandered about the facility. Nurse #10 stated side effect monitoring for Resident #52 should be on the MAR if it was being done. Nurse #10 verified no evidence of side effect monitoring on the December 2018 and January 2019 MAR related to Resident #52's psychotropic medications. She stated she wrote a nursing note for any behaviors she observed.

During an interview on 1/24/19 at 3:35 PM, Nurse #14 stated when she entered Resident #52' admission medication orders on 11/28/18, the computer must have generated the medication progress note. She stated if there was something wrong with Resident #52's medications, she thought the Pharmacist would have called to clarify the orders. She stated she was unable to recall if she notified the Medical Director of the possible drug interactions.

During an interview on 1/25/19 at 8:45 AM, Nurse #3 stated when she entered Resident #52' new order for Remeron on 12/18/18 and the computer must have generated the medication progress note. She stated if there was something wrong

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with Resident #52's medications, she thought the Pharmacist would have called to clarify the orders. She stated she was unable to recall if she notified the Medical Director of the possible drug interactions.

In another observation on 1/25/19 at 9:00 AM, Resident #52 was sitting on the side of her bed eating breakfast. There were no observed concerns.

During another interview on 1/25/19 at 2:40 PM, Nurse #3 stated that the facility utilized the MAR to document side effect monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any side effects. Nurse #3 stated that the nurse who completed the admission, was supposed to enter side effect monitoring onto the MAR for all residents who were on psychotropic medications. She indicated that this task was not always completed and that the Unit Managers (UMs) were responsible for reviewing the MAR to ensure the side effect monitoring was in place.

During a telephone interview on 1/25/19 at 3:00 PM, UM #1 stated the facility utilized the MAR to document side effect monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any side effects. UM #1 stated that the nurse who completed the admission, was supposed to enter ide effect monitoring onto the MAR for all residents who were on psychotropic medications. She reported that the Units Managers were responsible for reviewing the MARs to ensure side effect

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monitoring was in place for all residents on psychotropic medications and it must have been an oversight.

During an interview with the Pharmacy Consultant on 1/25/19 at 4:01 PM, he stated it was abnormal for a resident to be prescribed 3 different antidepressants, but it was possible some of the antidepressants were prescribed to treat pain. He confirmed the prescribed indication was depression and no diagnosis of pain. The Consultant Pharmacist stated the progress notes dated 11/28/18 and 12/18/18 were automatically generated when Resident #52's medication orders were entered into the computer system. He stated it alerts the facility of possible adverse side effects of drug interactions. He was unable to provide any evidence that the facility contacted the pharmacy for clarification. The Pharmacy Consultant further stated the Dementia without Behaviors was not a clinical indication for the use of Remeron.

During a telephone interview on 1/25/18 at 5:10 PM, the Medical Director (MD) stated Elavil was not an antidepressant normally used the elderly residents due to potential adverse side effects and other drug interactions. He stated apparently Resident #52 was taking these medications at home and when she was discharged from the hospital, her home medications were resumed. The MD stated it was his expectation that the facility identified duplication of medications, incorrect clinical indications for use of a medication and notify him of residents taking medications with high risk of adverse side effects

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in combination with other medications. He stated he would be at the facility on 1/26/19 to "wean" Resident #52 off some of those medications, especially the Elavil due to concerns with interactions with other medications. The MD stated it was his expectation that side effect monitoring was completed for residents prescribed psychotropic medications.

During an interview on 1/25/19 at 5:50 PM, the Administrator stated it was her expectation the facility identified and addressed potential drug interactions immediately for clarification with the prescriber. She stated it was her expectation that the facility addressed the lack of side effect monitoring for any resident on psychotropic medications.

2. Resident #69 was admitted 12/28/18 with cumulative diagnoses of Altered Mental Status, Malnutrition, Bacteremia (bacteria in the blood stream), pressure ulcer, Depression and Post Traumatic Stress Disorder (PTSD).

Review of Resident #69's admission orders dated 12/28/18 indicated he was prescribed Remeron (antidepressant) every day for depression. His admission orders read if psychotropic medications are used, include a clinical rationale and monitor/address adverse consequences.

Review of Resident #69's December 2018 Medication Administration Record (MAR) indicated he received his antidepressant daily. A review of Resident #69's December 2018 MAR indicated no listed targeted behaviors to be

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monitored.

Resident #69's admission Minimum Data Set (MDS) dated 1/4/19 indicated he was cognitively intact, no mood disturbance and exhibited no behaviors. He coded as having received 6 doses of an antidepressant during the look back period. The Care Area Assessment (CAA) was triggered for psychotropic medications. The CAA indicated Resident #69 would be care planned for psychotropic medications related to his Depression.

Review of Resident #69's care plan dated 1/7/19 indicated he was at risk for sadness/depression due to his diagnosis of Depression. The care plan did not include the use of psychotropic medications for his depression.

Review of Resident #69's January 2019 MAR indicated he received his antidepressant daily from 01/01/19 to 1/22/19. A review of Resident #69's January 2019 MAR indicated no listed targeted behaviors to be monitored.

Review of a Drug Regime Review (DRR) completed by the Consultant Pharmacist dated 1/21/19 at 2:41 PM read a medication regime review was performed with no irregularities found.

In an interview on 1/22/19 at 11:00 AM, Resident #69 stated he was diagnosed with Depression and PTSD and had a history of psychological services with medication interventions. He stated he understood he was prescribed an antidepressant while at the facility. Resident #69 started waving his arms, became tearful and stated his children had not come to see his since his admission and that made him sad. He stated

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he did not understand why his kids did not care about him anymore. Resident #69 went on the state he experienced "shell shock" after returning from Vietnam and it affected his first marriage that resulted in a divorce. He stated his second wife died a year ago.

Review of Resident #69's nursing notes from 12/28/18 to 1/23/19 indicated Resident #69 exhibited an incident of "jerking motions with arms", several instances staff assisted him with eating, multiple occasions of Resident #69 yelling out for staff and multiple request for snacks.

During an interview on 1/24/19 at 3:35 PM, Nurse #14 stated Resident #69 was "very needy and inpatient" with frequent episodes of yelling out for staff to come and fed him or bring him a snack. She stated Resident #69 can feed himself.

During an interview on 1/25/19 at 2:40 PM, Nurse #3 stated that the facility utilized the MAR to document targeted behavior for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any behaviors. Nurse #3 stated that the nurse who completed the admission, was supposed to enter the targeted behavior monitoring onto the MAR for all residents who were on psychotropic medications. She indicated that this task was not always completed and that the Unit Managers (UMs) were responsible for reviewing the MAR to ensure the behavior monitoring was in place. Nurse #3 stated Resident #69 exhibited episodes of yelling for staff, asking staff to feed him, being upset that his kids did not come to see and that nobody cared.

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During a telephone interview on 1/25/19 at 3:00 PM, UM #1 stated that the facility utilized the MAR to document targeted behavior monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any behaviors. UM #1 stated that the nurse who completed the admission, was supposed to enter targeted behavior monitoring onto the MAR for all residents who were on psychotropic medications. She reported that the Units Managers were responsible for reviewing the MARs to ensure target behaviors monitoring was in place for all residents on psychotropic medications and it must have been an oversight.

During a telephone interview on 1/25/19 at 3:45 PM, Physician #2 stated it was expectation that the facility reviewed the medical record for behavior monitoring and the medication effectiveness for Resident #69. He stated Resident #69 was a "very sick man" and recently was discharged from the hospital after a very prolonged stay.

During an interview on 1/25/19 at 5:50 PM, the Administrator stated it was her expectation the facility identified and monitored targeted behaviors for residents prescribed psychotropic medications.

3. Resident #2 was admitted to the facility on 9/8/18 and most recently readmitted on 12/20/18 with diagnoses that included bipolar disorder.

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The care plan for Resident #2, initiated on 9/16/18, included the focus area of the risk for complications related to the use of psychotropic medications. The interventions included, in part, monitor for side effects (initiated 9/16/18).

The admission Minimum Data Set (MDS) assessment dated 9/18/18 indicated Resident #2 ' s cognition was intact. He had verbal behaviors and rejection of care on 1 to 3 days during the MDS look back period. Resident #2 received antipsychotic medication and antidepressant medication on 7 of 7 days. The psychotropic drug use Care Area Assessment (CAA) for the 9/18/18 MDS indicated Resident #2 was at risk for side effects and/or reactions to psychotropic medications

A review of Resident #2 ' s September 2018 physician ' s orders and Medication Administration Record (MAR) indicated he received the following psychotropic medications: Seroquel (antipsychotic medication), Trazodone (antidepressant medication), and Lexapro (antidepressant medication). There were no target behaviors identified, no behavior monitoring, and no side effect monitoring documented on this MAR for the psychotropic medications in use for Resident #2.

A review of Resident #2 ' s October 2018 physician ' s orders and MAR indicated he received the following psychotropic medications: Seroquel, Lexapro, Trazodone, and Buspar (antianxiety medication). There were no target behaviors identified, no behavior monitoring, and no side effect monitoring documented on this MAR for the psychotropic medications in use for

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Resident #2.

A review of Resident #2 ' s November 2018 physician ' s orders and MAR indicated he received the following psychotropic medications: Seroquel, Lexapro, Trazodone, Buspar, Amitriptyline (antidepressant medication) and Cymbalta (antidepressant medication). There were no target behaviors identified, no behavior monitoring, and no side effect monitoring documented on this MAR for the psychotropic medications in use for Resident #2.

A review of Resident #2 ' s December 2018 physician ' s orders and MAR indicated he received the following psychotropic medications: Seroquel, Buspar, Amitriptyline, Cymbalta, and Remeron (antidepressant medication). There were no target behaviors identified, no behavior monitoring, and no side effect monitoring documented on this MAR for the psychotropic medications in use for Resident #2.

A review of Resident #2 ' s physician ' s orders and MAR for 1/1/19 through 1/24/19 indicated he received the following psychotropic medications: Seroquel, Buspar, Amitriptyline, Cymbalta and Remeron. There were no target behaviors identified, no behavior monitoring, and no side effect monitoring documented on this MAR for the psychotropic medications in use for Resident #2.

An observation was conducted of Resident #2 on 1/22/19 at 9:30 AM. Resident #2 was alert and was seated in a wheelchair. There were no signs or symptoms of behaviors noted.

An interview was conducted with Nurse #3 on 1/25/19 at 2:40 PM. She stated that the facility

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utilized the MAR to document behavior monitoring and side effect monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any of the target behaviors and/or side effects. Nurse #3 stated that the nurse who completed the admission for the resident was supposed to enter this behavior monitoring and side effect monitoring onto the MAR for all residents who were on psychotropic medications. She indicated that this task was not always completed as sometimes the admission nurse forgot to enter the behavior monitoring and side effect monitoring onto the MAR. She reported Unit Managers (UMs) were responsible for reviewing the MAR to ensure the behavior monitoring and side effect monitoring were in place. The September 2018 MAR through January 2019 MAR for Resident #2 were reviewed with Nurse #3. She confirmed that target behaviors had not been identified and that behavior monitoring, and side effect monitoring were not on Resident #2 ' s MARs. Nurse #3 indicated she worked with Resident #2 only a few times and she had not noticed that he had no place on the MAR to document behavior monitoring or side effect monitoring.

A phone interview was conducted with UM #1 on 1/25/19 at 3:01 PM. She stated that the facility utilized the MAR to document behavior monitoring and side effect monitoring for all residents on psychotropic medications. She reported that each shift the nurse was supposed to document on the MAR if the resident had any of the target behaviors and/or side effects. UM #1 stated that the nurse who completed the admission for the resident was supposed to enter

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the behavior monitoring and side effect monitoring onto the MAR for all residents who were on psychotropic medications. She reported that she was responsible for reviewing the MARs to ensure that target behaviors were identified and that behavior monitoring, and side effect monitoring were in place for all residents on psychotropic medications. UM #1 revealed that she should have recognized that Resident #2 had no target behaviors identified and no behavior monitoring or side effect monitoring on his MAR. She stated that this was an oversight. She was unable to explain how she had not identified the lack of behavior monitoring and side effect monitoring for more than 4 months (9/8/18 through 1/25/19) for Resident #2.

A phone interview was conducted with the Nurse Practitioner on 1/25/19 at 4:45 PM. He stated it was his expectation that target behaviors were identified and that behavior monitoring, and side effect monitoring were completed for the use of psychotropic medications. The NP stated that it was necessary to monitor behaviors to determine if the prescribed medication was effective. He further stated that psychotropic medications had the potential for multiple side effects requiring close monitoring to avoid harmful adverse consequences.

A phone interview was conducted with Resident #2 ' s physician/facility ' s Medical Director on 1/25/19 at 5:15 PM. He stated it was his expectation that target behaviors were identified and that behavior monitoring, and side effect monitoring were completed for the use of psychotropic medications. The physician explained that Resident #2 was on multiple psychotropic medications and it was essential to

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F 758	Continued From page 196 have target behaviors identified and behavior monitoring conducted on those target behaviors in order to determine if the medications were effective. He further explained that the use of psychotropic medications, particularly antipsychotic medications, required close monitoring for the presence of side effects as these medications had to potential to cause serious and harmful adverse consequences. An interview was conducted with the current Administrator on 1/25/19 at 6:10 PM. She stated it was her expectation that target behaviors were identified and that behavior monitoring, and side effect monitoring were completed for the use of psychotropic medications. She indicated she had been the Administrator at the facility for less than a month and she was unsure whose responsibility it was to ensure this task was complete.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		2/27/19

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F 761	Continued From page 197 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews and record reviews, the facility failed to discard an opened expired insulin for Resident #34 and failed to store unopened insulin in the refrigerator until opened for Resident #29 for 2 of 2 medication carts reviewed for medication storage. The findings included: A review of the facility policy titled "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" and dated October 2016, read in part that once any medication is opened the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications and the facility should store all medications and biologicals requiring special containers for stability in accordance with manufacturer/supplier specifications. 1. On 1/25/19 at 2:30pm, an observation of the medication cart for the 300 Hall was conducted with Nurse #6. The following was observed: *Humalog Insulin for Resident #34 was opened and dated 11/11/18. In an interview on 1/25/19 at 2:30pm, Nurse #6	F 761	F761: Labeling /Storage of Medications: F761: Labeling /Storage of Medications: Element One: • Resident # 34 expired insulin was discarded by the Unit Manager 1/30/19 . Resident # 29 unrefrigerated insulin was discarded on 1/30/19 by the Unit Manager. Element Two: • 100% audit of all medication carts and medication rooms was completed on 2/8/09 by the Unit Managers to ensure appropriate labeling, dating and storage of medications. No discrepancies were noted on this audit. Element Three: • Education provided to all licensed staff on policy and regulation for labeling, dating and storage of medications. This education was completed by the Unit Managers on or before 2/20/19. FT/PT/PRN/agency staff were included in the training. Currently 99% of staff have been educated, remaining staff will not work until they receive training. Element Four: • The unit manager, nursing supervisor,	

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F 761	Continued From page 198 confirmed the date on the insulin was 11/11/18 and stated that it was expired. She stated that she doesn't administer insulin to Resident #34 on her shift, but the nurses are responsible for discarding expired medications and reordering when found. Nurse #6 stated that she would reorder the medication at that time. During an interview on 1/25/19 at 4:20pm, the Pharmacist stated that Humalog Insulin expired 28 days after opening, agreed that the bottle had expired, and the staff should have discarded and reordered a new bottle. On 1/25/19 at 6:10pm, an interview with the Director of Nursing stated that it was her expectation for expired insulins to be discarded by any nurse that finds them. 2. During an observation on 1/25/19 at 2:30 PM, the medication cart for 100 Hall, contained an unopened Lantus Insulin Pen for Resident #29. The pen was dated as filled on 10/21/18. During an interview on 1/25/19 at 2:30pm, Nurse #7 confirmed the date filled on the insulin pen was 10/21/18. She stated Resident #29 received insulin daily on first shift, but that unopened insulin pen was to be stored in the medication refrigerator until time of use in order maintain the insulin's effectiveness. Nurse #7 stated she did not know how long the unopened Insulin Pen had been stored in the medication cart and the Lantus Insulin Pen would need to be discarded. Nurse #7 stated all nurses were responsible for checking the medication carts for proper medication storage and to her knowledge, no shift was assigned to check the medication carts or	F 761	or the director of nursing will complete audits of the Medication Rooms and Med Carts weekly for four weeks, for three months, quarterly for three quarters, to ensure appropriate labeling/dating and storage of medications. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing, with the QAPI Committee responsible for on-going compliance.	

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F 761	Continued From page 199 medication room. During an interview on 1/25/19 at 4:20pm, the facility's Consultant Pharmacist stated that the Lantus Insulin Pen manufacture stated that unopened insulin pens should be stored in the refrigerator until ready to use. He stated this was to ensure the effectiveness and stability of the insulin. During an interview on 1/25/19 at 5:50pm, the Director of Nursing stated she started her position last week and she was uncertain of who was responsible to checking the medication cart and medication rooms for proper medication storage. She stated it was her expectation that unopened insulin pens be stored in the medication room refrigerator until the time of use as recommended by the manufacturer.	F 761		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		2/27/19

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F 842	Continued From page 200 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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	345277	A. BUILDING _____ B. WING _____	C 01/25/2019

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F 842	Continued From page 201 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain complete and accurate medical records related to behaviors and wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) monitoring for 1 of 1 residents (Resident #48) sampled for wandering behaviors. The findings included: 1a. Resident #48 was admitted to the facility on 11/28/17 with diagnoses that included altered mental status, anxiety, and insomnia. The admission Minimum Data Set (MDS) assessment dated 12/5/17 indicated Resident #48' s cognition was severely impaired. He was assessed with wandering behaviors daily. A physician ' s order dated 1/15/18 indicated behavior monitoring every shift for Resident #48 ' s restless and/or exit seeking behavior. This order was placed on the Medication Administration Record (MAR) on 1/15/18 and staff were required to document a "y" or "n" to answer the question, "Is resident behavior free	F 842	F842: Resident Records: Element One: • Resident # 48 has Wander Guard checks documented as ordered. Element Two: • All current resident with orders for Wander Guards were audited to ensure that the ordered checks of placement and function were documented accordingly. This audit was completed by the Director of Nursing on 1/25/19, no discrepancies noted. Element Three: • Licensed Nurses were educated on the importance of monitoring and documenting the placement and function of Wander Guard bracelets per order. This education was completed by the Unit Managers on or before 2/20/19. Education included FT/PT/PRN/agency staff. Currently 99% of staff have been educated, remaining staff will not work until they receiving training. Element Four: • Unit Managers or Director of Nursing	

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F 842	Continued From page 202 (restless, exit seeking behavior) every shift [?]". An incident report dated 4/9/18 indicated Resident #48 had an unsupervised exit from the facility. He was found outside of the facility without supervision by Nursing Assistant (NA) #1 at approximately 8:00 PM. A review of the April 2018 MAR for 4/9/18 for the time of Resident #48 ' s unsupervised exit (8:00 PM) revealed Nurse #4 documented a "y" on the MAR for the 3:00 PM to 11:00 PM shift to answer the question, "Is resident behavior free (restless, exit seeking behavior)" indicating that Resident #48 was free of exit seeking behaviors. A phone interview was conducted with Nurse #4 on 1/24/19 at 2:31 PM. The April 2018 MAR for Resident #48 that showed documentation completed by Nurse #4 that indicated Resident #48 was free of exit seeking behavior during the time of his unsupervised exit on 4/9/18 at 8:00 PM was reviewed. Nurse #4 denied documenting this information. She stated that she was not present at the time of Resident #48 ' s unsupervised exit on 4/9/18 and that she thought someone else may have signed in with her password and completed this documentation. An incident report dated 5/16/18 completed by Nurse #2 indicated Resident #48 had an unsupervised exit from the facility. He was found outside of the facility without supervision by a facility visitor at approximately 7:15 PM. A review of the May 2018 MAR for 5/16/18 for the time of Resident #48 ' s unsupervised exit (7:15 PM) revealed Nurse #2 documented a "y" on the MAR for the 3:00 PM to 11:00 PM shift to answer	F 842	will audit Wander Guard Checks for placement and function 5 X week for four weeks, then weekly for four weeks then randomly thereafter. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing, with the QAPI Committee responsible for on-going compliance. F867: QAPI Element One: • Plan of correction developed and brought before the Quality Assurance and Performance Improvement Committee on 2/20/19 to address non-compliance with F656/Care Plan Development and Implementation and F758/Unnecessary Medications related to behavior Monitoring. Element Two: • Administrator will review the current action plans for outstanding areas out of compliance weekly to ensure that the plans are being followed. Element Three: • The Regional Nurse provided education to the Administrator, Director of Nursing and Interdisciplinary Team regarding the Quality Assurance and Performance Improvement System/regulation and tools. This education was completed on 2/22/19. Element Four: • Administrator will audit clinical meeting, customer at risk meeting and review audits stated in this plan of	

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the question, "Is resident behavior free (restless, exit seeking behavior)" indicating that Resident #48 was free of exit seeking behaviors.

A phone interview was attempted with Nurse #2 on 1/24/19 at 1:16 PM. She was unable to be reached.

An interview was conducted with the Corporate Nurse/former interim Director of Nursing on 1/24/19 at 2:45 PM. She stated the 4/9/18 and 5/16/18 documentation on Resident #48 ' s MARs related to exit seeking behaviors were not accurate. She revealed that Resident #48 had exit seeking behaviors exhibited by unsupervised exits from the facility on 4/9/18 and 5/16/18.

An interview was conducted with the Administrator on 1/25/19 at 6:10 PM. She stated that she expected the medical record documentation to be complete and accurate.

1b. Resident #48 was admitted to the facility on 11/28/17 with diagnoses that included altered mental status, anxiety, and insomnia.

A review of Resident #48 ' s December 2017 physician ' s orders indicated a wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) was initiated on 11/30/17 due to poor safety awareness. The wanderguard was to be checked for function and placement every shift. This order was placed on the Treatment Administration Record (TAR).

The admission Minimum Data Set (MDS) assessment dated 12/5/17 indicated Resident

correction weekly for four weeks, monthly for three months, quarterly for three quarters and report compliance in monthly Quality Assurance meeting.

- The Regional Nurse will review Quality Assurance and Performance Improvement Committee Minutes Monthly to include the action plans for all outstanding citations to ensure compliance.

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#48 ' s cognition was severely impaired. He was assessed with wandering behaviors daily.

A review of the December 2017 TAR indicated 13 instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 12/8/17 (2nd shift), 12/14/17 (2nd shift), 12/15/17 (1st shift) 12/23/17 (1st and 2nd shifts), 12/25/17 (1st and 2nd shifts), 12/25/17 (3rd shift), 12/27/17 (2nd shift), 12/30/17 (1st and 2nd shift), and 12/31/17 (1st and 2nd shift).

A review of the January 2018 TAR indicated 11 instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 1/7/18 (1st shift), 1/14/18 (1st shift), 1/15/18 (2nd and 3rd shift), 1/16/18 (2nd and 3rd shift), 1/20/18 (1st and 2nd shift), 1/21/18 (1st and 2nd shift), and 1/22/18 (3rd shift).

A review of the February 2018 TAR indicated 9 instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates were as follows: 2/5/18 (3rd shift), 2/9/18 (2nd shift), 2/10/18 (2nd shift), 2/11/18 (2nd shift), 2/15/18 (3rd shift), 2/16/18 (3rd shift), 2/19/18 (2nd shift), 2/24/18 (1st shift), and 2/28/18 (2nd shift).

A review of the March 2018 TAR indicated 15 instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 3/13/18 (2nd shift), 3/15/18 (2nd shift), 3/16/18 (2nd and 3rd shift), 3/19/18 (2nd shift), 3/20/18 (2nd shift), 3/21/18 (2nd shift),

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3/22/18 (2nd shift), 3/25/18 (1st and 2nd shift), 3/27/18 (2nd shift), 3/28/18 (2nd shift), 3/29/18 (2nd shift), and 3/30/18 (2nd and 3rd shift).

A review of the April 2018 TAR indicated 21 instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 4/1/18 (2nd shift), 4/2/18 (2nd and 3rd shift), 4/4/18 (2nd shift), 4/8/18 (1st and 2nd shift), 4/10/18 (2nd shift), 4/11/18 (2nd shift), 4/12/18 (2nd shift), 4/13/18 (2nd shift), 4/18/18 (2nd shift), 4/19/18 (2nd shift), 4/20/18 (2nd shift), 4/23/18 (2nd shift), 4/24/18 (2nd shift), 4/25/18 (2nd shift), 4/26/18 (2nd shift), 4/27/18 (2nd shift), 4/29/18 (3rd shift), and 4/30/18 (2nd and 3rd shift).

A review of the May 2018 TAR indicated 13 instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 5/4/18 (2nd shift), 5/5/18 (1st shift), 5/7/18 (2nd shift), 5/14/18 (2nd and 3rd shift), 5/15/18 (3rd shift), 5/17/18 (2nd and 3rd shift), 5/18/18 (3rd shift), 5/21/18 (2nd shift), 5/22/18 (2nd shift), and 5/21/18 (2nd and 3rd shift).

A review of the June 2018 TAR indicated 8 instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 6/12/18 (1st shift), 6/17/18 (1st shift), 6/23/18 (1st and 2nd), 6/24/18 (2nd shift), 6/25/18 (3rd shift), and 6/30/18 (1st and 2nd shift).

A review of the July 2018 TAR indicated 10

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instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 7/1/18 (2nd shift), 7/13/18 (2nd shift), 7/14/18 (1st shift), 7/21/18 (1st shift), 7/22/18 (1st and 2nd shift), 7/23/18 (3rd shift), 7/28/18 (2nd shift), and 7/29/18 (1st and 2nd shift).

A review of the August 2018 TAR indicated 5 instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 8/3/18 (2nd shift), 8/10/18 (2nd shift), 8/12/18 (1st and 2nd shift), and 8/28/18 (1st shift).

A review of the September 2018 TAR indicated 1 instance that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. This was on 9/11/18 during the 2nd shift.

A review of the October 2018 TAR indicated 3 instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 10/5/18 (2nd shift), 10/10/18 (2nd shift), and 10/14/18 (3rd shift).

A review of the November 2018 TAR indicated 7 instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 11/3/18 (1st shift), 11/4/18 (1st shift), 11/8/18 (3rd shift), 11/18/18 (1st shift), 11/23/18 (3rd shift), 11/24/18 (3rd shift), and 11/29/18 (2nd shift).

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A review of the December 2018 TAR indicated 6 instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 12/6/18 (2nd shift), 12/11/18 (3rd shift), 12/20/18 (3rd shift), 12/26/18 (3rd shift), 12/30/18 (1st shift), and 12/31/18 (2nd shift).

A review of the January 2019 TAR from 1/1/19 through 1/23/19 indicated 2 instances that Resident #48 ' s wanderguard check for function and placement was not initialed as complete. These dates and shifts were as follows: 1/1/19 (first shift) and 1/17/19 (2nd shift).

An interview was conducted with Nurse #3 on 1/25/19 at 2:40 PM. She stated that wanderguard monitoring for function and placement was documented on the TARs. She reported that the Unit Managers were responsible for monitoring the TARs to ensure they were complete.

A phone interview was conducted with Unit Manager (UM) #1 on 1/25/19 at 3:01 PM. She stated that she had been a UM at the facility since September/October of 2018. She reported that wanderguard monitoring for function and placement was documented on the TARs. She confirmed she was responsible for monitoring he TARs for completeness. She reported that any missed documentation on the TAR was an oversight.

An interview was conducted with the Corporate Nurse/former interim Director of Nursing (DON) on 1/24/19 at 2:45 PM. The December 2017 through January 2019 TARs for Resident #48 were reviewed with the Corporate Nurse/former DON. She confirmed that the wanderguard

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F 842	Continued From page 208 monitoring for function and placement was not consistently initialed as complete. An interview was conducted with the Administrator on 1/25/19 at 6:10 PM. She stated that she expected the medical record documentation to be complete and accurate.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and resident and staff interviews the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification/complaint survey of 12/01/17. This was for 2 deficiencies originally cited 12/1/17 and were subsequently recited on the current recertification survey of 1/25/19. The two recited deficiencies were in develop and implement resident care plans and psychotropic drug use. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: The tag is cross referenced to: 1a.F-656 Comprehensive Resident Centered	F 867	F867: QAPI F867: QAPI Element One: • Plan of correction developed and brought before the Quality Assurance and Performance Improvement Committee on 2/20/19 to address non-compliance with F656/Care Plan Development and Implementation and F758/Unnecessary Medications related to behavior Monitoring. Element Two: • Administrator will review the current action plans for outstanding areas out of compliance weekly to ensure that the plans are being followed. Element Three: • The Regional Nurse provided education to the Administrator, Director of Nursing and Interdisciplinary Team	2/27/19

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F 867	Continued From page 209 Care Plans: Based on record review, observation, resident interview, staff interview, and Product Manager interview, the facility failed to develop comprehensive care plans (Residents #16, #25, #28, #34, #36, #69, #75, and #81) and failed to implement care plans (Residents #1, #2, #48, and #52) for 12 of 25 sampled residents. During the prior survey of 12/1/17 the facility failed to have a comprehensive and individualized care plan in the areas of respiratory care (Resident #44), dialysis (Resident #176) and Preadmission Screening and Resident Review (PASRR) (Resident #67 and #54) for four of eighteen sampled residents. 1b. F-758 Psychotropic Drug use: Based on record review, observation, and interviews with staff, Pharmacy Consultant, Nurse Practitioner, and Physician, the facility failed to act on irregularities in a resident's medication orders regarding possible drug interactions and side effects, the use of 3 antidepressants and an antidepressant prescribed for Dementia without behaviors This was for 1 (Resident #52) of 6 residents reviewed for unnecessary medications. The facility also failed to identify and address the lack of behavior monitoring and side effect monitoring for residents on psychotropic medications for 3 of 6 residents reviewed for unnecessary medications (Residents #52 and #69 and #2). During the facility ' s prior survey of 12/1/17 the facility failed to ensure physician's orders for as needed (PRN) psychotropic medications were time limited in duration for 3 of 5 residents (Residents #53, #54, and #66) reviewed for unnecessary medications.	F 867	regarding the Quality Assurance and Performance Improvement System/regulation and tools. This education was completed on 2/22/19. Element Four: • Administrator will audit clinical meeting, customer at risk meeting and review audits stated in this plan of correction weekly for four weeks, monthly for three months, quarterly for three quarters and report compliance in monthly Quality Assurance meeting. • The Regional Nurse will review Quality Assurance and Performance Improvement Committee Minutes Monthly to include the action plans for all outstanding citations to ensure compliance.	

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F 867	Continued From page 210 On 1/25/19 at 4:55 pm an interview was conducted with the Administrator who stated the root cause for repeat tags was turnover in management and nursing. There have been 4 Administrators in the past 2years and two Director of Nurses in the past year. There is currently an open Minimum Data Set Coordinator position with a person in training and the Staff Development Coordinator position remains vacant.	F 867		