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	345421	A. BUILDING _____ B. WING _____	C 02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 2/11/19 through 2/14/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #PVRD11.	E 000		
F 000	INITIAL COMMENTS The Statement of Deficiencies was amended on 3/26/19 at tags F756 and F758. On 4/09/19 an amended Statement of Deficiencies was provided to the facility based on the results of the facility's Informal Dispute Resolution meeting deleting an example from tag F-756 and F-758. The scope and severity levels of both of these citations was changed to a D level. Additionally, information was included in tag F-0000 to describe the results of the IDR. Event ID #PVRD11.	F 000		
F 550 SS=G	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 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.	F 550		3/29/19

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

Electronically Signed | 03/11/2019

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F 550	Continued From page 1 §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 review, observation, and resident and staff interview, the facility failed to honor the resident ' s request to remove the wander alarm system bracelet from his wheelchair which resulted in the resident to state he "felt like a dog on a leash" (Resident #88) and failed to ensure the resident council members were treated with respect during their resident council meetings (Residents #35, #40, #45, #80, #87, and #91) for 7 of 8 residents reviewed for dignity. Findings included:	F 550	The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is 3-29-19. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.	

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F 550	Continued From page 2 1. Resident #88 was admitted to the facility on 11/17/17 with diagnoses of anxiety, insomnia and seizure disorder. A review of Resident #88 ' s nurses ' note dated 10/17/18 at 5:00 pm revealed the resident exited the building alone onto the front patio with other residents and a staff member immediately assisted him back in until staff was ready to accompany the resident outside. The resident threw his coffee on the staff member in protest and used foul language (written by Nurse #2). A review of Resident #88 ' s quarterly Minimum Data Set (MDS) dated 12/2/18 revealed an intact cognition. A review of the resident ' s care plan updated 1/16/19 revealed goals and interventions for bowel incontinence, self-care deficit for activities of daily living (ADLs) secondary to spinal cord injury, at risk for fall, refused personal care, pain, contractures, and seizure. A review of Resident #88 ' s quarterly MDS dated 1/18/19 revealed the resident had adequate hearing, clear speech and was understood and understands. The cognition was unable to be assessed. The resident had other behaviors not directed toward others and rejection of care. The resident required extensive assistance of 2 staff for all transfers and bed mobility and of 1 staff for all other (ADL). The active diagnoses were neurogenic bladder, obstructive uropathy, seizure, anxiety, quadriplegia, polyneuropathy, neurogenic bowel, and other cord compression. The resident received as needed and scheduled	F 550	F550 Resident Rights Corrective Action: On 2/13/19 the wanderguard was removed from resident #88□s wheelchair. The facility counseled nurse #1 on the right to privacy during the scheduled resident council meeting on 2-15-19. In addition, all staff will be educated by 3-21-19, or they will not be scheduled until they are educated. Education sessions are going on currently at various times, given by the Assistant Director of Nurses (ADON). Identification of others potentially at risk: Other residents with wanderguard bracelets are potentially at risk. Residents with wanderguards were audited by the Director of Nurses (DON)to ensure they had physician order for wanderguard, it is listed on the resident□s care card, there is an elopement assessment that indicates the resident is at risk, residents at risk for elopement are listed in the elopement book, and that cognitively resident is appropriate for wanderguard. If any of these residents had wanderguards during the last Minimum Data Set assessment (MDS) the MDS will be checked to ensure accuracy of coding. Any discrepancies will be corrected as identified. All residents who attend resident council meetings are potentially at risk. Systemic Changes: The Assistant Director of Nursing/Staff Development Coordinator will complete	

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F 550	Continued From page 3 pain medication. The MDS did not code him as an elopement risk. On 02/11/19 at 9:15 am an interview was conducted with Resident #88. The resident stated that the staff was rude to him by pulling the wheelchair and called the police on him on 10/17/18. The resident stated that the staff tried to put a wander alarm (bracelet that triggers a door alarm when approached) on his extremity and he refused so staff placed the device on his wheel chair. The resident stated he did not want the wander alarm on his wheel chair. The resident stated that when he neared the door it alarmed, and he felt trapped. The resident does not like the alarm and feels like a dog on a leash with an alarm that had tried to run away and feels like a prisoner in the facility. The resident had no concerns regarding his care, meals, or staffing. The resident admitted that he threw hot coffee on a nurse and used foul language when he was not allowed to exit the building alone. The resident does not want to be at the facility, but he is aware he cannot live alone. On 2/11/19 an observation of Resident #88 ' s wheel chair was done, and a bracelet wander alarm bracelet was attached to the side of his wheel chair (out of the resident ' s reach) and had an expiration date of 5/2019. The wheel chair was motorized and the resident was independent to travel throughout the facility. On 2/13/19 at 2:00 pm an interview was conducted with Nursing Assistant (NA) #3 who stated she was regularly assigned on day shift to Resident #88. NA #3 was assigned on 10/19/18. NA #3 stated that she remembered the resident had gone onto the front porch with other residents	F 550	education to staff on Resident Rights to include the use of Wanderguard bracelets and the right to have a resident council meeting uninterrupted by staff. New signs have been developed that will go on the doors to the activity room to make staff aware to not enter. The Activity Director has been educated to let the Administrator or Director of Nurses know right away if anyone enters during the meeting so that immediate corrective action can be taken. Monitoring: Residents with wanderguards will be audited by the Director of Nurses and/or the Unit Nurse Managers, bimonthly for 2 months then monthly for 1 month to ensure appropriate documentation and use of wanderguards. The Activities Director will report to the Administrator monthly for 3 months any interruptions by staff in the resident council meetings. Results of the audits will be taken to the Quality Assurance (QA) Committee by the DON and be reviewed at the monthly Quality Assurance meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 550	Continued From page 4	F 550		

without supervision on 10/17/19. The resident was angry, had increased behaviors, and was resistive to care on 10/19/18 for her shift. NA #3 stated that the resident was offered his care as usual, there was no change on this date. It was believed the resident was angry about not being able to go outside alone. The resident had also made comments about not wanting to be here.

On 2/13/18 at 3:00 pm an interview was conducted with NA #2 who stated she was regularly assigned to Resident #88 and was assigned on 10/18/18. NA #2 commented that she remembered when the resident went outside the front door to sit on the porch with other residents on 10/17/18. The resident was not independent outside of the facility and had to wait for a staff member to accompany him. The resident was accompanied to the porch but entered back into the building shortly thereafter. The resident was angry on her evening shift 10/18/18 and personal care was offered and refused. The resident was not his usual self for a couple of days. The resident verbalized anger because he does not want to be at the facility, will use foul language when he is mad and not talk to staff or cooperate. Nursing was made aware. NA #2 stated that she was aware that in the past the resident had a wander alarm because he was a wander risk. NA #2 was not aware that the resident had a wander alarm attached to his wheel chair. NA #2 stated that she currently observed the resident had gone to the front door and the wander alarm would alarm. NA #2 was requested and demonstrated that the resident's wheel chair with the wander alarm attached was operational

On 2/13/19 at 3:20 pm an interview was

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conducted with Nurse #3 who was regularly day-shift assigned to Resident #88. The resident has had a decline of weakness, decreased ADLs and desire to get out of bed, a refusal of everything including care and medication, and increased confusion. Nurse #3 stated that she was not aware the resident had a wander alarm on his wheel chair and was not aware that the resident requested the wander alarm be removed. The resident had no order for a wander alarm, was not documented in the elopement book, and was not care planned for a wander guard. Nurse #3 was aware that the resident was an elopement risk in the past (wore a wander alarm on his person), but not at present. Nurse #3 commented that the resident was a risk months ago but not at this time due to decline.

On 2/13/19 at 3:25 pm an interview was conducted with Nurse #4 who was regularly evening-shift assigned to Resident #88. The resident has had a decline of weakness, decreased ADLs and desire to get out of bed, a refusal of everything including care and medication, and increased confusion. Nurse #3 stated that she was not aware the resident had a wander alarm on his wheel chair and that he wanted it taken off. Nurse #4 agreed that the resident was alert and oriented able to make his needs known and if he wanted the wander alarm taken off his wheel chair his request should be honored. Nurse #4 stated the resident had no order for a wander alarm, was not documented in the elopement book, and was not care planned for a wander alarm to prevent elopement. Nurse #4 was not aware that the resident was an elopement risk.

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F 550	Continued From page 6 On 2/13/19 at 4:10 pm an interview was conducted with the Director of Nursing (DON) who stated she was aware Resident #88 had a wander alarm bracelet attached to his wheel chair and that he wanted it taken off. The DON stated that the resident was an elopement risk and needed the wander alarm to prevent elopement. The DON was aware that the resident would not keep a wander alarm bracelet on his extremity and that was why the bracelet was placed on the wheel chair. After being informed, the DON agreed the resident had the right to refuse the wander alarm bracelet. The DON was not aware there was no physician order for the wander alarm bracelet and was not aware that the wander alarm manufacturer does not endorse placing the bracelet on a resident ' s wheel chair for safety reasons. The DON then stated she would remove the bracelet. 2. A Resident Council meeting was conducted on 2/12/19 at 1:30 PM with 6 alert and oriented residents (Residents #35, #40, #45, #80, #87, and #91) who were active participants in the facility's Resident Council. The meeting was held in the resident day room and a sign was hung on the door that read "Resident Council meeting in progress". During the meeting, Nurse #1 opened the day room door, entered the room without being invited in, and utilized the vending machine. She indicated that she was sorry for interrupting the meeting. After Nurse #1 exited the room the residents stated that their meetings were frequently interrupted by staff for reasons such as needing to get something from the room or needing to give a resident in attendance a	F 550		

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medication. They stated that they felt this was disrespectful as it disrupted their meeting and they had to stop talking until the staff member left the room. The residents indicated that they only had one meeting a month and they felt the staff should wait until the meeting was over to enter the room.

An interview was conducted with the Activities Director on 2/12/19 at 2:00 PM following the Resident Council meeting. She stated that she always hung a sign on the door when a Resident Council meeting was held to alert staff that a meeting was in progress. She reported that the Resident Council meetings were sometimes interrupted by staff entering the room during the meeting. She stated that she had not known the residents felt disrespected by staff entering the room during the meeting but indicated that it was not a surprise to her as the residents normally stopped talking when staff entered the room and their conversation wasn' t reconvened until the staff member exited.

An interview was conducted with Nurse #1 on 2/13/19 at 5:28 PM. She acknowledged that she entered the day room on 2/12/19 after seeing the sign on the door that a Resident Council meeting was in progress. She explained that she needed to access the vending machine and that the only vending machine in the facility was in the day room. She stated that she had not known the resident council members were bothered by the meeting interruption.

An interview was conducted with the Director of Nursing (DON) on 2/12/19 at 2:40 PM. She stated that her expectation was for the Resident Council members to be treated with respect and

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F 550	Continued From page 8 for their meetings to be uninterrupted by staff unless there was an emergency.	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		3/29/19

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F 565	Continued From page 9 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 repeat concerns reported during Resident Council meetings for 4 of 4 consecutive months. The findings included: Review of the monthly Resident Council meeting minutes dated 11/6/18 included, in part, the concern of nurses putting residents' medications in their hand instead of using a pill cup. The Response to Resident Council Meeting form dated 11/8/18 indicated no mention of nurses placing resident medications in their hand instead of a pill cup. This form was signed by the Director of Nursing (DON) and the Administrator. Review of the monthly Resident Council meeting minutes dated 12/4/18 included, in part, the repeat concern of nurses putting residents ' medications in their hands instead of using a pill cup and a new concern of bed linens not being changed on the residents ' shower days. The Response to Resident Council Meeting form dated 12/6/18 indicated medication pass observations were ongoing and linens were being changed on shower days. This form was signed by the DON and the Administrator. Review of the monthly Resident Council meeting minutes dated 1/1/19 included, in part, repeat concerns of nurses putting medications in their hands instead of in pill cups, bed linens not being changed on the residents ' shower days, and a new concern with call lights not being answered timely during the 3rd shift. The Response to	F 565	F565 Resident/Family Group Response Corrective Action: The Director of Nurses (DON) has investigated the repeated issues that have been brought up in Resident Council and has not been able to identify any particular nurse that is popping the medication into their hand. She has been doing audits of residents on bath day to ascertain if the sheets are being changed on bath day, and she has been coming in on night shift to determine call bell response time. She has not been able to confirm the concerns. Results of her audits will be relayed back to Resident Council at the next meeting. The Activity Director has been educated to bring any repeated concerns from Resident Council to the administrators attention immediately. The DON has interviewed the residents that attend resident council to obtain any additional specific information that may help with any necessary corrective action. Results will be shared in the next council meeting held in April. Identification of others potentially at risk: All residents have the potential to be affected by this alleged deficient practice. As the audits have been extensive, not other resident has been found to be affected. Systemic Changes: The concerns that come out of Resident	

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F 565	Continued From page 10 Resident Council Meeting form dated 1/3/19 indicated that random Nursing Assistants (NAs) were interviewed about Resident Council concerns. These NAs reported that they changed the bed linens on residents ' shower days. Random call light audits were conducted, and the results were noted to not reflect the allegation. Nursing management observed nurses passing medications and educated the nurses on maintaining infection control precautions. This form was signed by the DON and the Administrator. Review of the monthly Resident Council meeting minutes dated 2/5/19 included, in part, repeat concerns with nurses putting medications in their hands instead of in pill cups, bed linens not being changed on the residents ' shower days, and call lights not being answered timely. The Response to Resident Council Meeting form dated 2/12/19 indicated that the concerns related to nursing from the 2/5/19 resident council meeting were all "repeats of previous meetings". Staff were noted to be educated and random audits were completed. The plan of action was for nurses to validate that linens were changed on shower days and for medication pass observations to continue to be conducted. This form was signed by the DON and the Administrator. A Resident Council meeting was conducted on 2/12/19 1:30 PM with 6 alert and oriented residents who were active participants in the facility's Resident Council. The residents reported that they had repeat concerns over the past several months with nurses putting medications in their hands instead of in pill cups, bed linens not being changed on the residents ' shower days, and call lights not being answered	F 565	Council will be noted on the Response to Resident Council form. These forms will now be sent to the Administrator, who will fill out concern forms as appropriate and will forward them to the appropriate department manager to address. Once the form is returned to the Administrator, he will upload the concern form to the Electronic Risk Management Assistant (ERMA), our online tracking tool, which will determine if there is any repeat concerns or patterns to address. Department managers will be available to attend if invited to Resident Council to discuss repeated concerns. Monitoring: The Director of Nurses, and/or her nurse manager, will perform audits bi-weekly for one month and then monthly for one quarter, of all interviewable residents to determine if the reported issues of medications being popped into hands instead of med cups, bed linens not being changed on shower days, and appropriate call bell response, has been addressed and resolved. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. Resident Council concerns will be monitored via the ERMA system to further determine if there are any patterned or unresolved issues. The Administrator will be responsible to ensure any further recommendations from the Quality Assurance and Performance Improvement committee (QAPI) are carried out.	

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F 565	Continued From page 11	F 565		

timely. The meeting attendees all stated that these concerns had not been resolved. When asked what the facility ' s response was to them regarding these repeat concerns the group indicated they were informed the facility staff had been re-educated.

An interview was conducted with the Activities Director on 2/12/19 at 2:00 PM following the Resident Council meeting. She confirmed she was aware that the resident council had repeated concerns with nurses putting medications in their hands instead of in pill cups, bed linens not being changed on the residents ' shower days, and call lights not being answered timely. She stated that after each of the resident council meetings she completed a Response to Resident Council Meeting form and gave it to the DON to address. She indicated the DON wrote a response on the form and she gave the form back to her. The Activities Director stated that she presented the response to the residents at the next monthly meeting. She indicated that she asked the residents if the issue had been resolved and if they reported that it was a repeat issue she wrote it up on another Response to Resident Council Meeting form and gave it to the DON again.

An interview was conducted with the DON on 2/12/19 at 2:40 PM. She stated that she was aware of the resident council ' s repeated concerns with nurses putting medications in their hands instead of in pill cups, bed linens not being changed on the residents ' shower days, and call lights not being answered timely. She indicated that nurses and NAs had been re-educated. The DON stated that the residents had also been asked to report any concerns immediately so that the issue was able to be addressed with the

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 565	Continued From page 12 specific staff member rather than waiting until the next resident council meeting. The DON stated that she expected concerns discussed at the Resident Council meetings to be addressed and resolved.	F 565		
F 580 SS=D	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 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	F 580		3/29/19

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F 580	Continued From page 13 (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 staff, Psychiatric Nurse Practitioner (PNP) and Responsible Party (RP) interviews, the facility failed notify the RP of newly prescribed psychotropic medications for 1 (Resident #120) of 1 reviewed for notification of changes. The findings included: Resident #120 was admitted on 3/22/18 with cumulative diagnoses of Metabolic Encephalopathy, Diabetes, Seizures. Chronic Kidney Disease, Sleep Apnea, Pneumonia and Pseudobulbar Affect (PBA). Review of a consent for Psychiatric Services was signed by Resident #120 on 4/6/18. Resident #120's admission Minimum Data Set dated 4/8/18 indicated severe cognitive impairment with no exhibited behaviors. She was not coded for taking any antipsychotic, antianxiety	F 580	F580 Notification Corrective Action: It is duly noted that there is no documentation that Resident #120□s RP was notified of new psychotropic medication. Resident #120 no longer resides at facility. Identification of others potentially at risk: Other residents with orders for new psychotropic medications are potentially at risk. An audit of residents that required proper notification for the previous 2 months was performed by the DON and/or Unit Nurse Managers on 2-18-2019.No other issues were identified at time of survey. Systemic Changes:	

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F 580	Continued From page 14 or antidepressant medications. Review of Resident #120's care plan dated 4/10/18 read she was at risk for mood issues with history of restlessness, crying, sad facial expressions and diagnosis of depression. Interventions included administering antidepressant as ordered and Psychiatric consults as needed. Review of an initial evaluation Psychiatric note dated 4/10/18 read Resident #120 was being seen due to Depression. The note read that since Resident #120's admission, she had been tearful and yelling out. The note indicated Resident #120 would start Klonopin 0.25 milligrams (mg) twice daily for anxiety and Zoloft 25 mg daily for Depression. The note did not mention that the RP was notified of the new psychotropic medications. Review of the nursing notes did not indicate the RP was notified of the new psychotropic medications ordered on 4/10/18. Review of a Behavior Data and Analysis Assessment dated 4/20/18 read Resident #120 was a new admission with frequent crying and calling out spells. She was seen by Psychiatrist on 4/17/18 and prescribed Klonopin, Zoloft and Nuedexta (PBA medication). Review of a Psychiatric note dated 4/24/18 read Resident #120 was started on Nuedexta on 4/17/18 for PBA and there was noted improvement in her yelling out. Her Klonopin was increased to 1 mg three times daily on 4/17/18 and subsequently reduced to 0.25 mg on 4/24/18. The note did not mention that the RP was notified of the new medication or the increase then	F 580	The Director of Nurses (DON), and Unit Managers, will identify new orders for psychotropic medications at clinical operations (which consists of the Director and Assistant Director of Nurses, three Unit Managers, the Rehab Director, Minimum Data Set Nurse, Social Worker, Activities Director, Food Service Director and Medical Records Director) meetings Monday through Friday and ensure documentation for Responsible Party (RP) notification is present in medical record). Any alteration will be corrected as identified. DON will inservice Clinical Operations team on this expectation by 3-15-19. ADON/staff development will inservice licensed staff on the regulation for RP notification by 3-21-19. Licensed staff will not be able to work prior to being inserviced. Monitoring: RP notification documentation of newly started psychotropic medication will be audited by the Director Of Nurses and/or the Unit Nurse Managers, monthly for 3 months as identified through the behavior management committee to ensure that RP notification is documented as appropriate. Results of the audits will be taken to the Quality Assurance (QA) Committee by the DON and be reviewed at the monthly Quality Assurance meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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decrease in the dose of her Klonopin prescribed by the PNP on 4/17/18.

Review of the nursing notes did not indicate the RP was notified of the new medication Neudexta ordered 4/17/18 or the increase in the Klonopin on 4/17/18 then decrease in her Klonopin on 4/24/18.

Review of a Physician Progress Note dated 4/24/18 read he had a telephone conversation with the RP regarding a communication error in Resident #120's Klonopin dosing but it was corrected.

Review of a nursing note dated 4/24/18 at 2:43 AM read Resident #120 had new orders for Klonopin. The note did not mention that the RP was notified.

Review of a nursing note dated 5/18/18 at 11:23 PM read Resident #120 was being admitted directly to the hospital from scheduled doctor's appointment.

Review of a nursing note dated 5/19/18 at 2:35 PM read the Neurology Department at the hospital called and inquired about Resident #120's medications. Resident #120's medications was reviewed with the caller and told she was admitted under Neurology services.

Review of the hospital discharge summary dated 5/22/18 read Resident #120 experienced a "downturn" in her mental status consistent with the use of multiple psychotropic medications. The summary read Resident #120's Klonopin should not be restarted, the Neudexta should not be restarted and a Zoloft taper off was started on

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5/21/18.

In a telephone interview on 2/13/18 at 9:46 AM, the RP stated he consented to Psychiatric services but that he was never informed of the medications Klonopin, Zoloft or Neudexta. He stated he made the appointment with her Neurologist on 5/18/18 because Resident #120 was "not acting right" and she was directly admitted to the hospital from the appointment. The RP stated the Neurologist stopped all those medications because they were making Resident #10 worse. He stated the Medical Director called in and discussed his concerns at the time of the incident.

In an interview on 2/13/18 at 10:43 AM, Social Worker (SW) #1 stated she spoke with the RP about the referral for Psychiatric services but if any medications were prescribed, the PNP or nurses would be responsible to discussing that with the RP.

In a telephone interview on 2/14/18 at 9:20 AM, the PNP stated she was referred to Resident #120 for extreme anxiety and calling out. She stated after reviewing her notes, there was no specific mention of a phone conversation with the RP. The PNP stated it was her policy that anytime she saw a new resident, she attempted to call the RP at least once and leave a voicemail if she was unable to reach the RP. The PNP stated that if she spoke with the RP, it would have been documented in her note and that she could only assume that she left a voicemail. She added that there was an electronic communication portal that was set up for RPs if they wished to participate. The PNP stated that Resident #120's RP had signed up for this portal but there was no

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F 580	Continued From page 17 way to tell if the RP had signed into the portal and reviewed Resident #120's notes. She stated that the RP had requested to discontinue his participation in the portal usage in June 2018 and that was the only communication she was able to see from the RP on the portal. During an interview on 2/14/18 at 11:54 AM, the Director of Nursing (DON) stated the Medical Director (MD) was unavailable for interview. She further stated the author of the nursing note dated 4/24/18 at 2:43 AM was completed by a nurse who recently died. The DON stated it was her expectation that the PNP or floor nurse would have contacted the RP prior to the prescribing of the multiple psychotropic medications.	F 580		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid	F 622		3/29/19

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under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident

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F 622	Continued From page 19 needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review, and Nurse Practitioner, Ombudsman and staff interviews, the facility failed to allow a resident to remain in the facility with behaviors and failed to provide written documentation which stated the reason the facility could not meet the resident's needs for 1 of 1 resident reviewed for facility-initiated transfer (Resident #169). Findings included: Resident #169 was admitted to the facility on	F 622	F622 Transfer and Discharge Requirements Corrective Action: Although resident #169□s wife agreed to transfer to another facility, we are unable to provide timely transfer notification, as the resident has discharged from our facility. Identification of others potentially at risk: Any resident that is transferred to a higher	

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F 622	Continued From page 20 3/1/18 with diagnoses that included Alzheimer's disease, psychosis, insomnia, aphasia (impaired language) and polyarthritis. A review of the most recent comprehensive Minimum Data Set (MDS) coded as a Significant Change in Assessment and dated 6/15/18 revealed the resident had severe cognitive impairment with wandering noted one to three days during the 7 day look back period and no behaviors coded. He required supervision of one staff member for bed mobility and transfers and received limited to extensive assistance of one staff member for all Activities of Daily Living (ADLs) except total assistance for bathing. The most recent MDS coded as a Quarterly assessment and dated 12/11/18 revealed the resident had severe cognitive impairment and displayed no wandering or other types of behaviors. He was independent with supervision for bed mobility and received limited to extensive assistance from one staff member for all ADLs except for total assistance with bathing. Review of the care plan dated 12/18/18 included wandering around the memory care unit, paranoid thoughts and episodes of thinking female residents were his wife. There were no care plans for other behaviors, discharge to home or assisted living facility. Review of Resident #169's nursing notes revealed that since admission he had behaviors such as wandering in and out of rooms, moving furniture, touching blinds, thinking female residents were his wife, urinating in inappropriate areas and insomnia. He had an aggressive episode on 11/19/18 with another aggressive	F 622	level of care if we are unable to meet their needs in our facility, and any resident that is being discharged for improved health, safety of others, health of individuals would be endangered, failure to pay for services, or the facility will cease to operate, can be affected by this alleged deficient practice and is identified at the time of transfer if medically necessary, and for the remaining reasons, are identified in the daily stand up meeting, attended by all managers. At the time of survey, the Social Worker reviewed the previous two months of discharges to determine if any other resident was affected by this alleged deficient practice. No other resident was found to be affected. Systemic Changes: Any resident that is transferred to a higher level of care if we are unable to meet their needs in our facility, and any resident that is being discharged for improved health, safety of others, health of individuals would be endangered, failure to pay for services, or the facility will cease to operate, will be given proper discharge notice, utilizing the Department of Medical Assistance Form 9050, which is a Nursing Home Notice of Transfer/Discharge form, completed by and sent by the Administrator, along with the responsible party and the Ombudsman. Information will be entered into the chart as to why the facility cannot meet the residents needs. An order will be entered to discharge the resident to where, what level of care, along with contact information of the	

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F 622	Continued From page 21 resident and an aggressive episode with his roommate on 12/16/18, at which time one on one supervision was initiated. No further reports of aggression were noted. Review of a physician note dated 12/20/18 mentioned the two aggressive behaviors and that the resident had progressive memory problems which led to his need of long-term care at the facility. He stated that the problem was worsening despite psychiatric and medication management and the behavior disturbance endangered other residents in the memory unit. He suggested that the resident could benefit from more intensive psychiatric intentions that were not available at the facility. A social service note dated 12/24/18 revealed the social worker spoke with the resident's spouse and informed her that the a Behavioral Management center did not accept the resident and that other placement would be looked at that would be more conducive to the resident. Review of the interdisciplinary discharge summary dated 12/31/18 revealed the resident was transferred to an Assisted Living Facility (ALF) accompanied by his spouse. The behavior section was marked as cooperative with a statement "most of the time" and activity section noted that the resident enjoyed socializing with others, reading the newspaper, spending time outdoors, cooking group and food related activities. Review of the medical records revealed no statement describing the specific needs of Resident #169 that could not be managed or met at the facility.	F 622	practitioner responsible for the care of the resident. Advance directive information, any special instructions, comprehensive care plan goals, and any other pertinent information will be provided to the facility receiving the resident. Monitoring: The Director of Social Services, using a QA auditing tool, will review all discharges, bi-weekly for the next 2 months, and then monthly for the next quarter to ensure that proper notification is given for any and all transfers and discharges. The results will be reported by the Director of Social Service, to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. The Administrator will be responsible to follow up on any recommendations out of the QAPI committee.	

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Resident #169 was transferred to an Assisted Living Facility on 12/31/18.

On 2/14/19 at 9:30am an interview was completed with the Director of Nursing. She stated that Resident #169's behaviors fluctuated and that he would go for days without any negative behaviors. She explained that the night of the aggressive incident towards his roommate (12/16/18) the two residents were separated, but there was not an empty room to move him to which is why one to one supervision was initiated, psychiatry services were involved, medication changes were made, and activity was increased. She explained that the Interdisciplinary Team (IDT) felt like he would do well in an ALF memory care setting due to his high functioning with behaviors.

On 2/14/19 at 9:40am an interview was conducted with the Administrator. He stated he felt the transfer was appropriate as the resident had impulsive behavior issues and "he was destroying the property". He further stated that Resident #169 would have good behaviors and then would have periods of aggressive behaviors.

An interview was held with Social Worker #1 on 2/14/19 at 9:45am. She explained that on admission the residents and responsible parties are told the facility could manage behaviors, but the goal was to keep all the resident's safe. She stated that at the time of the aggressive behaviors hospitalization or involuntary commitment (IVC) was not attempted, stating that the hospital would have sent him back and she didn't feel the magistrate would have agreed to an IVC. She further stated that it was felt a transfer

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was warranted due to the safety of the other residents and "we felt like with the group of men back there and their behaviors combined it wasn't a good fit". The social worker explained that after the inpatient behavioral health program did not accept the resident, it was felt an ALF would have been better due to his high function.

A phone interview was completed with the Psychiatric Nurse Practitioner (NP) on 2/14/19 at 9:50am. She stated that the resident was stable at the beginning of December and when she saw him on 12/4/18 he had had an aggressive incident towards his roommate. She explained that medications were altered, labs were completed to rule out any medical causes and one on one had been started. She stated that she assessed the resident again on 12/20/18 where he had thoughts of a female resident being his wife, one on one continued and the staff were educated on deflecting and redirecting him instead of arguing with him when he thought someone was his wife. When she followed up with him on 12/27/18 he was back at his baseline behavior, no longer on the one to one supervision, had no aggression or inappropriate behaviors and was not obsessing over other resident's being his wife. She stated that it was then she was informed he was moving to a different facility.

On 2/14/19 at 11:25am a phone call was made with the Ombudsman. She explained that the resident was admitted for long term care in the facility's memory care unit as the wife was no longer able to care for him at home due to his behaviors. She stated that the social worker verbally told the resident's wife of the need for a transfer on 12/24/18 but was not given a reason

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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F 622	Continued From page 24 or a written notice. On 2/14/19 at 12:15pm a phone call was placed to Resident #169's wife with a request for a return call. No return call was received from the responsible party.	F 622		
F 623 SS=D	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 (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	F 623		3/29/19

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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 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

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F 623	Continued From page 26 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 § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the responsible party (RP) in writing of the reason for the discharge/transfer when 2 of 2 sampled residents were discharged (Residents #8 and #169). Findings included: 1. Resident #8 was admitted to the facility on 7/3/15 with multiple diagnoses including Hypertension and Anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 11/11/18 indicated that Resident #8 had memory	F 623	F623 Notice Requirements before Transfer/Discharge Corrective Action: Resident #8 continues to live in the facility. We are unable to provide notification requirements for resident #169, as the resident is no longer in our facility. Identification of others potentially at risk: Any resident that is transferred to a higher level of care if we are unable to meet their	

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F 623	Continued From page 27 and decision making problems. Review of Resident #8's nurse's notes revealed that he was discharged to the hospital on 5/16/18 for gastrostomy tube (G) placement, 8/3/18 for low hemoglobin requiring blood transfusion, 10/21/18 for G tube replacement and 11/2/18 for low hemoglobin requiring blood transfusion. Review of Resident #8's electronic medical records revealed that the RP was not notified in writing when the resident was discharged to the hospital. On 2/14/19 at 8:40 AM, the Unit Coordinator was interviewed. She stated that nurses were calling the RP to inform her/him that the resident was discharged to the hospital but not in writing. On 2/14/19 at 11:52 AM, the Director of Nursing (DON) was interviewed. She stated that she didn't know the regulation that the RP has to be notified in writing when the resident was discharged to the hospital. The DON further indicated that the nurses were calling the RP to notify her/him that the resident was discharged to the hospital but not in writing. 2) Resident #169 was admitted to the facility on 3/1/18 with diagnoses that included Alzheimer's disease, psychosis, insomnia and polyarthritis. A review of the Minimum Data Set (MDS) coded as a Quarterly assessment and dated 12/11/18 revealed the resident had severe cognitive impairment. He was independent with supervision for bed mobility and received limited to extensive assistance from one staff member	F 623	needs in our facility, and any resident that is being discharged for improved health, safety of others, health of individuals would be endangered, failure to pay for services, or the facility will cease to operate, can be affected by this alleged deficient practice and is identified at the time of transfer if medically necessary, and for the remaining reasons, are identified in the daily stand up meeting, attended by all managers. At the time of survey, the Social Worker reviewed the previous two months of discharges to determine if any other resident was affected by this alleged deficient practice. No other resident was found to be affected. Systemic Changes: Any resident that is transferred to a higher level of care if we are unable to meet their needs in our facility, and any resident that is being discharged for improved health, safety of others, health of individuals would be endangered, failure to pay for services, or the facility will cease to operate, will be given proper discharge notice, utilizing the Department of Medical Assistance Form 9050, which is a Nursing Home Notice of Transfer/Discharge form, will now be completed by and sent by the Administrator, along with the responsible party and the Ombudsman. Information will be entered into the chart as to why the facility cannot meet the residents needs. An order will be entered to discharge the resident to where, what level of care, along with contact information of the practitioner responsible for the care of the	

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F 623	Continued From page 28 for all Activities of Daily Living (ADLs) except for total assistance with bathing. Resident #169 was transferred to an Assisted Living Facility on 12/31/18. Review of the medical records revealed no documentation of a written notice provided to the responsible party. During an interview on 2/13/19 at 2:00pm, Social Worker #1 stated that she was aware transfer and discharge notices should be provided for all facility-initiated transfers to the responsible party/resident. She further stated that since she had been in constant contact with the resident's spouse and verbal agreement was received a written discharge notice was not provided. On 2/13/19 at 3:45pm, an interview was completed with the Administrator. He stated that he was aware a written notice was required to be provided to all Responsible parties/residents when facility-initiated transfers were made. He provided a Performance Improvement Plan for citation F623 dated 1/29/19 and stated that it was intended to provide correct education to the social worker regarding who gets discharge and transfer notices. He confirmed that the corrective action did not involve the resident in question or written notices provided to responsible parties/residents. A review of the F623 Performance Improvement Plan dated 1/29/19 read in part that on 1/29/19 notification was received from an outside agency regarding the discharge information of Resident #129. The social worker stated that the wife was notified and did not disagree with the discharge. Corrective Action for those having potential to be	F 623	resident. Advance directive information, any special instructions, comprehensive care plan goals, and any other pertinent information will be provided to the facility receiving the resident. Monitoring: The Director of Social Services, using a QA auditing tool, will review all discharges, bi-weekly for the next 2 months, and then monthly for the next quarter to ensure that proper notification is given for any and all transfers and discharges. The results will be reported by the Director of Social Service, to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. The Administrator will be responsible to follow-up on any recommendation from the QA committee with additional training to be provided by the Clinical Resource Specialist, as indicated.	

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F 623	Continued From page 29 affected noted that all transfers for the past two months were reviewed with a list of all discharged resident's provided to the Ombudsman on 1/29/19. No corrective action was mentioned about written notices to responsible parties or residents. On 2/14/19 at 11:25am a phone interview occurred with the Ombudsman. She stated that a written notice was not provided to the resident's wife when a transfer from the facility had been discussed on 12/24/18. On 2/14/19 at 12:15pm a phone call was placed to Resident #169's wife with a request for a return call. No return call was received from the responsible party. An interview was conducted with the Administrator on 2/14/19 at 12:20pm. He stated it was his expectation for the facility to provide written transfer and discharge notices to the responsible party/resident's as appropriate.	F 623		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set assessment accurately in the areas of falls (Resident #270 and #28), medications (Residents #57 and #81), active diagnoses (Resident #8), bowel and bladder (Resident #119), and range of motion (Residents #41 and #61) for 8 of 30	F 641	F641 Accuracy of Assessments: Corrective Action: Corrections have been made in the areas of falls for Resident #270 and #28, medications for Residents #57 and #81, active diagnosis for Resident #8, bowl and	3/29/19

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F 641	Continued From page 30 sampled residents. The findings included: 1. Resident #270 was admitted on 9/1/17 with diagnoses that included dementia. A review of the incident reports for Resident #270 indicated she had a fall on 10/5/18 with complaints of pain to her elbow and a fall on 12/15/18 with no injury. The quarterly Minimum Data Set (MDS) assessment dated 12/27/18 indicated Resident #270' s cognition was severely impaired. She was assessed with one fall with no injury since her previous MDS assessment (10/2/18). An interview was conducted with MDS Nurse #1 on 2/14/19 at 10:08 AM. She stated that she coded Resident #270 ' s 12/27/18 quarterly MDS in the area of falls. The 10/5/18 incident report and the 12/15/18 incident report for Resident #270 were reviewed with MDS Nurse #1. She revealed she had not been made aware of the 10/5/18 fall for Resident #270. She explained that the incident reports were documented on hard copy forms and that she depended on staff to review all falls during the morning meetings, so she was made aware of any new incidents. She stated the 12/27/18 MDS for Resident #270 was coded inaccurately for falls. An interview was conducted with the Director of Nursing (DON) on 2/14/19 at 11:54 AM. She stated that she expected the MDS to be coded accurately.	F 641	bladder for Resident #119, and range of motion for Residents #41 and #61 on the Minimum Data Set assessment (MDS), by the MDS nurse. Corrections were completed the week of February 18th, and transmitted the same week. Identification of others potentially at risk: Residents that have had falls, are on medications, have diagnosis□s and/or require range of motion, are subject to this alleged deficient practice, and are identified through the care plan process. At the time of the survey, all resident□s assessments that were performed in the past 3 months were reviewed by the MDS/Care Plan Team to determine if there were any residents that required corrections to the MDS. No other resident was found to need corrections. Systemic Changes The MDS nurse has been re-educated by the regional nurse consultant on 03-15-2019 to ensure that all falls, residents requiring range of motion, active diagnosis□s, bowl and bladder, and counting of medications that require care plans, are identified and care planned for. The MDS nurse will attend each daily clinical meeting to ensure items are not missed. Monitoring The Director of Nurses, and/or her nurse manager, will perform audits bi-weekly for one month and then monthly for one quarter, to determine if all falls, residents requiring range of motion, active	

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F 641	Continued From page 31 2. Resident #28 was admitted to the facility on 11/2/18 with diagnoses that included psychotic disorder. A review of the incident reports for Resident #28 revealed he had one fall with no injury on 2/3/19 which was during the 2/4/19 MDS review period. The quarterly Minimum Data Set (MDS) assessment dated 2/4/19 indicated Resident #28 ' s cognition was severely impaired. He was assessed with no falls since his previous MDS assessment. An interview was conducted with MDS Nurse #1 on 2/14/19 at 10:08 AM. She stated that she coded Resident #28 ' s 2/4/19 quarterly MDS in the area of falls. The 2/3/19 incident report for Resident #28 was reviewed with MDS Nurse #1. She revealed she had not been made aware of the 2/3/19 fall for Resident #28. She explained that the incident reports were documented on hard copy forms and that she depended on staff to review all falls during the morning meetings, so she was made aware of any new incidents. She stated the 2/3/19 MDS for Resident #28 was coded inaccurately for falls. An interview was conducted with the Director of Nursing (DON) on 2/14/19 at 11:54 AM. She stated that she expected the MDS to be coded accurately. 3. Resident #57 was admitted to the facility on 3/6/18 with diagnoses that included psychotic disorder.	F 641	diagnosis□s, and accuracy of the count of medications on the MDS, are captured on the MDS. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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A review of Resident #57 ' s Medication Administration Record (MAR) for the look back period of his 1/4/19 MDS assessment (12/29/18 through 1/4/19) indicated he received routine Seroquel (antipsychotic medication) on 7 of 7 days.

The quarterly Minimum Data Set (MDS) assessment dated 1/4/19 indicated Resident #57 ' s cognition was intact. He received antipsychotic medication on 7 of 7 days during the review period. The Antipsychotic Medication Review for Resident #57 was coded to indicate that he had not received antipsychotic medication.

An interview was conducted with MDS Nurse #1 on 2/12/19 at 4:35 PM. She stated that she coded the medications section of Resident #57 ' s 1/4/19 quarterly MDS. She revealed that she miscoded the Antipsychotic Medication Review section of Resident #57 ' s 1/4/19 MDS. She stated that this section should have been coded to indicate that antipsychotics had been received by Resident #57 on a routine basis only. She reported that this was an error.

An interview was conducted with the Director of Nursing (DON) on 2/14/19 at 11:54 AM. She stated that she expected the MDS to be coded accurately.

4) Resident #119 was admitted to the facility on 10/8/18 and was discharged home on 10/25/18 with diagnoses that included cerebral palsy, muscle weakness, ileostomy status and pressure ulcer to sacral region.

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The most recent Minimum Data Set (MDS) coded as an admission assessment and dated 10/15/18 assessed the resident as having severely impaired cognition and required total dependence on one to two staff members for all Activities of Daily Living (ADL's) to include eating. The assessment had documentation that an external catheter and ostomy were present, however he was coded as always incontinent of urine instead of not rated due to external catheter status.

Review of the baseline care plan dated 10/9/18 revealed the resident had a condom catheter and an ileostomy.

Review of physician orders for October 2018 showed the need to monitor and assure the condom catheter was in place every shift for sacral wound healing.

On 2/13/19 at 5:00pm an interview was conducted with the MDS Nurse #1, who confirmed that the resident had an external catheter and the urinary incontinence section should have been coded as not rated.

An interview was completed with the Director of Nursing on 2/14/19 at 11:50am. She stated it was her expectation for the MDS to coded correctly.

5) Resident #81 was originally admitted to the facility on 6/5/17 with a readmission date of 6/1/18. Her diagnoses included malignant neoplasm of lung and cervix, Chronic Obstructive Pulmonary Disease (COPD), anxiety disorder and

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insomnia.

The most recent MDS coded as a modified Quarterly assessment and dated 1/11/19, revealed she was cognitively intact, alert and oriented and able to make needs known. She received supervision of one staff member for ADL's except needing limited assistance of one staff member for transfers. She was marked with diagnoses of anxiety disorder, COPD and cancer. It was coded that she received 6 days of an antianxiety during the 7 day look back period.

Review of the January 2019 MAR's revealed the resident received 5 days of an antianxiety on 1/5/19, 1/6/19, 1/7/19, 1/10/19 and 1/11/19.

On 2/13/19 at 8:25am an interview was conducted with the MDS Nurse #1. She confirmed that Resident #81 received only 5 days of an antianxiety during the look back period and stated that marking her for 6 days was an error.

An interview was completed with the Director of Nursing on 2/14/19 at 11:50am. She stated it was her expectation for the MDS to coded correctly.

6) Resident #41 was admitted to the facility on 12/6/18 with diagnoses that included CVA (stroke) with hemiplegia/hemiparesis (paralysis/weakness to one side of body), muscle weakness, dysphagia (difficulty swallowing) and muscle weakness.

Review of the most recent MDS coded as a

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Significant Change assessment and dated 1/30/19 revealed the resident was cognitively intact. He received limited to extensive assistance of one staff member for all ADL's to include eating. He was not coded with any impairment to upper or lower extremities.

Review of the resident's active care plan dated 1/7/19 revealed there was a care plan present for complications of left sided hemiplegia due to CVA.

Review of a physician progress note dated 12/19/18 noted Resident #41 had a CVA with left facial drooping and hemiplegia present.

Review of the Admission MDS dated 12/13/18 revealed the resident had limitation in range of motion to one side of his upper and lower extremity.

On 2/12/19 at 1:40pm, an observation and interview were conducted with Resident #41. He was lying in his bed watching TV and was observed with left sided hemiplegia.

An interview was conducted with NA #1 on 2/12/19 at 3:10pm who stated that she sets up his meal trays so that he could use his right hand since he was unable to use his left hand.

On 2/14/19 at 10:00am an interview was conducted with the MDS Nurse #1. She confirmed that limitation in range of motion for the assessment dated 1/30/19 was not coded in error.

An interview was completed with the Director of Nursing on 2/14/19 at 11:50am. She stated it

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F 641	Continued From page 36	F 641		

was her expectation for the MDS to coded correctly.
7. Resident #8 was admitted to the facility on 7/3/15 with multiple diagnoses including depression. The quarterly Minimum Data Set (MDS) assessment dated 11/11/18 indicated that Resident #8 had memory and decision making problems. The assessment further indicated that Resident #8 had received an antidepressant medication for 7 days during the assessment period. The assessment indicated that Resident #8 did not have a diagnosis of depression.

Resident #8 had a physician's order dated 5/19/18 for Zoloft (antidepressant drug) 50 milligrams (mgs) - give 0.5 tablet via gastrostomy (G) tube three times a day for depression.

The November 2018 Medication Administration Record (MAR) revealed that Resident #8 had received Zoloft from November 5-11, 2018.

On 2/12/19 at 4:23 PM, the MDS Nurse #1 was interviewed. She reviewed the records and verified that Resident #8 had received Zoloft during the assessment period for depression. The MDS Nurse stated that she should have coded the diagnosis of depression on the quarterly MDS assessment dated 11/11/18 but she missed it.

On 2/14/19 at 11:52 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessment to be coded accurately.

8. Resident #61 was admitted to the facility on 4/3/18 with multiple diagnoses including

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F 641	Continued From page 37 depression and anxiety. The quarterly Minimum Data Set (MDS) assessment dated 1/8/19 revealed that Resident #61 had no impairment in range of motion (ROM) on upper extremity. Resident #61's care plan dated 1/8/19 included at risk for contracture and the approaches included right hand and right elbow extension splint to be applied twice a day. On 2/11/19 at 9:45 AM and on 2/13/19 at 8:57 AM, Resident 61 was observed with his right hand/elbow contracted. On 2/13/19 at 8:15 AM, the MDS Nurse #1 was interviewed. She verified that Resident #61's right hand/arm was contracted and he had an order for splint for the contracture. She stated that she should have coded the quarterly MDS assessment dated 1/8/19 with impairment in ROM on upper extremity but she missed it. On 2/14/19 at 11:52 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessment to be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		3/29/19

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F 656	Continued From page 38 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document 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, and staff interview, the facility failed to implement care plan interventions related to falls (Resident #270) and contracture management (Resident #61) for 2 of 27 sampled residents.	F 656	F656 Develop Comprehensive Care Plans Corrective Action The care plans that are developed and transferred to the care cards for staff to	

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F 656	Continued From page 39 The findings: 1. Resident #270 was initially admitted to the facility on 9/1/17 and most recently readmitted on 2/7/19 with diagnoses that included dementia, anxiety, and repeated falls. The quarterly Minimum Data Set (MDS) assessment dated 10/2/18 indicated Resident #270' s cognition was severely impaired. She had no behaviors and no rejection of care. Resident #270 was assessed with wandering behaviors 1 to 3 days during the MDS 7 day review period. She required the limited assistance of 1 for bed mobility and transfers, supervision of 1 for walking in corridor and locomotion on/off the unit, and supervision with set up only for walking in room. Resident #270 had no impairment with range of motion and she utilized no mobility devices. She had no falls since her previous MDS assessment (7/2/18). Resident #270 ' s care plan included the identified need of the risk for fall related injury due to psychotropic drug use, vision, and dementia. This area was most recently revised on 10/3/18. The interventions were all initiated on 3/22/18 and included, in part, the provision of clean eyeglasses daily. An incident report dated 12/15/18 indicated Resident #270 had an observed fall at 5:20 PM in the dining room area of the secured unit. Resident #270 was trying to sit in a chair and missed the chair. A review of the post incident analysis dated 12/17/18 and completed by Unit Manager (UM) #1 indicated the post-incident follow up/action plan included, in part, to ensure Resident #270 ' s eyeglasses were in place while	F 656	know how to care for the residents they are assigned to for resident #270 has been updated to include the recent falls, and the care card has been corrected for resident #61, to include contracture management. Interventions for both residents are being carried out and monitored. Corrective Action for those having the potential to be affected At the time of the survey, residents that had an assessment and resultant care cards updated in the past two months, were reviewed by the Minimum Data Set care plan (MDS) nurse, and/or the nurse managers. to determine if interventions are being carried out for falls and contractures. No other resident was found to not be receiving planned interventions. Systemic Changes The MDS nurse has been re-educated by the regional nurse consultant on 3-15-19,to ensure that all falls and contractures that are captured on the MDS, have person-centered care plans developed for them. Nurses and Nursing Assistants have been reeducated regarding the implementations for falls and contracture management by the Assistant Director of Nurse at various meetings over the weeks of 2-18 and 2-25-19. No staff will be scheduled to work after 3-29-19 without being inserviced first. Monitoring The Director of Nurses, and/or her nurse	

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F 656	Continued From page 40 she was awake. An interview was conducted with UM #1 on 2/3/19 at 3:30 PM. The 12/15/18 incident report and 12/17/18 post incident analysis for Resident #270 were reviewed with UM #1. She revealed that Resident #270 had not had her eyeglasses on at the time of the fall. She stated she was not sure where the eyeglasses were at, but she knew they were not on Resident #270. She indicated that the root cause analysis for this fall was Resident #270 ' s impaired vision and impaired depth perception. UM #1 explained that this fall occurred when Resident #270 was attempting to sit in a chair. She further explained that she believed that if Resident #270 was not wearing her eyeglasses that she was unable to see the chair when she looked behind her. She indicated it was pertinent for staff to ensure Resident #270 had her eyeglasses in place to reduce the risk of another fall. An interview was conducted with NA #7 on 2/13/19 at 4:55 PM. She was asked if Resident #270 had any vision problems. She indicated that Resident #270 had impaired vision, she had eyeglasses, and her eyeglasses were supposed to be put in place by staff when she was out of bed as a fall risk intervention. She reported that Resident #270 always took her eyeglasses off. She stated that staff were supposed to put the eyeglasses on her, but she revealed they didn ' t always perform this task. NA #7 explained that most of the time when the eyeglasses were put on Resident #270 she just took them right back off. She acknowledged that eventhough Resident #270 frequently removed her eyeglasses that it was the staff ' s responsibility to continue to place the eyeglasses on the resident	F 656	manager, will perform audits bi-weekly by direct observations on all shifts and all days, randomly, for one month and then monthly for one quarter, to determine if the fall and contracture management interventions captured on the care cards,is being implemented by staff. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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as they were a fall risk intervention. The 1/31/19 incident report for Resident #270 ' s fall was reviewed with NA #7. NA #7 stated that this 1/31/19 fall for Resident #270 occurred when it was almost dinner time and she and NA #8 were trying to get all of the residents into the dining room. She reported that Resident #270 was at one of the tables in the dining room area and she tried to sit down but missed the chair and fell. She revealed that she thought Resident #270 ' s impaired vision was the cause of this fall as she believed the resident was unable to see where the chair was located when she went to sit down. She further revealed that Resident #270 had not had her eyeglasses on at the time of the fall. NA #7 was unable to recall where Resident #270 ' s eyeglasses were at when she fell on 1/31/19.

An interview was conducted with NA #8 on 2/14/19 at 9:00 AM. She stated that she had not worked regularly on the secured unit, but she was aware that Resident #270 had impaired vision and she had eyeglasses that were supposed to be put on her when she was out of bed. The 1/31/19 incident report for Resident #270 ' s fall was reviewed with NA #8. She stated that the 1/31/19 fall for Resident #270 occurred when it was almost dinner time and she and NA #7 were trying to get all of the residents into the dining room. She reported that Resident #270 was at one of the tables in the dining room area and she tried to sit down but missed the chair and fell. NA #8 was asked if Resident #270 had eyeglasses on at the time of the fall. She stated that she was not sure if Resident #270 had eyeglasses on at the time of fall. She explained that Resident #270 frequently removed her eyeglasses and placed them in random spots on the secured unit.

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An observation was conducted of Resident #270 on 2/13/19 at 4:45 PM. She was seated in a wheelchair at a table in the dining room area of the secured unit. Her eyeglasses were observed on the table in front of her.

An interview was conducted with NA #6 on 2/13/19 at 4:46 PM. She was asked if Resident #270 had any vision problems. She indicated that Resident #270 had impaired vision and she had eyeglasses. She stated that Resident #270 rarely kept her eyeglasses on. She indicated that the staff tried to encourage Resident #270 to wear the eyeglasses, but that she always took them off. NA #6 revealed she was aware the eyeglasses were not on Resident #270 at this present time. She acknowledged that although she knew the eyeglasses were not on the resident, she had not put them back on her.

An interview was conducted with MDS Nurse #1 on 2/14/19 at 10:08 AM. Resident #270 ' s care plan related to falls and the intervention of the provision of clean eyeglasses daily was reviewed with MDS Nurse #1. MDS Nurse #1 stated that Resident #270 had impaired vision that required the use of eyeglasses. She revealed that Resident #270 had multiple falls. She further revealed that Resident #270 sustained 3 falls (10/5/18 fall, 12/15/18 fall, and 1/31/19) that occurred when she was attempting to sit in a chair. She stated that through root cause analysis of the falls it was determined the causes were related to impaired vision and impaired depth perception. She indicated it was pertinent for staff to ensure Resident #270 had her eyeglasses in place to reduce the risk of another fall. MDS Nurse #1 was asked what staff were

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expected to do when Resident #270 removed her eyeglasses. She stated that staff were expected to put the eyeglasses back in place.

An interview was conducted with the Director of Nursing (DON) on 2/13/19 at 5:10 PM. She stated that she expected care plan interventions related to falls to be consistently implemented to prevent recurrence of falls.

2. Resident #61 was admitted to the facility on 4/3/18 with multiple diagnoses including anxiety and depression. The quarterly Minimum Data Set (MDS) assessment dated 1/8/19 revealed that Resident #61 had no impairment in range of motion (ROM) on upper extremity.

Resident #61's care plan dated 1/8/19 included at risk for contracture and the approaches included right hand and right elbow extension splint to be applied twice a day for 2 hours.

On 2/12/19 at 4:10 PM and on 2/13/19 at 8:57 AM, Resident #61 was observed with the right hand/elbow contracted and with no splints noted.

On 2/13/19 at 9:00 AM, Nursing Assistant (NA) #1 was interviewed. She stated that she was assigned to Resident #61 but she had not been applying the splint during her shift. NA #1 showed the NA care guide and stated that Resident #61 should have the splint on his right hand and right elbow 2 times a day for 2 hours but she didn't know what time to apply.

On 2/13/19 at 9:05 AM, Nurse #1 was interviewed. She stated that she was assigned to Resident #61. Nurse #1 stated that she didn't know that Resident #61 was supposed to have a

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F 656	Continued From page 44 splint. She revealed that she was new to the facility and this was her first time assigned to Resident #61. Nurse #1 further stated that the Medication Administration Record (MAR) indicated to remove the splint at 10:00 AM and 6:00 PM but she didn't know what the doctor's order said for the splint application. She reviewed the doctor's order for the splint and stated that the order indicated to apply the splints twice a day for 2 hours. Nurse #1 indicated that the splints should have been applied at 8:00 AM and removed at 10:00 AM and applied at 4:00 PM and removed at 6:00 PM. On 2/13/19 at 3:20 PM, NA #2 was interviewed. NA #2 stated that she regularly cared for Resident #61 on the second shift (3 PM - 11 PM) and she didn't know that Resident #61 was supposed to wear splints on his right hand and elbow from 4:00 PM to 6:00 PM each day. On 2/13/19 at 9:15 AM, the Nurse Coordinator was interviewed. She stated that she expected the NA to apply the splints and for the nurses to check behind them. On 2/14/19 at 11:52 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected nursing to apply the splints as care planned.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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.	F 657		3/29/19

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F 657	Continued From page 45 (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 observation, record review, and staff interview, the facility failed to review and revise care plans in the areas of wandering (Residents #28 and #88), falls (Resident #270), and behaviors (Resident #9) for 4 of 27 sampled residents. The findings included: 1. Resident #270 was initially admitted to the facility on 9/1/17 and most recently readmitted on 2/7/19 with diagnoses that included dementia, anxiety, and repeated falls.	F 657	F657 Care Plan Timing and Revision Corrective Action Resident #88 is currently out of the facility. Resident #28□s care plan has been updated to reflect no wanderguard is being used. Resident #270□s careplan has been updated to include recent falls and the careplan for Resident #9 has been updated to include behaviors. These updates have been completed by the Minimum Data Set (MDS) care plan nurse, during the week of February 18. Corrections were transmitted February 13, through the 15th.	

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F 657	Continued From page 46 The quarterly Minimum Data Set (MDS) assessment dated 10/2/18 indicated Resident #270' s cognition was severely impaired. She had no behaviors and no rejection of care. She required the limited assistance of 1 for bed mobility and transfers, supervision of 1 for walking in corridor and locomotion on/off the unit, and supervision with set up only for walking in room. Resident #270 had no impairment with range of motion and she utilized no mobility devices. She had no falls since her previous MDS assessment (7/2/18). Resident #270 ' s care plan included the identified need of the risk for fall related injury due to psychotropic drug use, vision, and dementia. This area was most recently revised on 10/3/18. The interventions were all initiated on 3/22/18. An incident report dated 10/5/18 indicated Resident #270 had an observed fall at 2:45 PM in the living room area of the secured unit that resulted in elbow pain. A Nursing Assistant (NA) witnessed Resident #270 trying to sit in a chair positioned near a door when she slid down the door and hit her elbow on the door handle. There were no revisions made to Resident #270 ' s care plan related to falls after this 10/5/18 fall. An incident report dated 12/15/18 indicated Resident #270 had an observed fall at 5:20 PM in the dining room area of the secured unit. Resident #270 was trying to sit in a chair and missed the chair. There were no revisions made to Resident #270 ' s care plan related to falls after this 12/15/18 fall. An interview was conducted with UM #1 on 2/3/19 at 3:30 PM. The 12/15/18 incident report was	F 657	Corrective Action for those having the potential to be affected At the time of the survey, all residents that had an assessment in the past three months were reviewed by the Minimum Data Set (MDS) assessment care plan nurse, and/or the nurse managers, to determine if comprehensive care plans have been updated for all recent falls, wandering behaviors, and behaviors in general. No other resident was found to not have timely updated care plans or care cards. Systemic Changes The MDS nurse has been re-educated by the regional nurse consultant on 3-15-19, to ensure that all falls, behaviors, and wandergurads are captured timely on the person-centered care plans and are updated on the care cards. The MDS nurse is now going to the daily clinical team meeting and is revising care plans and care cards as necessary. Monitoring The Director of Nurses, and/or her nurse manager, will perform audits bi-weekly for one month and then monthly for one quarter, to determine if there are any residents who have had wandering episodes, falls, and/or behaviors. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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reviewed with UM #1. She indicated that the root cause analysis for this fall was Resident #270 ' s impaired vision and impaired depth perception. UM #1 explained that this fall and the 10/5/18 fall had both occurred when Resident #270 was attempting to sit in a chair.

A nursing note dated 1/31/19 indicated the nurse (Nurse #6) was notified by an NA that Resident #270 was trying to sit in a chair for dinner and missed the chair landing on the floor.

An incident report dated 1/31/19 and completed by Nurse #6 indicated Resident #270 had an observed fall at 5:45 PM in the dining room area of the secured unit. NA #7 and NA #8 were noted as caregivers for Resident #270 at the time of the fall. There were no revisions made to Resident #270 ' s care plan related to falls after this 1/31/19 fall.

The NA care guide for Resident #270, most recently revised on 2/1/19, indicated that Resident #270 was a fall risk and she was to be observed when trying to sit down.

An interview was conducted with MDS Nurse #1 on 2/14/19 at 10:08 AM. Resident #270 ' s NA care guide was reviewed with MDS Nurse #1. She stated that the facility had just recently began putting dates on the NA care guides so that they were able to know when interventions were implemented. She reported that the intervention of observing Resident #270 when she was trying to sit down was put in place on the NA care guide following her 12/15/18 fall and before her 1/31/19 fall. She explained that the root cause analysis of Resident #270 ' s 12/15/18 fall was impaired vision and impaired depth perception. She

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further explained that that the 10/5/18 fall, 12/15/18 fall, and 1/31/19 fall all occurred when Resident #270 was attempting to sit in a chair. Resident #270 ' s care plan related to falls was reviewed with MDS Nurse #1. She confirmed the intervention of observing Resident #270 when she was trying to sit down was not added to her care plan. She revealed that she should have revised Resident #270 ' s interventions related to falls when she added it to the NA care guide.

An interview was conducted with the Director of Nursing on 2/13/19 at 5:10 PM. She stated that she expected interventions developed through root cause analyses to be added to the care plans interventions to prevent the recurrence of falls.

2. Resident #28 was admitted to the facility on 11/2/18 with diagnoses that included dementia and psychosis.

The admission Minimum Data Set (MDS) assessment dated 11/2/18 indicated Resident #28 ' s cognition was severely impaired. He was assessed with wandering behaviors on 1 to 3 days and a wander elopement alarm was not in use.

Resident #28 ' s active care plan, last reviewed on 2/11/19, included the focus area of wandering and exit seeking. The interventions for this focus area included, in part, ensure that 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 on each shift and

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functioning daily.

An observation was conducted of Resident #28 on 2/13/19 at 11:44 AM. Resident #28 was ambulating with a steady gait in a common area in the secured unit of the facility. He had no wanderguard in place.

An interview was conducted with Nursing Assistant (NA) #6 on 2/13/19 at 11:45 AM. She stated that Resident #28 had no wanderguard in place. NA #6 further stated that no residents on the secured unit of the facility had wanderguards.

An interview was conducted with MDS Nurse #1 on 2/14/19 at 10:08 AM. Resident #28 ' s care plan related to wandering and the intervention of the wanderguard was reviewed with MDS Nurse #1. She stated that this intervention was not accurate and confirmed that Resident #28 had no wanderguard. She explained that she thought Resident #28 was first admitted to an unsecured unit and had a wanderguard but was moved back to the secured unit shortly after admission and the wanderguard was removed. MDS Nurse #1 revealed that Resident #28 ' s care plan related to wandering should have been revised and the intervention for the wanderguard should have been removed.

An interview was conducted with the Director of Nursing on 2/13/19 at 5:10 PM. She stated that she expected care plan interventions to be reviewed and revised to reflect the current status of the resident.

3) Resident #9 was admitted to the facility on 7/30/18 with diagnoses that included vascular dementia with behavioral disturbance, psychosis and anxiety disorder.

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A review of the most recent Minimum Data Set (MDS) coded as a Significant Change in Condition and dated 11/12/18 assessed the resident with severe cognitive deficits. She received extensive to total assistance of one to two staff members for all Activities of Daily Living (ADL's) except for supervision with eating. She was marked with other behavioral symptoms not directed towards others one to three days during the look back period.

Review of Resident #9's active care plan dated 11/30/19 revealed she was care planned for cognitive impairment, sun downing, resistance to care and an actual behavior of hitting and cursing at her spouse, but no care plan was present for the repetitive statements that were made daily.

Review of the nursing notes from November 2018 to present revealed the resident had repetitive statements such as "Help me, where's Bill, take home, I love you, I need some water" with no distress noted.

Review of the Behavior Data and Analysis Reports dated 12/5/18, 1/4/19 and 2/8/19, showed repetitive statements were present.

Review of a PACE (Program of All-Inclusive Care for the Elderly) physician progress note dated 11/21/18 noted that the resident called out for help throughout the day and the night despite not having any complaints.

On 2/12/19 at 4:00pm Resident #9 was observed sitting in her wheelchair (WC) in the common area. She was yelling out "help me" repeatedly with no distress noted. Resident #9 was able to

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engage in simple conversation but when the conversation ended the repetitive statements began.

On 2/13/19 at 8:45am Resident #9 was observed coming out of the dining room following breakfast. She stated that she was going to PACE that day and began to state "take me now" repeatedly. She was able to engage in conversation but when the conversation ended, the repetitive statements began.

An interview was conducted with the MDS Nurse #1 on 2/13/19 at 3:40pm. She explained that the Social Workers manage the mood and behavior care plans, but she would expect the resident's repetitive vocalizations to be care planned.

On 2/13/19 at 4:00pm an interview was completed with Social Worker #1. She stated that she was aware of Resident #9's repetitive vocalizations and it was an oversight to not include it on the care plan.

On 2/14/19 at 11:50am an interview was held with the Director of Nursing who stated that it was her expectation for the care plan to be an accurate reflection of the resident in behaviors.

4.
Resident #88 was admitted to the facility on 11/17/17 with diagnoses of anxiety, paraplegia, seizure, and injury of the spinal cord.

A review of Resident #88 ' s nurses ' note dated 10/17/18 at 5:00 pm revealed the resident exited the building alone onto the front patio with other residents and a staff member immediately assisted him back in until staff was ready to

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accompany the resident outside (first sole incident not independent outside).

A review of the resident ' s prior care plans back to October of 2018 did not reveal goals and interventions for elopement potential or wander alarm.

A review of Resident #88 ' s Risk for Elopement evaluation dated 11/30/18 revealed the resident verbalized he wanted to leave the facility, had a motorized mobility device (motorized wheel chair) and was an elopement risk.

A review of Resident #88 ' s quarterly MDS dated 12/2/18 revealed an intact cognition.

A review of the resident ' s current care plan updated 1/16/19 did not identify the resident as an elopement risk or having a wander alarm bracelet.

A review of Resident #88 ' s quarterly Minimum Data Set (MDS) dated 1/18/19 revealed the resident had adequate hearing, clear speech and was understood and understands. The cognition was unable to be assessed. The resident required extensive assistance of 2 staff for all transfers and bed mobility and of 1 staff for all other activities of daily living (ADLs). The resident received as needed and scheduled pain medication. Wander elopement alarm was not coded.

On 02/11/19 at 9:15 am an interview was conducted with Resident #88. The resident stated that the staff tried to put a wander alarm (bracelet that triggers a door alarm when approached) on

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his extremity and he refused so staff placed the device on his wheel chair.

On 2/11/19 at 9:15 am an observation was done of Resident #88 ' s wheel chair and a wander alarm bracelet was attached to the lower left side. The bracelet was tested to be working.

On 2/13/19 at 2:00 pm an interview was conducted with NA #3 who stated she was regularly assigned on day shift to Resident #88. NA #3 stated that she remembered the resident had gone onto the front porch with other residents without supervision on 10/17/19. The resident had made comments to multiple staff members about not wanting to be here. Nurse #3 was aware that the resident was an elopement risk in the past (wore a wander alarm on his person), but not at present.

On 2/13/18 at 3:00 pm an interview was conducted with NA #2 who stated she was regularly assigned to Resident #88. NA #2 commented that she remembered when the resident went outside the front door to sit on the porch with other residents last October. The resident was not independent and had to wait for a staff member to accompany him.

On 2/13/19 at 3:25 pm an interview was conducted with Nurse #4 who was regularly evening-shift assigned to Resident #88. Nurse #4 stated that she was not aware the resident had a wander alarm on his wheel chair and that the resident was an elopement risk.

On 2/13/19 at 4:10 pm an interview was conducted with the Director of Nursing (DON) who stated she was aware Resident #88 had a

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F 657	Continued From page 54 wander alarm bracelet attached to his wheel chair and was an elopement risk and needed the wander alarm to prevent elopement. The DON was not aware that there was no care plan for the wander alarm bracelet and elopement risk. On 2/14/19 at 1:30 pm an interview was conducted with MDS Coordinator who stated she was responsible for the residents ' care plan development and revision. She was not aware that the resident had a wander alarm device on his wheel chair or was an elopement risk. The MDS Coordinator confirmed the resident ' s elopement risk should be on the resident ' s plan of care.	F 657		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 688		3/29/19

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F 688	Continued From page 55 Based on record review, observation, and staff and physician interview, the facility failed to apply the splints as ordered by the physician (Resident #61) and failed to provide range of motion (Resident #39) to maintain or prevent further decrease in range of motion for 2 of 3 sampled residents reviewed for range of motion. Findings included: Resident #61 was admitted to the facility on 4/3/18 with multiple diagnoses including anxiety and depression. Resident #61 had a doctor's order dated 6/28/18 to wear right elbow extension splint and right hand T-bar splint. The splinting schedule was twice a day (morning and afternoon) for 2 hours each time. The order indicated that the resident required total assist with the splint application and for nursing to apply. The quarterly Minimum Data Set (MDS) assessment dated 1/8/19 revealed that Resident #61 had no impairment in range of motion (ROM) on upper extremity. Resident #61's care plan dated 1/8/19 included at risk for contracture and the approaches included right hand and right elbow extension splint to be applied twice a day for 2 hours. The Nurse Aide (NA) care guide posted in Resident #61's closet was reviewed. The care guide included to apply right elbow extension and right hand T bar splint twice a day for 2 hours. The care guide did not specify the times of the splint application.	F 688	688 Increase/Prevent Decrease ROM/Mobility Corrective Action: Resident #61 no longer resides at facility. If he returns to facility his splint will be reassessed and clarified for appropriateness. Resident #39□s orders have been reviewed and his order for Restorative Nursing Services has been discontinued as he is not appropriate for restorative program. He receives passive range of motion with his daily care, provided by the nursing assistant assigned to him. Identification of other residents at risk: Other residents with orders for splints and residents that require passive range of motion with care are potentially at risk. A list has been obtained from therapy, of residents that wear splints. The orders have been reviewed, and wearing schedules for splints will be clarified as needed. A review of care cards has been completed by the Minimum Data Set Nurse, the week of February 18th, to ensure that schedule for splints is clear to certified nursing assistants (CNAs). The order will also be checked to ensure that it pulls to the Medication Administration Record (MAR) so nursing can remind and/or report to CNAs wearing schedule for splints. Nursing in conjunction with therapy will complete an audit to determine what residents are not on Restorative Nursing that would require passive range of motion (PROM) with care. This audit will	

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F 688	Continued From page 56 On 2/12/19 at 4:10 PM and on 2/13/19 at 8:57 AM, Resident #61 was observed with the right hand/elbow contracted and with no splints noted. On 2/13/19 at 9:00 AM, Nursing Assistant (NA) #1 was interviewed. She stated that she was assigned to Resident #61 but she had not been applying the splint during her shift. NA #1 showed the NA care guide and stated that Resident #61 should have the splint on his right hand and right elbow 2 times a day for 2 hours but she didn't know what time to apply. On 2/13/19 at 3:20 PM, NA #2 was interviewed. NA #2 stated that she regularly cared for Resident #61 on the second shift (3 PM - 11 PM) and she didn't know that Resident #61 was supposed to wear splints on his right hand and elbow from 4:00 PM to 6:00 PM each day. On 2/13/19 at 9:05 AM, Nurse #1 was interviewed. She stated that she was assigned to Resident #61. Nurse #1 stated that she didn't know that Resident #61 was supposed to have a splint. She revealed that she was new to the facility and this was her first time assigned to Resident #61. Nurse #1 further stated that the Medication Administration Record (MAR) indicated to remove the splint at 10:00 AM and 6:00 PM but she didn't know what the doctor's order said for the splint application. She reviewed the doctor's order for the splint and stated that the order indicated to apply the splints twice a day for 2 hours. Nurse #1 indicated that the splints should have been applied at 8:00 AM and removed at 10:00 AM and applied at 4:00 PM and removed at 6:00 PM. On 2/13/19 at 9:15 AM, the Unit Coordinator was	F 688	identify what joints require PROM and this information will be recorded on care cards OR the CNA documentation system Point of Care. Systemic Changes: CNA□s and licensed staff have been inserviced by the ADON/staff development Coordinator the week of March 11th for full time, part time, and PRN staff. Staff not inserviced by March 29 will not be able to work until educated on splint wearing schedules, passive range of motion exercises, as well as where this information can be found for reference and documentation. Monitoring: Audits will be completed by the Director of Nurses and/or the Assistant Director of Nurses, weekly for residents with splints to ensure wearing schedules are being followed and observation of 2 residents per week for PROM to ensure provision of PROM is being provided for 4 weeks and then monthly for 2 months. The results will be reported by the DON, to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from the QA committee.	

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interviewed. She stated that she expected the NA to apply the splints and for the nurses to check behind them.

On 2/14/19 at 11:52 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected nursing to apply the splints as ordered. The DON confirmed that Resident #61's hand and elbow splint were to be applied daily for 2 hours at 8:00 AM and 4:00 PM.

2.
Resident #39 was admitted to the facility on 8/19/14 with diagnoses to include anoxic brain damage, tracheostomy, contracture, convulsions, abnormal posture, and muscle spasm.

A review of Resident #39 ' s Minimum Data Set dated 6/19/18 revealed range of motion of upper and lower extremities was impaired on both sides.

Resident #39 had a physician order dated 7/6/18 specified therapy services discontinued due to achieved goals. The resident was recommended to get out of bed into high-back wheel chair 3-4 times per week for up to 2 hours per day to decrease risk of skin breakdown and to interact with environment to fullest potential.

Resident #39 had a physician order dated 7/12/18 for restorative nursing services.

Resident #39 had a physician order dated 9/26/18 for staff to place a pillow between the knees.

A review of Resident #39 ' s quarterly Minimum Data Set (MDS) dated 12/12/18 revealed the

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resident was in a persistent and vegetative state. The resident required extensive, total care for all ADLs. The relevant active diagnoses were seizure, persistent and vegetative state, tracheostomy, contracture, abnormal posture, and muscle spasm.

A review of the Resident #39 ' s care plan dated 12/18/18 revealed goals and interventions for contractures and potential for further contractures related to non-functional mobility. The goal was for the resident not to develop any further contractures and interventions were body alignment, therapy evaluation for assistive devices, report findings to physician, and splints as ordered. No intervention for range of motion was identified. The nursing assistant care card had no task for passive range of motion

On 2/11/19 at 9:30 am an observation was done of Resident #39 who was in his bed with the head of the bed elevated. The resident had moderate to severe contracture of his arms, wrists, and hands and had a rolled wash cloth inside of both hands. The resident had severe contractures to bilateral legs including his hips, knees, and ankles with severe foot drop. The resident had a pillow between his knees and bilateral heel protectors to reduce pressure.

On 2/13/19 at 10:30 am an interview was conducted with the Director of Nursing (DON) who stated the resident was not receiving restorative nursing at this time and for the past 2 months of look back in the record. The DON was aware of the resident ' s severity of contractures and commented that the resident was admitted to the facility with contractures and has periodically received therapy services but was not aware

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when the last service was provided. The DON commented that the contractures were too severe to provide passive range of motion.

On 2/13/19 at 10:50 am an observation was conducted with Nurse #4 was assigned to Resident #39. Nurse #4 observed the resident ' s position on his side and pressure prevention devices and exited the room.

On 2/13/19 at 10:50 am an interview was conducted with Nurse #4 who stated Resident #39 was severely contracted and received rolled wash clothes to each hand. Nurse #4 also stated that the resident was not receiving range of motion treatment (restorative nursing) other than when the resident received a bath it required 2 staff to move his legs due to the severity of the contractures. Nurse #4 commented that she was not aware of nursing assistant care card having task or being provided passive range of motion.

On 2/14/19 at 12:50 pm an interview was conducted with Resident #39 ' s physician who stated the resident was admitted with fairly significant contractures that can worsen without treatment. The physician felt the resident would require and expect continued passive range of motion therapy to prevent worsening contractures. The physician commented that there was an order for nursing rehabilitation after therapy services (dated 7/12/18). If the resident had not received regular passive range of motion services since therapy discharged (7/6/18) he would have had experienced increased contracture of his joints.

On 2/14/19 at 2:30 pm an interview was conducted with the DON who stated that she

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F 688	Continued From page 60 expected a resident who had contractures to receive as least passive range of motion by nursing assistants to prevent further contracture. On 2/14/19 at 3:00 pm an interview was conducted with the Rehabilitation Director who stated that the resident last had therapy services on 7/6/18 and nursing rehabilitation was not following for continued range of motion. Therapy discharged to staff nursing (not restorative nursing) and they would be responsible. The resident was not a candidate for splints on the lower extremities due to the severity of the contracture. The resident's contractures were severe. The Director had not assessed the resident since 7/16/18 and was not aware if the contractures were at baseline.	F 688		
F 689 SS=G	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 observation, record review, and staff interview the facility failed to implement effective interventions for a resident with repeated falls for 1 of 8 residents (Residents #270) reviewed for falls. One of these falls resulted in Resident #270 sustaining a femur fracture (fracture of the upper part of the thigh bone).	F 689	F 689 Free from accidents Corrective Action Resident #270'□s care card has been updated by the Minimum Data Set Nurse (MDS) at the time of survey to reflect the fall risk and to reflect history and dates of falls as well as the interventions have	3/29/19

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F 689	Continued From page 61 The findings included: Resident #270 was initially admitted to the facility on 9/1/17 and most recently readmitted on 2/7/19 with diagnoses that included dementia, anxiety, repeated falls and fractured right femur. The quarterly Minimum Data Set (MDS) assessment dated 10/2/18 indicated Resident #270' s cognition was severely impaired. She had no behaviors and no rejection of care. She required the limited assistance of 1 for bed mobility and transfers, supervision of 1 for walking in corridor and locomotion on/off the unit, supervision with set up only for walking in room, and extensive assistance of 1 for toileting. Resident #270 had no impairment with range of motion and she utilized no mobility devices. She was assessed as not steady, but able to stabilize without assistance for moving from seated to standing position, walking, turning around and facing the opposite direction while walking, and moving on and off the toilet. She was steady at all times for surface to surface transfers. She had no falls since her previous MDS assessment (7/2/18). Resident #270 ' s care plan included the identified need of the risk for fall related injury due to psychotropic drug use, vision, and dementia. This area was most recently revised on 10/3/18. The goals were to be free from injury daily through next assessment (3/26/19) and free from falls due to side effects daily through next assessment (3/6/19). The interventions were all initiated on 3/22/18 and included, in part, the provision of clean eyeglasses daily. The remaining interventions were to administer medications as ordered, abnormal involuntary	F 689	been updated. Resident #270 has had an eye exam and continues to choose to not wear her glasses frequently. The care plan has been updated to reflect this. Corrective action for those who have the potential to be affected At the time of survey, all care cards were reviewed by the Director of Nurses and the unit managers. The cards were reviewed for the most recent quarterly fall risk assessment that noted medium to high risk for falls to ensure the fall risk was noted on the care card. No other care card was found to be affected by this alleged deficient practice. Systemic changes Care cards for residents that have had a fall, will be brought to the daily clinical ops meeting, reviewed by the interdisciplinary team, and will be updated by the unit manager and/or MDS Care Plan Nurse, for any falls and/or change in fall risk. All licensed staff has been in- serviced the week of March 11th by the Staff Development Coordinator, to include information on the care card regarding history of falls and fall risk. No staff will be allowed to work after March 29, if not inserviced. Monitoring The Director of Nurses, using a QA auditing tool, will review all care cards, weekly for the next 2 months, and then will review random care cards weekly for the next two months to ensure that any and all falls are available for the aide to	

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F 689	Continued From page 62 movement scale (AIMS) assessment every 6 months, behavior management per protocol, complete fall risk per protocol, encourage guest to wear non-skid foot wear when out of bed, assist guest as needed, keep items of frequent use within reach, low bed, observe for fatigue and/or unsteadiness and encourage rest periods. Review of the fall risk assessment dated 9/14/18 and signed as complete by Unit Manager (UM) #1 on 10/2/18 indicated Resident #1 had no falls in the previous 3 months. She was assessed as intermittently confused, ambulatory, and incontinent. She had adequate vision (with or without assistive device) and a normal gait/balance. Resident #270 took 3-4 at risk medications and had 3 or more at risk conditions and was at low risk for falls. Review of the incident report dated 10/5/18 indicated Resident #270 had an observed fall at 2:45 PM in the living room area of the secured unit that resulted in elbow pain. A Nursing Assistant (NA) witnessed Resident #270 trying to sit in a chair positioned near a door when she slid down the door and hit her elbow on the door handle. The immediate interventions to prevent recurrence was to make sure nothing was close by the door. A review of the post incident analysis dated 10/8/18 and completed by UM #1 indicated the post-incident follow up/action plan was for Resident #270 ' s supervision to be modified to prevent the recurrence of a fall. There was no care plan revision related to Resident #270 ' s fall risk interventions after the 10/5/18 fall. An interview was conducted with UM #1 on 2/3/19 at 3:30 PM. The 10/5/18 incident report and	F 689	review, as well as the fall risk. In addition, the DON and Unit Managers will conduct random audits of residents to ensure interventions are in place as care planned for. The results will be reported by the DON, to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from the QA committee with additional training to be provided by the Clinical Resource Specialist, as indicated.	

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10/8/18 post incident analysis for Resident #270 were reviewed with UM #1. UM #1 was asked how Resident #270 ' s supervision was modified after the 10/5/18 fall. She stated that she wasn ' t sure, but she thought it meant for "closer" monitoring of Resident #270. She verified that this "closer" monitoring had not been added to Resident #270 ' s care plan related to falls.

Review of the fall risk assessment dated 12/14/18 and signed as complete by UM #1 on 12/18/18 indicated Resident #1 had 1-2 falls in the previous 3 months. She was assessed as intermittently confused, ambulatory, and incontinent. She had adequate vision (with or without assistive device), gait problems (such as jerking, shuffling), and a change in her gait pattern when walking through doorways. Resident #270 took 3-4 at risk medications and had 3 or more at risk conditions and was at risk for falls.

Review of the incident report dated 12/15/18 indicated Resident #270 had an observed fall at 5:20 PM with no injury in the dining room area of the secured unit. Resident #270 was trying to sit in a chair and missed the chair. The immediate intervention to prevent recurrence was to assess for injury. A review of the post incident analysis dated 12/17/18 and completed by UM #1 indicated the post-incident follow up/action plan was to ensure Resident #270 ' s eyeglasses were in place while she was awake and to check on her eye exam.

Review of the resident ' s care plan revealed there was no care plan revision related to Resident #270 ' s fall risk interventions after the 12/15/18 fall.

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An interview was conducted with UM #1 on 2/3/19 at 3:30 PM. The 12/15/18 incident report and 12/17/18 post incident analysis for Resident #270 were reviewed with UM #1. She revealed that Resident #270 had not had her eyeglasses on at the time of the fall. She indicated that the root cause analysis for this fall was Resident #270 ' s impaired vision and impaired depth perception. UM #1 explained that this fall and the 10/5/18 fall had both occurred when Resident #270 was attempting to sit in a chair. She was asked if Resident #270 had an eye exam after this fall and she stated that she was unsure. She reported that the Medical Records Director (MRD) scheduled appointments for eye examinations.

An interview was conducted with the MRD on 2/13/19 at 4:25 PM. She confirmed that she was responsible for scheduling eye examinations for the residents. She indicated that the eye care provider came to the facility twice per year and that Resident #270 was last seen by this eye care provider for an examination in May of 2018. She stated that she contacted this eye care provider and they indicated they were unable to see Resident #270 until 1 year from her previous appointment had passed. She reported that this would have made her next eye examination appointment May of 2019. The MRD indicated that because Resident #270 ' s 12/15/18 fall was thought to be caused by impaired vision She confirmed that Resident #270 had not been seen for an eye examination since March of 2018.

Review of the nursing note dated 1/31/19 indicated the nurse (Nurse #6) was notified by an NA that Resident #270 was trying to sit in a chair for dinner and missed the chair landing on the

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floor. Resident #270 initially denied pain or discomfort when assessed by the nurse. The resident was transferred to a shower chair for easier transportation to her room and as she was assisted into bed she began to cry and scream loudly when her right leg was touched or moved. Resident #270 was medicated for pain and the Nurse Practitioner (NP) was contacted and she ordered x-rays of the right hip, right thigh, right knee, and right ankle. X-ray results were received and were all negative for fracture or dislocation. The NP was notified and the x-ray results were faxed for her review.

Review of the incident report dated 1/31/19 completed by Nurse #6 indicated Resident #270 had an observed fall at 5:45 PM in the dining room area of the secured unit. This fall resulted in right hip. NA #7 and NA #8 were noted as caregivers during the time of the fall. Nurse #6 noted that the immediate interventions to prevent recurrence was re-education to Resident #270 on waiting for assistance. A review of the post incident analysis dated 2/1/19 and completed by UM #1 indicated the post incident follow up/action plan was for x-rays, an eye exam, and Physical Therapy evaluation. There was no care plan revision related to Resident #270 ' s fall risk interventions after the 1/31/19 fall.

An interview was conducted with Nurse #6 on 2/14/19 at 8:50 AM. She stated that she had only worked on the secured unit a handful of times and was not very familiar with residents who resided on that unit. The 1/31/19 incident report was reviewed with Nurse #6. She stated that she had not observed this fall for Resident #270 as she split her shift between the secured unit and

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the unsecured unit.

An interview was conducted with NA #7 on 2/13/19 at 4:55 PM. She stated that she regularly worked on the secured unit and that she was familiar with Resident #270. NA #7 indicated that Resident #270 had impaired vision and she had eyeglasses but always took her eyeglasses off and staff were supposed to put the eyeglasses on her but she revealed they didn ' t always perform this task. NA #7 explained that most of the time when the eyeglasses were put on Resident #270 she just took them right back off. She further explained she thought the eyeglasses weren ' t helping Resident #270 ' vision because they were so old, and she thought Resident #270 needed an eye examination to get an updated prescription for new eyeglasses. NA #7 acknowledged her awareness that this intervention of making sure Resident #270 ' s eyeglasses were on when she was out of bed was listed on her NA care guide. The 1/31/19 incident report for Resident #270 ' s fall was reviewed with NA #7. She indicated she and NA #8 were assigned on the secured unit during the 2nd shift (3:00 PM to 11:00 PM) on 1/31/19 and that they shared responsibility for all of the residents on the unit. She reported there was also a nurse who worked on the unit, but the nurse split their time between the secured unit and one of the other unsecured units. NA #7 stated this 1/31/19 fall for Resident #270 occurred when it was almost dinner time and she and NA #8 were trying to get all of the residents into the dining room. She stated that Resident #270 was ambulatory, and she walked to the dining room independently. She reported that Resident #270 was at one of the tables in the dining room area and she tried to sit down but missed the chair and

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fell. NA #7 She stated she was in the living room area assisting other residents to the dining room area at the time of the actual fall, but she heard the fall happen. She was unable to recall if NA #8 was with Resident #270 at the time of the fall. She revealed she thought Resident #270 ' s impaired vision was the cause of this fall as she believed the resident was unable to see where the chair was located when she tried to sit down and she did not have her eyeglasses on at the time of the fall. The NA care guide that indicated Resident #270 was to be observed when trying to sit down was reviewed with NA #7. She indicated that she was aware Resident #270 had a previous fall when trying to sit down but revealed she had not been observing the resident on 1/31/19 at the time of this fall to ensure she sat down safely.

An interview was conducted with NA #8 on 2/14/19 at 9:00 AM. She stated she had not worked regularly on the secured unit. The 1/31/19 incident report for Resident #270 ' s fall was reviewed with NA #8. She stated the 1/31/19 fall for Resident #270 occurred when it was almost dinner time and she and NA #7 were trying to get all of the residents into the dining room. She reported Resident #270 was at one of the tables in the dining room area and she tried to sit down but missed the chair and fell. She stated she was in the living room area of the secured unit trying to get other residents from that area to the dining room area at the time of the 1/31/19 fall for Resident #270. She indicated that Resident #270 was ambulatory, and she walked to the dining room independently. She stated that she had not observed the fall, but she heard the fall happen. She indicated that she was not aware

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Resident #270 had 2 previous falls when trying to sit down but she was aware that the resident needed help to sit down because she had bad vision. She verified that she was not observing Resident #270 at the time of 1/31/19 fall to ensure she sat down safely. NA #8 was asked if Resident #270 had eyeglasses on at the time of the fall and stated that she was not sure if Resident #270 had eyeglasses on at the time of fall. She explained that Resident #270 frequently removed her eyeglasses and placed them in random spots on the secured unit.

Review of the NA care guide for Resident #270, most recently dated 2/1/19, indicated that Resident #270 was a fall risk, she was to be observed when trying to sit down, and NAs were to ensure her eyeglasses were on when she was out of bed. This care guide also indicated that Resident #270 ' s right lower extremity was to be elevated as tolerated and for her right hip dressing to be left on.

A nursing note dated 2/1/19 indicated that Resident #270 continued to have pain and discomfort to the right hip and leg. Routine and as needed (PRN) pain medication was administered as well as muscle rub cream with some relief noted. The NP saw Resident #270 this morning (2/1/19).

A nursing note dated 2/2/19 indicated that Resident #270 was in bed and was medicated for pain as needed indicated the NP on-call was notified that Resident #270 screamed and cried in pain when moved. Resident #270 had no bruising or swelling. The NP on-call indicated to continue with current treatment with included pain

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management with routine pain medications, as needed pain medications, and muscle rub cream with effective results.

Nursing notes dated 2/4/19 indicated that Resident #270 continued to complain of right hip pain during patient care and when she was examined by nurse. The NP was contacted and another x-ray was ordered for Resident #270 ' s right hip. The x-ray results were obtained and indicated a right hip fracture with mild displacement. The physician was notified and an order was received to transfer Resident #270 to the Emergency Room for evaluation and treatment.

Hospital records indicated Resident #270 was admitted on 2/4/19 for an intertrochanteric right femur fracture (a fracture of the upper part of the thigh bone). This femur fracture was repaired through open treatment of right intertrochanteric hip fracture was repaired and she was discharged back to the facility on 2/7/19.
An observation was conducted of Resident #270 on 2/13/19 at 4:45 PM. She was seated in a wheelchair at a table in the dining room area of the secured unit. Her eyeglasses were observed on the table in front of her.

An interview was conducted with NA #6 on 2/13/19 at 4:46 PM. She was asked if Resident #270 had any vision problems. She indicated that Resident #270 had impaired vision and she had eyeglasses. She stated that Resident #270 rarely kept her eyeglasses on. She stated staff tried to encourage Resident #270 to wear the eyeglasses, but she always took them off. NA #6 revealed she was aware the eyeglasses were not on Resident #270 at this present time.

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An interview was conducted with MDS Nurse #1 on 2/14/19 at 10:08 AM. Resident #270 ' s NA care guide was reviewed with MDS Nurse #1. She stated that the 2/1/19 revision date on the NA care guide was related to the interventions of elevating Resident #270 ' s lower extremity and leaving her right hip dressing on. She explained that this was added after Resident #270 returned from the hospital on 2/7/19 and it was dated 2/1/19 even though the dressing was in place when she returned from the hospital after her surgery. MDS Nurse #1 further explained that the NA care guide interventions of observing Resident #270 when she was trying to sit down and ensuring her eyeglasses were on when she was out of bed were in place on the NA care guide after the 12/15/18 fall. She reported that the root cause analysis of Resident #270 ' s 12/15/18 fall was impaired vision and impaired depth perception. She further explained that that the 10/5/18 fall, 12/15/18 fall, and 1/31/19 fall all occurred when Resident #270 was attempting to sit in a chair. Resident #270 ' s care plan related to falls was reviewed with MDS Nurse #1. She confirmed the intervention of observing Resident #270 when she was trying to sit down was not added to her care plan. She revealed that she should have revised Resident #270 ' s interventions related to falls when she added it to the NA care guide after the 12/15/18 fall.

An interview was conducted with the Director of Nursing (DON) on 2/13/19 at 5:10 PM. She stated she expected interventions developed through root cause analyses to be implemented to prevent recurrence of falls. She indicated this included the interventions for observing Resident #270 when she was trying to sit down (NA care

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F 689	Continued From page 71 guide intervention) and ensuring her eyeglasses were on when she was out of bed were in place (NA care guide and care plan intervention). She reported that the facility had been trying to get Resident #270 in for an eye exam since December 2018, but that the earliest appointment they were able to obtain was in March 2019. She stated that it was difficult to find an eye care provider to complete eye examinations for their residents in a timely fashion. She reported that their eye care provider came to the facility once every 6 months. The DON was unable to explain why no other interventions were attempted when they were unable to get an eye examination scheduled until March of 2019.	F 689		
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 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'	F 700		3/29/19

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F 700	Continued From page 72 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interview, the facility failed to assess the resident for alternative to side rails before use and failed to assess the risk and benefits of using side rail (Resident #88) for 1 of 2 residents reviewed for side rails. Findings included: Resident #88 was admitted to the facility on 11/17/17 with diagnoses of anxiety, paraplegia, insomnia, seizure, and injury of the spinal cord. A review of the Determination of Device Usage form dated 12/6/17 revealed the side rails improved or maintained the resident ' s functional status and the device was an enabler. The question whether the device (side rails) was "a restraint or not" was not completed. A review of the Pre-restraint Intervention Evaluation form (to evaluate alternative interventions to side rails before use) revealed the form had no signature and no date (it was believed this form was completed at the same time as the Determination of Device Usage form). "Number 8 for other interventions, Number 9 results of the interventions attempted, and Number 10 have all interventions been attempted and if not state why" were not completed. A risk benefit analysis for the use of the side rails was not identified as being documented. A review of Resident #88 ' s quarterly Minimum Data Set (MDS) dated 12/2/18 revealed the resident had an intact cognition.	F 700	F700 Bedrails Corrective Action: We are unable to correct this alleged deficient practice for Resident #88, as he is not in the facility. We will reassess when he returns. Identification of others potentially at risk: Residents that have side rails on their bed, have had their medical record reviewed by the DON and/or unit managers, to determine if the Determine of Device Usage has been utilized and completed. The form was reviewed for completeness and accuracy by the nurse managers. The audit was completed the week of 3-11-19. No other side rail was found to be in use without proper, completed documentation. Systemic Changes: The nurse managers have been re-educated by the Director of Nursing, on March 11th, regarding the use of side rails, and the proper filling out of the Device Usage form. Side rails will not be used as an intervention unless decided upon in the clinical operational meeting, and then only after the appropriate forms are filled out in their entirety. The clinical team will review new admissions for the device audit form to ensure it is filled out completely as well.	

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F 700	Continued From page 73 A review of the resident ' s care plan updated 1/16/19 revealed goals and interventions for self-care deficit for activities of daily living (ADLs) secondary to spinal cord injury and at risk for fall, goal resident will not fall through the next review period and intervention for fall prevention 1/2 bilateral side rails. A review of Resident #88 ' s quarterly MDS dated 1/18/19 revealed the resident had adequate hearing, clear speech and was understood and understands. The cognition was unable to be assessed (the resident refused to answer staff). The resident required extensive assistance of 2 staff for all transfers and bed mobility and of 1 staff for all other (ADLs). On 02/11/19 at 9:15 am an interview was conducted with Resident #88. The resident stated he wanted and used the side rails to grab hold of. On 2/13/19 at 2:00 pm an interview was conducted with Nursing Assistant (NA) #3 who stated the resident was able to hold on to the side rails during care. On 2/13/19 at 3:00 pm an interview was conducted with NA #2 who stated she was regularly assigned to Resident #88. The resident liked to hold on to the side rail (has bilateral side rails) during care and preferred to have them. The resident was not able to get out of bed on his own. On 2/13/19 at 3:20 pm an interview was conducted with Nurse #3 who was regularly day-shift assigned to Resident #88. Nurse #3	F 700	Monitoring The Director of Nurses, using a QA auditing tool, has reviewed all residents that use side rails, to ensure that all residents that are using side rails have had the Determine of Device Usage and a Pre-Restraint Intervention Form completed. We will review new admissions side rails weekly for 4 weeks and then monthly for two months, for the same documentation. The results will be reported by the DON, to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from the QA committee with additional training to be provided by the Clinical Resource Specialist, as indicated.	

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F 700	Continued From page 74 had observed the resident hold the side rail during care and cannot exit the bed on his own with or without the side rails. On 2/13/19 at 4:10 pm an interview was conducted with the Director of Nursing (DON) who stated she was not aware that Resident #88 ' s side rail assessment had incomplete areas and would expect the entire form to be completed and accurate.	F 700		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		3/29/19

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F 732	Continued From page 75 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to post the daily nurse staffing information accurately as evidenced by inaccurate actual hours worked for licensed and unlicensed nursing staff and by not entering the facility's name on the form for 2 of 2 weeks staffing information reviewed. Findings included: On 2/13/19 at 4:05 PM, the daily nurse staffing information forms for the last 2 weeks including 2/10/19, 2/11/19, 2/12/19 and 2/13/19 were observed. The forms did not include the name of the facility and the actual hours worked for Registered Nurse (RN), Licensed Practical Nurse (LPN) and nurse aides (NAs) were not accurate. On 2/10/19, the form read: 7-3 shift- 0 RN 8 actual hours worked 3-11 shift - 1 RN 36 actual hours worked 11-7 shift- 1 LPN 16 actual hours worked 7 NAs 72 actual hours worked On 2/11/19, the form read:	F 732	F732 Posted Nurse Staffing Corrective Action: The posted staffing form has been updated to include the pre-printed name of the facility and is hand calculated, not an excel sheet. Identification of others potentially at risk: The staffing sheet is a single sheet of paper and does not put others at risk. Systemic Changes: The staffing clerk and the night shift nurses have been educated on the updated form, by the Assistant Director of Nurses the week of 3-11-19. The posted staffing form has been updated to include the pre-printed name of the facility and is hand calculated, not an excel sheet now, where the formulas can become unintentionally broken. The night shift nurse on station is now putting out the nursing staff information sheet after determining the staffing for each shift. The staffing sheet is updated each shift by the	

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F 732	Continued From page 76 7-3 shift - 0 RN 8-actual hours worked 12 NAs 104 actual hours worked 3-11 shift - 2 RN 36 actual hours worked 11-7 shift - 1 LPN 16 actual hours worked 7 NAs 72 actual hours worked On 2/12/19, the form read: 7-3 shift - 0-RN 8 - actual hours worked 12 NAs 104 actual hours worked 3-11 shift - 1 RN 36 actual hours worked 10 NAs 96 actual hours worked 11-7 shift - 1 LPN 16 actual hours worked 5 NAs 72 actual hours worked On 2/13/19, the form read: 7-3 shift - 0 -RN 8 -actual hours worked - 11 - NAs 104 -actual hours worked 3-11 shift- 2 -RN 36 -actual hours worked 11-7 shift - 1- RN 12 hours 7 NAs 72 actual hours worked On 2/13/19 at 4:50 PM, the Scheduler was interviewed. She stated that she was responsible for completing and posting the daily nurse staffing information form. She stated that she was trained by the Staff Development Coordinator (SDC) to complete the form electronically by entering the number of RN, LPN and NAs worked per shift. She was told that the computer filled in the actual hours worked and she didn't know that the hours were not accurate. The Scheduler also stated that she did not know that the form needed to have the facility's name on it. On 2/13/19 at 4:55 PM, the SDC was interviewed. She stated that the Scheduler was responsible for	F 732	staffing clerk, or the charge nurse on station one. Monitoring The Director of Nurses, using a QA auditing tool, will review the daily posted staffing sheet, weekly for the next 2 months, and then will review randomly monthly for the next two months, to ensure that the staffing sheet is accurately posted. The results will be reported by the DON, to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from the QA committee with additional training to be provided by the Clinical Resource Specialist, as indicated.	

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F 732	Continued From page 77 completing and posting the daily nurse staffing information. The SDC indicated that the computer was supposed to calculate the actual hours worked after the Scheduler entered the number of RN, LPN and NAs. The SDC stated that she had not been monitoring the nurse staffing information and she was not aware that the actual hours worked were not accurate and the form did not include the facility's name. On 2/14/19 at 10:40 AM, the Administrator was interviewed. He stated that the previous administrator had changed the daily nurse staffing information form. He indicated that after the staff entered the number of RN, LPN and NAS, the computer was supposed to calculate the actual hours worked. The Administrator stated that he was not aware that the form did not include the facility's name and the actual hours worked were not accurate.	F 732		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		3/29/19

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F 756	Continued From page 78 (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: Based on record review, and Pharmacy Consultant and staff interview, the Pharmacy Consultant failed to report drug irregularities to the Attending Physician and or Director of Nursing for 2 of 8 sampled residents reviewed for unnecessary medications. The Pharmacy Consultant failed to address the use of prophylactic antibiotic without an active infection and without a stop date (Residents #74), failed to address the use of as needed (PRN) psychotropic medication without a stop date (Residents # 74 and #57), failed to address the need for Abnormal Involuntary Movement Scale (AIMS) test (used to assess for extrapyramidal symptoms on residents receiving antipsychotic	F 756	F756 Drug Regimen Review Corrective Action: The physician discontinued the antibiotic for resident #74 at the time of survey. He has made recommendations regarding the PRN psychotropic medication for Residents #74 and it was discontinued on 3-5-19. The pharmacist recommendation for PRN psychotropic for Resident #57 has been acted upon and discontinued. The Nurse Manager has also for resident #74 completed an Abnormal Involuntary Movement Scale (AIMS) test.	

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F 756	Continued From page 79 medication) (Resident #74). The facility also failed to act upon pharmacy recommendations for Resident #57. Findings included: 1a. Resident #74 was admitted to the facility on 10/8/18 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 1/14/19 indicated that Resident #74 had severe cognitive impairment and she had received an antibiotic for 7 days during the assessment period. Resident #74 had a physician's order dated 10/9/18 for Nitrofurantoin (an antibiotic) 100 milligrams (mgs) - 1 capsule by mouth daily for Chronic Urinary Tract Infection (UTI) prevention. Review of the laboratory reports revealed that Resident #74 did not have a urinalysis nor urine culture done since admission. Review of the Pharmacy Consultant's monthly drug regimen review (DRR) was conducted. The DRR notes revealed that Resident #74's drug regimen was reviewed on 10/27/18, 11/27/18, 12/24/18 and 1/27/19. The DRR notes did not address the long term use of the antibiotic. The notes did not identify the indefinite use of the antibiotic without an active infection and without a stop date. An interview with the Pharmacy Consultant was conducted on 2/13/19 at 2:52 PM. The Pharmacy Consultant reviewed his notes and stated that because there was not enough information from the hospital records to support the use of the prophylactic antibiotic without a stop date, he	F 756	Identification of others potentially at risk: All residents that have chronic infections and are prescribed antibiotics, residents that are prescribed PRN psychotropic□s, and those that are routinely prescribed antipsychotics and require an AIMS test are potentially at risk for this alleged deficient practice and are identified during the monthly pharmacy review. Systemic Changes: The pharmacist at the time of survey is no longer servicing our facility. A contracted independent consultant pharmacist(s) will provide consulting services for at least one quarter starting March 14th. The consultant pharmacist will address all antibiotic use, PRN psychotropic use and if AIMS testing has been completed timely, during the monthly drug regimen review. The pharmacist will monitor in their executive summary and detail the response rate from the previous month reported. In order to prevent future omission of AIMS tests, all residents receiving antipsychotics will have an information order added to the Electronic Medication Administration Record (EMR) indicating that the resident is on an antipsychotic and requires an AIMS test minimally every 6 months. This order will be timed so it will alert staff when it is due. The Nurse Manager will be responsible to put this order in upon admission or when a an antipsychotic is started. The pharmacy drug regimen will be required of the Medical Director to be acted upon within the week received. If not, the Administrator will address with the	

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F 756	Continued From page 80	F 756		

should have addressed it with the Physician or Director of Nursing (DON) but he did not. The Pharmacy Consultant further stated that he was aware of the Antibiotic stewardship program, to use antibiotic only when there was an active infection, to prevent unnecessary use of the antibiotic and to prevent resistance to an antibiotic. He did not comment as to why he did not address or identify the indefinite use of antibiotic for Resident #74.

An interview with the Director of Nursing (DON) was conducted on 2/14/19 at 11:52 AM. The DON stated that she expected the Pharmacy Consultant to address drug irregularities to the physician including the use of prophylactic antibiotic without a stop date.

1b. Resident #74 was admitted to the facility on 10/8/18 with multiple diagnose including dementia. The quarterly Minimum Data Set (MDS) assessment dated 1/14/19 indicated that Resident #74 had severe cognitive impairment and she had not received an antianxiety medication during the assessment period.

Resident #74 had a physician's order dated 10/8/18 for lorazepam or Ativan (anti-anxiety medication) 0.5 milligrams (mgs) 1 tablet by mouth every 6 hours as needed (PRN) for anxiety/agitation.

Review of the Medication Administration Records (MARs) revealed that Resident #74 had received Ativan once in November 2018 (11/27/18 at 8:14 AM), once in December 2018 (12/20/18 at 8:18 AM), twice in January 2019 (1/3/19 at 5:41 AM

Medical Director.

Monitoring
An independent consultant pharmacist(s) will provide the monthly drug regimen review, for at least one quarter as above. The results will be reported to the Director of Clinical Services of the provider pharmacy and to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. In addition, response time will be reported to the committee as well via the executive summary, provided by the consultant. The Administrator will be responsible to follow-up on any recommendation from the QA committee with additional training to be provided by the Clinical Resource Specialist, as indicated.

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F 756	Continued From page 81	F 756		

and 1/20/19 at 7:37 AM) and none in February 2019.

Review of the Pharmacy Consultant's monthly drug regimen review (DRR) was conducted. The DRR notes revealed that Resident #74's drug regimen was reviewed on 10/27/18, 11/27/18, 12/24/18 and 1/27/19. The DRR notes did not address the use of the PRN Ativan without a stop date to the physician or the Director of Nursing (DON).

Interview with the Pharmacy Consultant was conducted on 2/13/19 at 2:52 PM. The Pharmacy Consultant reviewed his records and stated that he should have addressed the use of the PRN Ativan without a stop date to the physician because Resident #74 was not using it often only once or twice a month. He did not comment as to why he did not address or identify the use of the PRN Ativan without a stop date to the physician.

An interview with the Director of Nursing (DON) was conducted on 2/14/19 at 11:52 AM. The DON stated that she expected the Pharmacy Consultant to address drug irregularity to the physician including the use of PRN psychotropic medication without a stop date.

1c. Resident #74 was admitted to the facility on 10/8/18 with multiple diagnose including dementia. The quarterly Minimum Data Set (MDS) assessment dated 1/14/19 indicated that Resident #74 had severe cognitive impairment and she had received an antipsychotic medication for 7 days during the assessment period.

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Resident #74 had a physician's order dated 10/8/18 for Seroquel (antipsychotic medication) 25 mgs., 1 tablet by mouth twice a day for psychosis.

Review of the Medication Administration Records (MARs) revealed that Resident #74 had received Seroquel twice a day as ordered from October 9, 2018 through February 13, 2019.

Review of the electronic medical records revealed that there was no AIMS test completed for Resident #74.

An interview with the Unit Manager (UM) on 2/12/19 at 3:20 PM was conducted. She stated that she was responsible for completing the AIMs test on admission and every 6 months. The UM verified that Resident #74 was on Seroquel and AIMS test should have been completed on admission. She stated that she missed the completion of an AIMS test for Resident #74 on admission.

Review of the Pharmacy Consultant's monthly drug regimen review (DRR) was conducted. The DRR notes revealed that Resident #74's drug regimen was reviewed on 10/27/18, 11/27/18, 12/24/18 and 1/27/19. The DRR notes did not address the need for AIMS test to the DON.

Interview with the Pharmacy Consultant was conducted on 2/13/19 at 2:52 PM. The Pharmacy Consultant reviewed his records and stated that Resident #74 was on Seroquel and AIMS test should have been done on admission and every 6 months. He indicated that he failed to address the need for AIMS test to the nursing staff on admission.

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An interview with the Director of Nursing (DON) was conducted on 2/14/19 at 11:52 AM. The DON stated that she expected the Pharmacy Consultant to address drug irregularity to the physician and or DON including the need for AIMS test for residents receiving antipsychotic medication.

2a. Resident #57 was admitted to the facility on 3/6/18 with diagnoses that included psychosis.

A review of Resident #57's medical record revealed his medication orders included an order last written on 3/6/18 for Seroquel (antipsychotic medication) 75 milligrams (mg) in the evening and an order last written 3/7/18 for Seroquel 50 mg in the morning.

The quarterly Minimum Data Set (MDS) assessment dated 1/4/19 indicated Resident #57 ' s cognition was severely impaired. He had no behaviors, no rejection of care, and had received antipsychotic medication on 7 of 7 days during the MDS review period.

A review of the Pharmacy Consultant ' s monthly drug regimen reviews (DRRs) for Resident #57 from March 2018 through January 2019 was conducted. A DRR dated 12/23/18 indicated a recommendation was made for a Gradual Dose Reduction (GDR) of Seroquel. There was no indication in the medical record that this recommendation had been responded to and/or acted upon by the physician.

Review of Resident #57 ' s current physician orders was conducted on 2/13/19 and revealed the 3/6/18 order for Seroquel 75 mg in the

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evening and the 3/7/18 order for Seroquel 50 mg in the morning continued to be active orders.

An interview was conducted with the Pharmacy Consultant on 2/13/19 at 2:49 PM. He indicated that he had been completing DRRs at the facility since July 2018. He stated that he expected his recommendations to be responded to by his next DRR the following month. He revealed he had noticed that his recommendations were not always responded to timely. He further revealed that it was regularly taking 2 months to receive a response from the physician for his recommendations. The Pharmacy Consultant reported that he thought about making repeat recommendations each month, but that in most cases he waited for two months and then made a repeat recommendation if it still had not been responded to. The Pharmacy Consultant revealed he had not received a response from the physician related to his 12/23/18 recommendation for a GDR of Seroquel for Resident #57.

An interview was conducted with the Director of Nursing (DON) on 2/14/19 at 11:54 AM. The DON stated that Physician #2 responded to all pharmacy recommendations. She stated that Physician #2 was presently unreachable and was not available for interview. The DON reported that her expectation was for the physician to respond to pharmacy recommendations within a month. She revealed that she had been made aware on 2/13/19 by the Pharmacy Consultant that his recommendations were regularly taking 2 months to be responded to. She stated that she had been unaware of this information prior to 2/13/19.

2b. Resident #57 was admitted to the facility on

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3/6/18 with diagnoses that included depression, anxiety, and insomnia.

The quarterly Minimum Data Set (MDS) assessment dated 9/12/18 indicated Resident #57 ' s cognition was severely impaired, and he received antidepressant and antianxiety medication on 7 of 7 days during the MDS review period.

A review of Resident #57 ' s October 2018 Medication Administration Record (MAR) indicated he received Klonopin (antianxiety medication) 0.5 milligrams (mg) once daily at bedtime for anxiety, Remeron (antidepressant medication) 30 mg once daily at bedtime for anxiety, and Trazodone 50 (antidepressant medication) mg once daily at bedtime for sleep.

A pharmacy recommendation dated 10/24/18 indicated that Resident #57 was taking Remeron, Klonopin, and Trazodone at bedtime. The Pharmacy Consultant recommended a discontinuation of Trazodone as Remeron and Klonopin provided antianxiety and sleep benefits. This recommendation was agreed upon by Physician #2 on 12/26/18 and he indicated that Trazodone was to be discontinued.

A physician ' s order dated 12/27/18 indicated a discontinuation of Resident #57 ' s scheduled Trazodone.

An interview was conducted with Unit Manager (UM) #1 on 2/13/19 at 9:05 AM. She stated that the Pharmacy Consultant ' s recommendations were given to her by the Director of Nursing (DON). She reported that she separated the recommendations into nursing related

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recommendations and physician related recommendations. She indicated that she placed the recommendations in the physician ' s folder that was located in the medical records office. UM #1 stated when the physician had completed his responses on the forms they were brought back to the medical records office and she received the forms. She stated once she got the form back she normally completed the required action within a business day. Resident #57 ' s 10/24/18 pharmacy recommendation that was signed by Physician #2 on 12/26/18 was reviewed with UM #1. She stated that she had not noticed that this recommendation took over 2 months for Physician #2 to respond when she reviewed the form and discontinued Resident #57 ' s Trazodone on 12/27/18. She verified that Resident #57 received Trazodone daily through 12/26/18.

An interview was conducted with the Pharmacy Consultant on 2/13/19 at 2:49 PM. He indicated that he had been completing monthly drug regimen reviews (DRRs) at the facility since July 2018. He stated that he expected his recommendations to be responded to by his next DRR the following month. He revealed he had noticed that his recommendations were not always responded to timely. He further revealed that it was regularly taking 2 months to receive a response from the physician for his recommendations. The Pharmacy Consultant reported that he thought about making repeat recommendations each month, but that in most cases he waited for two months and then made a repeat recommendation if it still had not been responded to. Resident #57 ' s 10/24/18 pharmacy recommendation that was signed by

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Physician #2 on 12/26/18 was reviewed with the Pharmacy Consultant. He revealed that this was one of those instance in which it took two months to receive a response which delayed the discontinuation of Trazodone for Resident #57.

An interview was conducted with the on 2/14/19 at 11:54 AM. The DON stated that Physician #2 responded to all pharmacy recommendations. She stated that Physician #2 was presently unreachable and was not available for interview. The DON reported that her expectation was for the physician to respond to pharmacy recommendations within a month. She revealed that she had been made aware on 2/13/19 by the Pharmacy Consultant that his recommendations were regularly taking 2 months to be responded to. She stated that she had been unaware of this information prior to 2/13/19.

2c. Resident #57 was admitted to the facility on 3/6/18 with diagnoses that included depression, anxiety, and insomnia.

The quarterly Minimum Data Set (MDS) assessment dated 9/12/18 indicated Resident #57 ' s cognition was severely impaired, and he received antidepressant and antianxiety medication on 7 of 7 days during the MDS review period.

A Nurse Practitioner (NP) note dated 9/13/18 indicated the addition of Trazodone (antidepressant medication) 25 milligrams (mg) twice daily as needed (PRN) for anxiety per family ' s request.

A physician ' s order dated 9/14/18 indicated

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Trazodone 25 mg every 12 hours PRN for anxiety. There was no stop date for this 9/14/18 PRN Trazodone order.

A review of Resident #57 ' s September 2018 Medication Administration Record (MAR) indicated he was not administered PRN Trazodone.

A review of Resident #57 ' s October 2018 MAR indicated he was not administered PRN Trazodone.

A pharmacy recommendation dated 10/24/18 addressed Resident #57 ' s scheduled order for Trazodone and recommended its discontinuation. This recommendation had not addressed the PRN Trazodone order that was in place since 9/14/18 with no stop date.

A review of Resident #57 ' s November 2018 MAR indicated he was not administered PRN Trazodone.

The Pharmacy Consultant ' s monthly drug regimen review (DRR) for Resident #57 dated 11/27/18 indicated no recommendations were made related to PRN Trazodone.
A review of Resident #57 ' s December 2019 MAR indicated he was not administered PRN Trazodone.
The Pharmacy Consultant ' s monthly DRR for Resident #57 dated 12/23/18 indicated no recommendations were made related to PRN Trazodone.
The pharmacy consultants 10/24/18 recommendation to discontinue Resident #57 ' s scheduled Trazodone was responded to by Physician #2 on 12/26/18 and he indicated a

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F 756	Continued From page 89 discontinuation of scheduled and PRN Trazodone. Physician ' s orders dated 12/27/18 indicated a discontinuation of Resident #57 ' s scheduled and PRN Trazodone. An interview was conducted with the Pharmacy Consultant on 2/13/19 at 2:49 PM. He stated he was aware of the regulation related to PRN psychotropic medications needing to be time limited in duration. Resident #57 ' s order for PRN Trazodone that was in place from 9/14/18 through 12/26/18 was reviewed with the Pharmacy Consultant. He revealed he had not made any recommendations related to Resident #57 ' s PRN Trazodone. He explained that he was unaware the regulation related to PRN medications applied to antidepressant medications. An interview was conducted with the Director of Nursing (DON) on 2/14/19 at 11:54 AM. The DON stated that she expected the Pharmacy Consultant to identify and address the use of PRN psychotropic medications prescribed for greater than 14 days.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		3/29/19

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F 758	Continued From page 90 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended 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.	F 758		

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F 758	Continued From page 91 This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and Physician, Nurse Practitioner, Pharmacy Consultant interviews, the facility failed to ensure that as needed (PRN) psychotropic medications were time limited in duration (Residents #81, #9, #74 and #57), failed to address a Gradual Dose Reduction for antipsychotic medication as required (Resident #57), failed to complete an Abnormal Involuntary Movement Scale (AIMS) test (used to assess for extrapyramidal symptoms on residents receiving antipsychotic medication) (Resident #74), and also failed to address duplicate antidepressant therapy for a two month period (Resident #57) for 4 of 8 residents reviewed for medications. The findings included: 1) Resident #81 was originally admitted to the facility on 6/5/17 with a readmission date of 6/1/18. Her diagnoses included malignant neoplasm of lung and cervix, Chronic Obstructive Pulmonary Disease (COPD), anxiety disorder and insomnia. She has been under Hospice care since 6/27/17. A review of the physician orders revealed a physician order dated 9/27/17 for Trazodone 100 milligrams (mg) at bedtime PRN insomnia and an order dated 6/13/18 for Xanax 0.5mg every eight hours PRN anxiety. The orders did not include stop dates or durations for the PRN Trazodone or Xanax. Other physician orders for Resident #81 revealed an order dated 10/13/18 for Remeron 15mg one tablet by mouth at bedtime for appetite	F 758	758 Unnecessary Psychotropics Corrective Action: Residents #81, #9, #74 and #57□s PRN (as needed) psychotropic drug orders were reviewed by physician and either discontinued or rewritten to provide both an appropriate rationale and duration. Resident #57's medical record was reviewed by pharmacy for any further recommended dose reduction or identification of duplicative medication therapy and an Abnormal Involuntary Moment Scale has been completed. Identification of others potentially at risk: Residents who have orders for PRN psychotropic drugs are potentially at risk and residents who receive psychotropic medications are potentially at risk for not having a gradual dose reduction or duplicate therapy. Our pharmacy has completed a monthly medication review on 2-28-2019, to determine if there are any other PRN psychotropic medications that are not time limited and to determine if there are any gradual dose reductions that should be attempted or any duplicative therapy (these are identified through the monthly pharmacy review). Recommendations from these findings have been completed on Medication Recommendations to Physician and forwarded to physician for response. Based on the physician response to each recommendation, orders have been carried out by the Unit Managers.	

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F 758	Continued From page 92 stimulation. A review of the monthly pharmacy medication reviews revealed there was a recommendation dated 10/24/18 that read in part: Remeron was recently started and PRN Trazodone may no longer be needed. Discontinue Trazodone 100mg PRN. The physician signed and dated the recommendation on 12/25/18, disagreed and wrote, "Hospice patient. All comfort measures are appropriate". Resident #81's most recent Minimum Data Set (MDS) coded as a modified Quarterly assessment and dated 1/11/19 revealed the resident was cognitively intact and received antianxiety and antidepressant medications 6 of the 7 days during the look back period. A review of the January 2019 Medication Administration Record (MAR) revealed the resident had received PRN Trazodone 13 times and PRN Xanax 25 times in the month of January. During a review of the February 2019 MAR it was noted that Resident #81 had received PRN Trazodone twice and PRN Xanax nine times. A phone interview was completed with Physician #3 on 2/13/19 at 11:35 AM. He stated that he was aware of the PRN psychotropic regulations, felt that a one to two-week adjustment period would be acceptable and if resident continued to need the PRN medication it should be reevaluated. On 2/13/19 at 2:15pm an interview was conducted with Pharmacy Consultant #1. He was unable to locate a recommendation for the Xanax	F 758	Systemic Changes: ADON/staff development coordinator has inserviced licensed staff during the week of March 11th and March 18th, to include full time, part time and PRN staff, regarding the requirement that PRN psychotropic medications are time limited in duration not to exceed 14 days unless the provider believes that it is appropriate for the PRN order to be extended beyond 14 days, and he or she documents their rationale in the resident□s medical record and indicates the duration for the PRN order. If staff are not inserviced by March 29th, they will not be able to work. The Unit Manager nurses will review all new admission PRN psychotropic orders to ensure they are time limited. The pharmacist has been re-educated by the Director of Clinical Services of the provider pharmacy on March 6th.. An independent consultant pharmacist(s) will provide consulting services for at least one quarter starting in March 2019. The consultant pharmacist will address the above issues during the monthly drug regimen review. Monitoring: Medication reconciliation chart checks are done on newly admitted residents□ charts and a check to ensure that any PRN psychotropic medication has an appropriate duration and rationale will be a part of this check for ongoing monitoring. Also, orders are reviewed daily at clinical operations meetings and any orders for PRN psychotropic	

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F 758	Continued From page 93 PRN needing a time duration in his records. The Pharmacy Consultant stated that PRN psychotropics should be time limited in duration and couldn't state why a recommendation for the PRN Xanax was not addressed with the physician. An interview was completed with the Director of Nursing on 2/14/19 at 11:50am. She stated that the pharmacy consultant was a safety net to catch the irregularities and should be making repeat recommendations every month if original medication recommendations had not been responded to. She further stated that she expected all PRN psychotropics to be time limited in duration. 2) Resident #9 was admitted to the facility on 7/30/18 with diagnoses that included vascular dementia with behavioral disturbance, psychosis and anxiety disorder. A review of the most recent MDS coded as a Significant Change in Condition assessment dated 11/12/18 assessed the resident with severe cognitive impairment and received antipsychotic medication 3 out of 7 days and antidepressant medication 7 of the 7 day look back period. A review of the physician orders revealed the following orders: An order dated 1/16/19 for Risperdal 0.75mg by mouth two times a day for anxiety related to psychosis. An order dated 1/18/19 for Trazodone 0.5mg by mouth two times a day for anxiety. An order dated 1/23/19 for Rozerem 8mg by mouth at bedtime for insomnia.	F 758	medication will be reviewed for duration time limit and rationale. Orders will be corrected as identified for ongoing monitoring. An independent consultant pharmacist(s) will provide the monthly drug regimen review, for at least one quarter as above. The results will be reported to the Director of Clinical Services of the provider pharmacy and to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. The Administrator will be responsible to follow-up on any recommendation from the QA committee with additional training to be provided by the Clinical Resource Specialist, as indicated.	

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Another physician order dated 1/24/19 read: Trazodone 50mg Give 0.5 tablet by mouth every 12 hours as needed for anxiety. The order did not include a stop date or duration for the PRN Trazodone.

A review of the facility's monthly pharmacy medication review dated 1/28/19 revealed there was no pharmacy recommendation regarding a stop date or a request for time duration of the PRN Trazodone ordered 1/24/19.

During a review of the February 2019 MAR it was noted that Resident #9 had been given PRN Trazodone six times from 2/1/19 to 2/12/19.

A phone interview was completed with Physician #3 on 2/13/19 at 11:35 AM. He stated that he was aware of the PRN psychotropic regulations, felt that a one to two-week adjustment period would be acceptable and if resident continued to need the PRN medication it should be reevaluated.

On 2/13/19 at 2:15pm an interview was conducted with Pharmacy Consultant #1. He was unable to locate a recommendation for the PRN Trazodone needing a time duration in his records. The Pharmacy Consultant stated PRN psychotropics should be time limited in duration and couldn't state why a recommendation for the PRN Trazodone was not addressed with the physician.

On 2/14/19 at 10:10am a phone call was made to the physician with Programs of All-Inclusive Care for the Elderly (PACE). A message was left with a request to return call. No return call was received from the PACE physician.

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THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

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An interview was completed with the Director of Nursing on 2/4/19 at 11:50am. She stated her expectation was for all PRN psychotropic medications to be time limited in duration.
3a. Resident #74 was admitted to the facility on 10/8/18 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 1/14/19 indicated that Resident #74 had severe cognitive impairment and she had not received an antianxiety medication during the assessment period.

Resident #74 had a physician's order dated 10/8/18 for lorazepam or Ativan (anti-anxiety medication) 0.5 milligrams (mgs) 1 tablet by mouth every 6 hours as needed (PRN) for anxiety/agitation. The order did not have a stop date.

Review of the Medication Administration Records (MARs) revealed that Resident #74 had received Ativan once in November 2018 (11/27/18 at 8:14 AM), once in December 2018 (12/20/18 at 8:18 AM), twice in January 2019 (1/3/19 at 5:41 AM and 1/20/19 at 7:37 AM) and none in February 2019.

An interview with the Unit Manager (UM) on 2/12/19 at 3:20 PM revealed that she was not aware of the regulation regarding the use of the PRN psychotropic medications. The UM indicated that she didn't know that orders for PRN psychotropic medication should have a stop date.

An interview with the Director of Nursing (DON) was conducted on 2/14/19 at 11:52 AM. The DON stated that she expected the regulation to be followed regarding the use of PRN psychotropic

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medications by ensuring orders for PRN psychotropic medication to have a stop date.

3b. Resident #74 was admitted to the facility on 10/8/18 with multiple diagnose including dementia. The quarterly Minimum Data Set (MDS) assessment dated 1/14/19 indicated that Resident #74 had severe cognitive impairment and she had received an antipsychotic medication for 7 days during the assessment period.

Resident #74 had a physician's order dated 10/8/18 for Seroquel (antipsychotic medication) 25 mgs,1 tablet by mouth twice a day for psychosis.

Review of the Medication Administration Records (MARs) revealed that Resident #74 had received Seroquel twice a day as ordered from October 9, 2018 through February 13, 2019.

Review of the electronic medical records revealed that there was no AIMS (Abnormal Involuntary Movement Score) test completed for Resident #74.

An interview with the Unit Manager (UM) on 2/12/19 at 3:20 PM was conducted. She stated that she was responsible for completing the AIMS test on admission and every 6 months. The UM verified that Resident #74 was on Seroquel and AIMS test should have been completed on admission. She stated that she missed to complete an AIMS test for Resident #74 on admission.

An interview with the Director of Nursing (DON)

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was conducted on 2/14/19 at 11:52 AM. The DON stated that she expected AIMS test completed for residents receiving antipsychotic medication on admission.

4a. Resident #57 was admitted to the facility on 3/6/18 with diagnoses that included psychosis.

A review of Resident #57's medical record revealed his medication orders included an order last written on 3/6/18 for Seroquel (antipsychotic medication) 75 milligrams (mg) in the evening and an order last written 3/7/18 for Seroquel 50 mg in the morning.

The admission Minimum Data Set (MDS) assessment dated 3/13/18 indicated Resident #57 ' s cognition was severely impaired, he had no behaviors, and had received antipsychotic medication on 7 of 7 days during the MDS review period.

A review of Psychiatric Nurse Practitioner (PNP) notes dated 5/15/18, 6/26/18, 7/31/18, 9/10/18, 10/15/18, 11/28/18, and 1/28/19 indicated Resident #57 was stable with no acute issues, behavioral problems, or aggression.

Resident #57 ' s current physician orders were reviewed on 2/13/19 and revealed the 3/6/18 order for Seroquel 75 mg in the evening and the 3/7/18 order for Seroquel 50 mg in the morning continued to be active orders. No Gradual Dose Reduction (GDR) had been attempted for Resident #57 ' s Seroquel.

An observation was conducted of Resident #57 on 2/13/19 at 8:40 AM. He was ambulating on the secured unit and showed no signs or

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symptoms of behavioral issues.

An interview was conducted with Nursing Assistance (NA) #6 on 2/13/19. She stated that she was familiar with Resident #57 and reported that he was pretty calm and rarely had any behavioral issues.

An interview was conducted with the PNP by phone on 2/14/19 at 9:46 AM. She indicated that she reviewed her notes for Resident #57 and revealed that she should have addressed a Gradual Dose Reduction (GDR) of Seroquel for Resident #57. She stated that she planned to attempt a GDR of Seroquel with Resident #57 on her next visit with him.

An interview was conducted with the Director of Nursing (DON) on 2/14/19 at 11:54 AM. The DON stated that she expected GDRs to be addressed as indicated in the regulations.

4b. Resident #57 was admitted to the facility on 3/6/18 with diagnoses that included depression, anxiety, and insomnia.

The quarterly Minimum Data Set (MDS) assessment dated 9/12/18 indicated Resident #57 ' s cognition was severely impaired, and he received antidepressant and antianxiety medication on 7 of 7 days during the MDS review period.

A physician ' s order dated 9/14/18 indicated Trazodone (antidepressant medication) 25 milligrams (mg) every 12 hours as needed (PRN) for anxiety. There was no stop date for this 9/14/18 PRN Trazodone order

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A review of Resident #57 ' s October 2018 ' s physician ' s order included the following:
- Klonopin (antianxiety medication) 0.5 milligrams (mg) once daily at bedtime for anxiety
- Remeron (antidepressant medication) 30 mg once daily at bedtime for anxiety
- Trazodone (antidepressant medication) 50 mg once daily at bedtime for sleep

A pharmacy recommendation dated 10/24/18 indicated that Resident #57 was taking Remeron, Klonopin, and Trazodone at bedtime. The Pharmacy Consultant recommended a discontinuation of Trazodone as Remeron and Klonopin provided antianxiety and sleep benefits. This recommendation was agreed upon by Physician #2 on 12/26/18 and he indicated that Trazodone was to be discontinued.

A review of Resident #57 ' s September 2018, October 2018, November 2018, and December 2018 Medication Administration Records (MARs) indicated he was not administered PRN Trazodone

A physician ' s order dated 12/27/18 indicated a discontinuation of Resident #57 ' s scheduled Trazodone.

An interview was conducted with Unit Manager (UM) #1 on 2/13/19 at 9:05 AM. She stated that the Pharmacy Consultant ' s recommendations were given to her by the Director of Nursing (DON). She indicated that she placed the recommendations in the physician ' s folder that was located in the medical records office. UM #1 stated when the physician had completed his

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responses on the forms they were brought back to the medical records office and she received the forms. She stated once she got the form back she normally completed the required action within a business day. Resident #57 ' s 10/24/18 pharmacy recommendation that was signed by Physician #2 on 12/26/18 was reviewed with UM #1. She stated that she had not noticed that this recommendation took over 2 months for Physician #2 to respond to when she reviewed the form and discontinued Resident #57 ' s Trazodone on 12/27/18. She verified that Resident #57 received Trazodone daily through 12/26/18. She revealed she was not aware of the regulation regarding the use of PRN psychotropic medications and had not known that these PRN orders required a stop date. UM #1 confirmed the PRN Trazodone order for Resident #57 was in place from 9/14/18 through 12/27/18.

An interview was conducted with the Pharmacy Consultant on 2/13/19 at 2:49 PM. Resident #57 ' s 10/24/18 pharmacy recommendation that was signed by Physician #2 on 12/26/18 was reviewed with the Pharmacy Consultant. He revealed that this 10/24/18 pharmacy recommendation took two months to receive a response from the physician which delayed the discontinuation of Trazodone for Resident #57. He indicated that in his opinion, Trazodone was an unnecessary medication for Resident #57 as he was already receiving Klonopin and Remeron which provided the same effects.

An interview was conducted with the DON on 2/14/19 at 11:54 AM. The DON stated that Physician #2 responded to all pharmacy recommendations. She stated that Physician #2 was presently unreachable and was not available

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F 758	Continued From page 101 for interview. The DON reported that her expectation was for the physician to respond to pharmacy recommendations within a month. She acknowledged that a delayed response to pharmacy recommendations had the potential to continue administration of an unnecessary medication. The DON stated that she expected the regulations to be followed regarding the use of PRN psychotropic medications by ensuring orders for all PRN psychotropic medications had a stop date.	F 758		
F 761 SS=E	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. §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	F 761		3/29/19

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F 761	Continued From page 102 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to discard expired stock nutritional supplements in 1 of 2 medication storage rooms reviewed. Findings included: On 02/14/19 at 9:00 am an observation and interview were conducted with Nurse #4 of Station #2's medication storage room and 7 unopened bottles of Cholecalciferol D3-5 5000 units dietary supplement had a manufacturer's expiration date of 11/2018 for all bottles. Nurse #4 stated that the Supply Clerk and Unit Manager were responsible to check the stock medication for expiration date each week and discard as appropriate. Nurse #4 also stated that nursing staff would also discard if identified at the time of retrieval from storage. On 2/14/19 at 9:30 am an interview was conducted with the Unit Manager who stated that the Unit Managers, Supply Clerk, and Pharmacy were responsible to check for expired date medication and supplements each week and to discard accordingly. On 2/14/19 at 2:10 pm an interview was conducted with the Director of Nursing who stated she expected staff to check medication storage weekly and as needed for expired medication and supplements and to discard them and reorder.	F 761	F761 Label/Store Drugs and Biologicals Corrective Action: The 7 bottles of Cholecalciferol D-3-5 5000 were discarded during the survey when discovered. Identification of others potentially at risk: At the time of survey when notified of the expired supplements, the DON and nurse managers checked each area of medication storage and did not find any other expired items. Systematic Changes: As the nurse managers, the DON, central supply clerk, and Administrator routinely check daily for expired supplements in 6 med carts, three nourishment rooms, and two medication rooms, and we have added the pharmacy nurse to review these areas as well during their visit. If items are going to expire within the next 15 days, we will pull that item and discard it. The Central Supply coordinator has been educated the week of March 11th, to rotate stock each time new stock in put in and to pull any items that will expire in the next 15 days. Monitoring The Director of Nurses, using a QA auditing tool, will review each area of storage weekly for the next 4 weeks, and then monthly for the next quarter to determine how any expired supplement	

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F 761	Continued From page 103	F 761	could end up in a storage area and be not discarded. The results will be reported by the DON, to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from the QA committee with additional training to be provided by the Clinical Resource Specialist, as indicated.	
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 observations, staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the annual recertification survey dated 12/14/17. This was for two recited deficiencies in the areas of Care Plan Timing and Revision at F657- not reviewing and revising the care plan in falls previously cited on 12/14/17 and Free from Unnecessary Psychotropic Meds/PRN use at F758-not placing time duration on as needed (PRN) psychotropic medications previously cited 12/14/17. The findings included:	F 867	F867 Improvement Activities Corrective Action Resident #88 is currently out of the facility. Resident #28□s care plan has been updated to reflect no wanderguard is being used. Resident #270□s careplan has been updated to include recent falls and the careplan for Resident #9 has been updated to include behaviors. These updates have been completed by the Minimum Data Set (MDS) care plan nurse, during the week of February 18. Corrections were transmitted February 13, through the 15th.	3/29/19

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F 867	Continued From page 104 This citation is cross referenced to: F657- Based on observation record review and staff interview, the facility failed to review and revise care plans in the areas of wandering (Residents #28 and #88), falls (Resident #270) and behaviors (Resident #9) for 4 of 27 sampled residents. F758- Based on record reviews, staff interviews and Physician, Nurse Practitioner, Pharmacy Consultant interviews, the facility failed to ensure that as needed (PRN) psychotropic medications were time limited in duration (Residents #81. #9, #10, #74 and #57) for 5 of 8 residents reviewed medications. An interview was completed with the Administrator 2/14/19 at 12:40pm. He stated that the repeat citations in care plans, could be related to the size of the building, there was only one full time Minimum Data Set (MDS) nurse and a part time MDS nurse, until January 2019 when the part time MDS position became a full-time position. He stated that he was uncertain why there were repeat citations for the PRN psychotropic medications.	F 867	Residents #81, #9, #10, #74 and #57□s PRN (as needed) psychotropic drug orders were reviewed by physician and either discontinued or rewritten to provide both an appropriate rationale and duration. Resident #57's medical record was reviewed by pharmacy for any further recommended dose reduction or identification of duplicative medication therapy. Corrective Action for those having the potential to be affected At the time of the survey, all residents that had an assessment in the past three months were reviewed by the Minimum Data Set (MDS) assessment care plan nurse, and/or the nurse managers, to determine if comprehensive care plans have been updated for all recent falls, wandering behaviors, and behaviors in general. No other resident was found to not have timely updated care plans or care cards. Residents who have orders for PRN psychotropic drugs are potentially at risk and residents who receive psychotropic medications are potentially at risk for not having a gradual dose reduction or duplicate therapy. Our pharmacy has completed a monthly medication review on 2-28-2019, to determine if there are any other PRN psychotropic medications that are not time limited and to determine if there are any gradual dose reductions that should be attempted or any duplicative therapy (these are identified through the monthly pharmacy review).	

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F 867	Continued From page 105	F 867	Recommendations from these findings have been completed on Medication Recommendations to Physician and forwarded to physician for response. Based on the physician response to each recommendation, orders have been carried out by the Unit Managers. Systemic changes The QAPI committee includes the Medical Director, Administrator, Director of Nurses, Assistant Director of Nurses, Housekeeping Director, Social Worker, Pharmacist on a Quarterly Basis, and the Maintenance Director has been in-serviced by the Administrator the week of March 11th, on the procedure for developing and implementing appropriate plans of action to correct identified quality concerns. Education will include determining the root cause of the identified concern, identifying, implementing and monitoring the corrective action plan and recognizing when an action plan may need to be revised. The MDS/Care Plan Nurse and administrative nurses will have been re-educated on 3-15-19, by our Clinical Resource Specialist regarding coding accuracy of the MDS. ADON/staff development coordinator has inserviced nurses regarding the requirement that PRN psychotropic medications are time limited in duration not to exceed 14 days unless the provider believes that it is appropriate for the PRN order to be extended beyond 14 days, and he or she documents their rationale in the resident□s medical record and indicates	

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the duration for the PRN order. The pharmacist has been re-educated by the Director of Clinical Services of the pharmacy on March 6th.

Monitoring
The Director of Nurses, and/or her nurse manager, will perform audits bi-weekly for one month and then monthly for one quarter, to determine if there are any residents who have had wandering episodes, falls, and/or behaviors. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.
Medication reconciliation chart checks are done on newly admitted residents charts and a check to ensure that any PRN psychotropic medication has an appropriate duration and rationale will be a part of this check for ongoing monitoring. Also, orders are reviewed daily at clinical operations meetings and any orders for PRN psychotropic medication will be reviewed for duration time limit and rationale. Orders will be corrected as identified for ongoing monitoring.
An independent consultant pharmacist(s) will provide the monthly drug regimen review, for at least one quarter as above. The results will be reported to the Director of Clinical Services of the provider pharmacy and to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further

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F 867	Continued From page 107	F 867	recommendations. The Administrator will be responsible to follow-up on any recommendation from the QA committee with additional training to be provided by the Clinical Resource Specialist, as indicated	
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on observations, staff, Physician, Nurse Practitioner and Consultant Pharmacist interviews and record review, the facility failed to address the continued use of antibiotics with no stop date or re-evaluation in the absence of signs or symptoms of infection for 3 (Resident #71, Resident #72 and Resident #74) of 3 residents reviewed for antibiotic stewardship. The findings included: Review of the Antibiotic Stewardship Policy dated 5/2016 read as follows: The purpose of the policy was to preserve the effectiveness of antibiotic use. The procedures included the use of McGeer's Criteria (minimum criteria for infections) for infection control surveillance in Long Term Care. The procedure reads the Physician must order the use of antibiotics to include the dose,	F 881	F881 Antibiotic Stewardship Program Corrective Action: Residents number 71, 72, and 74 have been reviewed by the pharmacist with recommendations sent to the medical director to review. Recommendations have been reviewed the week of 3-4-19 and orders written if any changes were to be made. Resident #71 did have her Infectious Disease appointment on 9-11-18, and we do have the office documentation. Corrective action for those who have the potential to be affected Any resident that requires an antibiotic has the potential to be affected by this	3/29/19

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duration and indication for use. The facility would collaborate with the pharmacy to improve antibiotic use and educate the staff, Physician, residents and resident families about antibiotics resistance and opportunities for improving antibiotic use.

1. Resident #71 was admitted 10/21/15 with cumulative diagnoses of pressure ulcers and Osteomyelitis.

Review of an General Infectious Disease Consult note dated 8/14/18 while hospitalized from 8/9/18 through 8/20/18 read to restart the Cefdinir (antibiotic) and Metronidazole (antibiotic) on hospital discharge and follow up with Infectious Diseases on 9/6/18.

The facility was not able to provide any evidence of the follow up appointment with Infectious Diseases scheduled on 9/6/18.

Review of an Physician Discharge Summary dated 9/16/18 read Resident #71 was admitted to the hospital with Sepsis (potentially life-threatening response to infection which may result if multiple organ damage) due to a urinary tract infection (UTI). The discharge summary read she was to continue with Invaz (antibiotic) intravenously through 9/20/18 and she may benefit from UTI prophylaxis (preventive). Resident #71 was discharged on 9/16/18 taking Cefdinir and Metronidazole, both with no stop date.

Resident #71's quarterly Minimum Data Set (MDS) dated 9/23/18 indicated she was cognitively intact and exhibited no behaviors. She was coded for total assistance for all her activities

alleged deficient practice and can be identified by reviewing the weekly antibiotic reports generated from our pharmacy. The Director of Nurses preformed and audit during the week of 2-18-19, of all residents that were on antibiotics. No other resident was found to be on indefinite antibiotic therapy without appropriate documentation from the attending physician.

Systemic Changes
The pharmacist has been re-educated on 3-16-2019, by the Director of Clinical Services of the provider pharmacy to include reviewing of stop orders for antibiotics. An independent consultant pharmacist(s) will provide consulting services for at least one quarter starting in March 2019. The consultant pharmacist will address the above issues during the monthly drug regimen review.

Monitoring
The Director of Nurses/ Unit Managers, utilizing a QA auditing tool, will review the weekly antibiotic reports generated from our pharmacy, to ensure there are stop orders in place or to determine why there is not a stop order, weekly for the next 2 months, and then monthly for the next two months. The results will be reported by the DON, to the monthly QAPI meeting for any further recommendations or root cause analysis. The DON will be responsible to follow-up on any recommendation from the committee and additional training is indicated.

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of daily living except eating. Resident #71 was coded for 2 stage 4 pressure ulcers, a urinary catheter and a colostomy. She was coded for 3 days of antibiotic use for the 7 days look back. The MDS was coded for a UTI.

Review of the Treatment Administration Record (TAR) for October 2018 revealed multiple refusals of her second of her two daily dressing changes.

Review of Nurse Practitioner note dated 10/8/18 read Infectious Diseases did not want to restart Resident #71's Cefdinir and Metronidazole after her hospital discharge on 9/16/18 and on 9/30/18, she developed a fever and sent back to the hospital and diagnosed with Septic Shock (potentially fatal condition when Sepsis leads to a low blood pressure) due to a UTI. She returned to the facility on 10/6/18. The note indicated the Nurse Practitioner restarted the Cefdinir and Metronidazole after her other antibiotics were completed on 10/16/18. The note was initialed as reviewed by the Physician.

Resident #71's quarterly Minimum Data Set (MDS) dated 10/13/18 indicated she was cognitively intact and exhibited no behaviors. She was coded for total assistance for all her activities of daily living except eating. Resident #71 was coded for 2 stage 4 pressure ulcers, a urinary catheter and a colostomy. She was coded for 7 days of antibiotic use for the 7 days look back. The MDS was coded for a UTI and Sepsis.

Review of lab work dated 10/16/18 indicated Resident #71's white blood cell count was 7.1 with normal ranges from 4.0 to 11.0. An elevated white blood cell count is indicative of an infection and/or inflammation.

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Review of Resident #71's October 2018 Physician Orders read Cefdinir twice by mouth daily for osteomyelitis. This order was dated as initiated 10/18/18 with no stop date. There was also an order for Metronidazole three times daily for osteomyelitis maintenance with an initiation date of 10/19/19 and no stop date.

Review of lab work dated 10/24/18 indicated Resident #71's white blood cell count was 6.9 with normal ranges from 4.0 to 11.0.

Review of Resident #71's November 2018 Physician Orders read Cefdinir twice by mouth daily for osteomyelitis. This order was dated as initiated 10/18/18 with no stop date. There was also an order for Metronidazole three times daily for osteomyelitis maintenance with an initiation date of 10/19/19 and no stop date.

Review of the TAR for November 2018 revealed multiple refusals of her second of her two daily dressing changes.

Review of lab work dated 11/20/18 indicated Resident #71's white blood cell count was 7.3 with normal ranges from 4.0 to 11.0.

Review of Resident #71's December 2018 Physician Orders read Cefdinir twice by mouth daily for osteomyelitis. This order was dated as initiated 10/18/18 with no stop date. There was also an order for Metronidazole three times daily for osteomyelitis maintenance with an initiation date of 10/19/19 and no stop date.

Review of the TAR for December 2018 revealed multiple refusals of her second of her two daily

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dressing changes.

Review of lab work dated 12/3/18 indicated Resident #71's urinalysis was positive for Escherichia Coli (bacteria found in the environment, foods and intestines) and Extended Spectrum B-lactamases (ESBL-enzymes produced by bacteria that have an increased resistance to commonly used antibiotics). Resident #71's Physician orders read she was started in Invanz (antibiotic) intramuscularly on 12/3/18 and this was changed to Augmentin (antibiotic) by mouth for 7 days for a UTI.

Review of a Physician progress note dated 12/5/18 read staff report that Resident #71 was noncompliant sometimes with her medications and changing positions. Resident #71's pressure ulcers were a source of multiple infections and she was on chronic antibiotic. Resident #71 has a history of multiple UTI's with the culprit thought to be her chronic suprapubic catheter (a tube inserted below the navel into the bladder to drain urine). Her antibiotics were prophylactics and she was told an infection would likely kill her.

Review of Resident #71's oral temperatures in the electronic record from 10/10/18 through 12/14/18 were all without evidence of a fever. There were no additional temperatures documented after 12/14/18.

Review of Resident #71's January 2019 Physician Orders read Cefdinir twice by mouth daily for osteomyelitis. This order was dated as initiated 10/18/18 with no stop date. There was also an order for Metronidazole three times daily for osteomyelitis maintenance with an initiation date of 10/19/19 and no stop date.

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Review of the TAR for January 2019 revealed multiple refusals of her second of her two daily dressing changes.

Resident #71's quarterly Minimum Data Set (MDS) dated 1/11/19 indicated she was cognitively intact and exhibited no behaviors. She was coded for total assistance for all her activities of daily living except eating. Resident #71 was coded for 2 stage 4 pressure ulcers, a urinary catheter and a colostomy. She was coded for 7 days of antibiotic use for the 7 days look back. The MDS was coded for no infections.

Resident #71 was care planned on 9/17/18 for only allowing one pressure ulcer treatment per day and for choosing not to reposition as advised by wound physician. The interventions included giving Resident #71 her antibiotic as ordered for prevention of osteomyelitis dated initiated 11/15/18.This care plan was dated last revised on 1/16/2019.

Review of Resident #71's February 2019 Physician Orders read Cefdinir by mouth twice mouth daily for osteomyelitis. This order was dated as initiated 10/18/18 with no stop date. There was also an order for Metronidazole three times daily for osteomyelitis maintenance with an initiation date of 10/19/19 and no stop date.

Review of the TAR for February 2019 from 2/1/19 to 2/13/19 revealed multiple refusals of her second of her two daily dressing changes.

Resident #71's significant change Minimum Data Set (MDS) dated 2/1/19 indicated she was cognitively intact and exhibited no behaviors. She

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was coded for total assistance for all her activities of daily living except eating. Resident #71 was coded for 2 stage 4 pressure ulcers, a urinary catheter and a colostomy. She was coded for 7 days of antibiotic use for the 7 days look back. The MDS was coded for no infection.

During an observation and interview on 2/11/19 at 10:18 AM, Resident #71 was sitting up in a bariatric bed. She voiced no discomfort and confirmed the presence of one pressure ulcer. She stated one of the area was healed. Resident #71 stated she did not get up preferring to stay in bed.

During an interview on 2/12/19 at 2:30 PM, the Infection Control Preventionist (ICP) stated she was aware that antibiotic should have an indication for use and a stop date but there were some residents who were prescribed antibiotics indefinitely. The ICP confirmed the facility utilized the McGeer's Criteria for the treatment of infections. She stated the Nurse Practitioner and the Physician maintained oversight of Resident #71's antibiotic use.

During an interview on 2/13/19 at 8:30 AM, the Director of Nursing (DON) stated she had no pharmacy recommendations related to no stop date for Resident #71's antibiotics and she would have expected one.

During an interview on 2/13/19 at 9:00 AM, the Nurse Practitioner (NP) stated the previous NP left about a week ago and she was still going around to meet her residents. The NP stated it was unusual to see any resident on antibiotics so long and the continued use should have been reassessed.

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During a wound care observation on 2/13/19 at 10:35 AM, the left ischial Stage 4 wound was absent signs of infection and the right ischial area was healed.

During a telephone interview on 2/13/19 at 11:23 AM, Physician #3 stated the use of antibiotics for Resident #71 was not curative but rather to suppress and reduce hospitalizations due to Sepsis from her wounds. He stated he was not aware that the right ischial wound was healed but that the antibiotics were also indicated for the chronic UTI's associated with Resident #71's suprapubic catheter. Physician #3 stated when Resident #71 showed signs of an infection, she becomes very sick and ended up on a ventilator and at her age, the benefits outweigh the risk. He stated the Infectious Disease Department was following Resident #71, but he was unsure when she was last evaluated. He stated it would be his expectation that she be re-evaluated for the continued use of the antibiotics.

The facility was unable to provide evidence of any follow up with Infectious Disease since Resident #71 was hospitalized on 10/6/18.

During an interview on 2/13/19 at 1:20 PM, the Consultant Pharmacist stated he read that the Physician was aware of the open-ended use of Resident #71's antibiotics and that the documentation from Infectious Disease from the hospital recommended the continued use of her antibiotic. He stated he did not make any recommendations regarding Resident #71's Cefdinir or Metronidazole.

During an interview on 2/14/18 at 11:54 AM, the

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DON stated the Medical Director (MD) was unavailable for interview and that the other Physicians and MD always followed the recommendations of the Infectious Disease Specialist. The DON stated she was not aware the NP was the person who restarted Resident #71's Cefdinir and Metronidazole in October 2018 and she was not aware of any follow up with Infectious Disease since her hospitalization 10/6/18. The DON stated the use of prophylactics were not in accordance with the antibiotic stewardship policy and that the policy should be followed or Resident #71 reassessed for the continued need of her antibiotics.

2. Resident # 72 was admitted on 10/6/18 with cumulative diagnoses of Chronic Obstructive Pulmonary Disease and Diabetes.

Review of Resident #72's hospital discharge orders read she was to receive Nitrofurantoin (antibiotic) 50 milligrams (mg) four times daily for 7 days then daily thereafter to prevent urinary tract infections (UTIs).

Review of Resident #72's October 2018 Physician Orders read an order for Nitrofurantoin daily prophylactic. The order did not include an indication or a stop date.

Resident #72 was care planned on 10/19/18 for a risk of urinary tract infection (UTI's) related to a decline in mobility, frequent incontinence of bowel and bladder and history of recent UTI and urinary retention. Interventions included staff to administer her medication as ordered and monitor for effectiveness/side effects and report abnormal findings to physician.

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Review of Resident #72's November 2018 Physician Orders read an order for Nitrofurantoin daily prophylactic. The order did not include an indication or a stop date.

Review of Resident #72's December 2018 Physician Orders read an order for Nitrofurantoin daily prophylactic. The order did not include an indication or a stop date.

Review of a urinalysis dated 12/13/18 read Resident #72 was negative for an UTI.

Review of Resident #72's January 2019 Physician Orders read an order for Nitrofurantoin daily prophylactic. The order did not include an indication or a stop date.

Review of Resident #72's February 2019 Physician Orders read an order for Nitrofurantoin daily prophylactic. The order did not include an indication or a stop date.

Resident #72 quarterly Minimum Data Set dated 1/11/19 indicated moderate cognitive impairment with no behaviors. She was coded for extensive assistance with personal hygiene and total assistance with toileting. Resident #72 was coded as frequently incontinent of bladder and bowel, as having no infections and as having received 7 days of antibiotics during the 7 days look back period.

Review of a urinalysis dated 2/2/19 read Resident #72 was negative for an UTI.

During an observation and interview on 2/12/19 at 9:00 AM, Resident #72 was sitting up in bed. She was pleasant and well-groomed and voiced no

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discomfort.

During an interview on 2/12/19 at 2:30 PM, the Infection Control Preventionist (ICP) stated she was aware that antibiotics should have an indication for use and a stop date but there were some residents who were prescribed antibiotics indefinitely. The ICP confirmed the facility utilized the McGeer's Criteria for the treatment of infections and that Resident #72 did not meet the criteria for continued antibiotic use.

During an interview on 2/13/19 at 8:30 AM, the Director of Nursing (DON) stated she had no pharmacy recommendations related to the clinical indication or stop date for Resident #72's antibiotics and she would have expected one.

During an interview on 2/13/19 at 9:00 AM, the Nurse Practitioner (NP) stated the previous NP left about a week ago and she was still going around to meet her residents. The NP stated it was unusual to see a resident on prophylactic antibiotics for UTIs and that was a practice not commonly used anymore. She stated she spoke with the Responsible Party and Resident #72 about the risk associated with taking antibiotics in the absence of clinical indications and they agreed to discontinue the antibiotic.

During a telephone interview on 2/13/19 at 11:23 AM, Physician #3 stated Resident #72 was followed outside the facility by a well-known local Physician and that if he ordered the antibiotic for Resident #72, he would not discontinue it while Resident #72 was residing at the facility.

During an interview on 2/13/19 at 1:20 PM, the Consultant Pharmacist stated he did not write any

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recommendation about the continued use of Resident #72's antibiotic since it was ordered daily upon discharge from the hospital.

During an interview on 2/14/18 at 11:54 AM, the DON stated the Medical Director (MD) was unavailable for interview and that the other Physician and MD always followed the recommendations of the primary Physician for Resident #72. The DON stated the use of prophylactics were not in accordance with the antibiotic stewardship policy and that the policy should be followed for Resident #72.

3. Resident #74 was admitted to the facility on 10/8/18 with multiple diagnose including dementia.

Review of Resident #74's medical record revealed he had a physician's order dated 10/9/18 for Nitrofurantoin (an antibiotic) 100 milligrams (mgs) - 1 capsule by mouth daily for Chronic Urinary Tract Infection (UTI) prevention. The antibiotic order did not contain a stop date.

The quarterly Minimum Data Set (MDS) assessment dated 1/14/19 indicated that Resident #74 had severe cognitive impairment and she had received an antibiotic medication for 7 days during the assessment period.

Review of Resident #74's February 2019 Medication Administration Record (MAR) revealed the resident continued to receive use of Nitrofurantoin on a daily basis.

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F 881	Continued From page 119 On 2/12/19 at 2:26 PM, the Infection Control Nurse (IC) was interviewed. She stated that she was aware of the facility's antibiotic stewardship program that physician's order for antibiotic should have a stop date. The IC Nurse further stated that she was aware that the facility had several residents on prophylactic antibiotic but she didn't know the regulation that antibiotic should only be ordered for active infection and should be time limited in duration. On 2/12/19 at 3:20 PM, the Unit Manager (UM) was interviewed. She stated that she was aware that the facility had antibiotic stewardship program but she did not know what this was all about. The UM indicated that Resident #74 did not have an acute urinary tract infection (UTI) since admission. She verified that Resident #74 was admitted on Nitrofurantoin for UTI prevention. An interview with the Director of Nursing (DON) was conducted on 2/14/19 at 11:52 AM. The DON stated that she expected the facility's antibiotic stewardship program to be followed by ensuring orders for antibiotic have a stop date.	F 881		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		3/29/19

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immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal

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F 883	Continued From page 121 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to administer the Pneumonia Immunization Series as consented to on admission for 6 (Resident #92, Resident #98, Resident #64, Resident #61, Resident #118 and Resident #74) of 6 residents reviewed for Pneumonia Immunizations. The findings included: Review of the facility provided policy titled Pneumococcal Immunization dated revised 2/5/16 read in adults age 65 or older as well as residents of a long-term care facility should be administered both the Prevnar 13 (PCV13) and the Pneumovax23 (PPSV23) routinely as a series. 1. Resident #92 was admitted 3/3/16 with cumulative diagnoses of Paraplegia, Diabetes and Seizures. The medical record revealed a signed consent on admission for the Pneumonia Immunization. A review of Resident #92's medical record revealed there was no documentation to indicate whether the resident received or refused either of pneumococcal vaccines. A review of Resident #92's most recent quarterly Minimum Data Set (MDS) assessment dated 1/22/19 was reviewed. Section O of the MDS	F 883	F883 Influenza and Pneumococcal Immunization Corrective Action: Residents #92, #98, #61, #118, and #74 were reissued VIS (vaccine information statements) and immunization consent forms for pneumococcal vaccines (PCV13 and PPSV23) by the Unit Nurse Manager, and given the charge nurse on the unit has given the appropriate vaccine based on response. Administration of vaccine will be documented on the Medication Administration Record (MAR) and under the Immun (Immunization) tab of the electronic medical record. Identification of others potentially at Risk: Other current residents are potentially at risk of not receiving pneumococcal vaccines. An audit has been completed by the Director of Nurses and/or her Unit Managers determine who has received the pneumococcal vaccine and for those identified as not receiving vaccine(s) nursing will go through the process of re-issuing VIS (vaccine information statements) and immunization consent forms for pneumococcal vaccines (PCV13 and PPSV23) and identified residents will be given the appropriate vaccine based on response. Administration of vaccine	

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F 883	Continued From page 122 assessment indicated the resident's pneumococcal vaccination was offered and declined. During an interview on 2/12/19 at 1:50 PM, the Director of Nursing (DON) stated it was her expectation that residents residing at the facility that have consented to the Pneumonia Immunization receive the immunization series as ordered. She was unable to offer any explanation as to why the Pneumonia Immunizations were not administered for Resident # 92. The DON stated it was ultimately responsibility of the Unit Managers and Unit Coordinator with oversight by the Infection Control Preventioist (ICP) to ensure the immunizations were administered. During an interview on 2/12/19 at 2:30 PM, the Infection Control Preventionist (ICP) confirmed there was no information in Resident #92's medical record that reflected that the PCV13 or PPSV23 was administered. She was unable to offer any explanation as to why the consented Pneumonia Immunizations were not administered. She stated on admission, the Unit Managers and the Unit Coordinator were responsible for initiating the Pneumonia Immunization series on residents who have consented. She stated she did not routinely go behind the Unit Managers or Unit Coordinator to ensure the immunizations were completed. During an interview on 2/12/19 at 5:04 PM, Unit Coordinator (UC) stated she administered the Pneumonia Immunizations to residents who had consented, and she was under the impression that the PPSV23 immunization could not be given until 1 year after the initial PCV13 dose. She	F 883	will be documented on the Medication Administration Record (MAR) and under the Immun (Immunization) tab of the electronic medical record by the charge nurse who is giving the immunization. Systemic Changes: During the admission process residents will be given the VIS (vaccine information statements). Immunization consent forms for pneumococcal vaccines (PCV13 and PPSV23) and identified residents will be given the appropriate vaccine based on response. Administration of vaccine will be documented on the Medication Administration Record (MAR) and under the Immun (Immunization) tab of the electronic medical record. This information is reviewed at Clinical operations meeting and scheduled if needed if not already completed. The ADON/staff development coordinator will inservice nursing on the two pneumococcal vaccines (PCV13 and PPSV23) to include documentation, frequency and time intervals of these vaccinations. The inservices have been given at various times by over the weeks of February 25th and March 4th. All inservcies for all licensed staff, to include full time, part time, and as necessary staff, will be completed by 3-22-19, or will not be scheduled to work. Monitoring: The Director of Nurses, using a QA auditing tool, will review immunizations weekly for 3 months to determine compliance. The results will be reported	

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F 883	Continued From page 123 stated she learned on 2/11/19 that the PPSV23 could be administered 8 weeks after the PCV13. She was unable to explain why the initial doses of the missing PCV13 immunizations was not completed. During another interview on 2/14/19 at 11:54 AM, the DON stated it was her expectation that Resident #92's receive the Pneumonia Immunization as ordered and done timely. 2. Resident #98 was admitted 8/13/18 with cumulative diagnoses of Encephalopathy (brain damage) and Alcohol Abuse. Resident of the medical record revealed a signed consent on admission for the Pneumonia Immunization. A review of Resident #98's medical record revealed there was no documentation to indicate whether the resident received or refused either of pneumococcal vaccines. A review of Resident #98's most recent Minimum Data Set (MDS) assessment dated 1/22/19 was reviewed. Section O of the MDS assessment indicated the resident's pneumococcal vaccination was offered and declined. During an interview on 2/12/19 at 1:50 PM, the Director of Nursing (DON) stated it was her expectation that residents residing at the facility that have consented to the Pneumonia Immunization receive the immunization series as ordered. She was unable to offer any explanation as to why the Pneumonia Immunizations were not administered for Resident #98. The DON stated it was ultimately responsibility of the Unit Managers and Unit Coordinator with oversight by the	F 883	by the DON, to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from the QA committee with additional training to be provided by the Clinical Resource Specialist, as indicated.	

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Infection Control Preventioist (ICP) to ensure the immunizations were administered.

During an interview on 2/12/19 at 2:30 PM, the Infection Control Preventionist (ICP) confirmed there was no information in Resident #98's medical record that reflected that the PCV13 or PPSV23 was administered. She was unable to offer any explanation as to why the consented Pneumonia Immunizations were not administered. She stated on admission, the Unit Managers and the Unit Coordinator were responsible for initiating the Pneumonia Immunization series on residents who have consented. She stated she did not routinely go behind the Unit Managers or Unit Coordinator to ensure the immunizations were completed.

During an interview on 2/12/19 at 5:04 PM, Unit Coordinator (UC) stated she administered the Pneumonia Immunizations to residents who had consented, and she was under the impression that the PPSV23 immunization could not be given until 1 year after the initial PCV13 dose. She stated she learned on 2/11/19 that the PPSV23 could be administered 8 weeks after the PCV13. She was unable to explain why the initial doses of the missing PCV13 immunizations was not completed.

During another interview on 2/14/19 at 11:54 AM, the DON stated it was her expectation that Resident #98's receive the Pneumonia Immunization as ordered and done timely.

3. Resident #64 was admitted 2/17/18 with cumulative diagnoses of Congestive Heart Failure and Diabetes. Review of the medical record revealed a signed consent on admission for the

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Pneumonia Immunization.

A review of Resident #64's medical record revealed there was no documentation to indicate whether the resident received or refused either of pneumococcal vaccines.

A review of Resident #64's most recent quarterly Minimum Data Set (MDS) assessment dated 11/14/18 was reviewed. Section O of the MDS assessment indicated the resident's pneumococcal vaccination was up to date.

During an interview on 2/12/19 at 1:50 PM, the Director of Nursing (DON) stated it was her expectation that residents residing at the facility that have consented to the Pneumonia Immunization receive the immunization series as ordered. She was unable to offer any explanation as to why the Pneumonia Immunizations were not administered for Resident #64. The DON stated it was ultimately responsibility of the Unit Managers and Unit Coordinator with oversight by the Infection Control Preventioist (ICP) to ensure the immunizations were administered.

During an interview on 2/12/19 at 2:30 PM, the Infection Control Preventionist (ICP) confirmed there was no information in Resident #64's medical record that reflected that the PCV13 or PPSV23 was administered. She was unable to offer any explanation as to why the consented Pneumonia Immunizations were not administered. She stated on admission, the Unit Managers and the Unit Coordinator were responsible for initiating the Pneumonia Immunization series on residents who have consented. She stated she did not routinely go

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F 883	Continued From page 126	F 883		

behind the Unit Managers or Unit Coordinator to ensure the immunizations were completed.

During an interview on 2/12/19 at 5:04 PM, Unit Coordinator (UC) stated she administered the Pneumonia Immunizations to residents who had consented, and she was under the impression that the PPSV23 immunization could not be given until 1 year after the initial PCV13 dose. She stated she learned on 2/11/19 that the PPSV23 could be administered 8 weeks after the PCV13. She was unable to explain why the initial doses of the missing PCV13 immunizations was not completed.

During another interview on 2/14/19 at 11:54 AM, the DON stated it was her expectation that Resident #64's receive the Pneumonia Immunization as ordered and done timely.

4. Resident #61 was admitted 4/3/18 with cumulative diagnoses of Neurogenic Bladder and Dysphagia. Review of the medical record revealed a signed consent on admission for the Pneumonia Immunization.

A review of Resident #61's medical record revealed there was no documentation to indicate whether the resident received or refused either of pneumococcal vaccines.

A review of Resident #61's most recent quarterly Minimum Data Set (MDS) assessment dated 1/18/19 was reviewed. Section O of the MDS assessment indicated the resident's pneumococcal vaccination was up to date.

During an interview on 2/12/19 at 1:50 PM, the

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Director of Nursing (DON) stated it was her expectation that residents residing at the facility that have consented to the Pneumonia Immunization receive the immunization series as ordered. She was unable to offer any explanation as to why the Pneumonia Immunizations were not administered for Resident #61. The DON stated it was ultimately responsibility of the Unit Managers and Unit Coordinator with oversight by the Infection Control Preventioist (ICP) to ensure the immunizations were administered.

During an interview on 2/12/19 at 2:30 PM, the Infection Control Preventionist (ICP) confirmed there was no information in Resident #61's medical record that reflected that the PCV13 or PPSV23 was administered. She was unable to offer any explanation as to why the consented Pneumonia Immunizations were not administered. She stated on admission, the Unit Managers and the Unit Coordinator were responsible for initiating the Pneumonia Immunization series on residents who have consented. She stated she did not routinely go behind the Unit Managers or Unit Coordinator to ensure the immunizations were completed.

During an interview on 2/12/19 at 5:04 PM, Unit Coordinator (UC) stated she administered the Pneumonia Immunizations to residents who had consented, and she was under the impression that the PPSV23 immunization could not be given until 1 year after the initial PCV13 dose. She stated she learned on 2/11/19 that the PPSV23 could be administered 8 weeks after the PCV13. She was unable to explain why the initial doses of the missing PCV13 immunizations was not completed.

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During another interview on 2/14/19 at 11:54 AM, the DON stated it was her expectation that Resident #61's receive the Pneumonia Immunization as ordered and done timely.

5. Resident #118 was admitted 1/24/19 with cumulative diagnoses of Thrombocytopenia (low blood platelet count) and a Urinary Tract Infection. Review of the medical record revealed a signed consent on admission for the Pneumonia Immunization.

A review of Resident #118's medical record revealed there was no documentation to indicate whether the resident received or refused either of pneumococcal vaccines.

A review of Resident #118's admission Minimum Data Set (MDS) assessment dated 1/31/19 was reviewed. Section O of the MDS assessment indicated the resident's pneumococcal vaccination was up to date.

During an interview on 2/12/19 at 1:50 PM, the Director of Nursing (DON) stated it was her expectation that residents residing at the facility that have consented to the Pneumonia Immunization receive the immunization series as ordered. She was unable to offer any explanation as to why the Pneumonia Immunizations were not administered for Resident #118. The DON stated it was ultimately responsibility of the Unit Managers and Unit Coordinator with oversight by the Infection Control Preventioist (ICP) to ensure the immunizations were administered.

During an interview on 2/12/19 at 2:30 PM, the Infection Control Preventionist (ICP) confirmed

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there was no information in Resident #118's medical record that reflected that the PCV13 or PPSV23 was administered. She was unable to offer any explanation as to why the consented Pneumonia Immunizations were not administered. She stated on admission, the Unit Managers and the Unit Coordinator were responsible for initiating the Pneumonia Immunization series on residents who have consented. She stated she did not routinely go behind the Unit Managers or Unit Coordinator to ensure the immunizations were completed.

During an interview on 2/12/19 at 5:04 PM, Unit Coordinator (UC) stated she administered the Pneumonia Immunizations to residents who had consented, and she was under the impression that the PPSV23 immunization could not be given until 1 year after the initial PCV13 dose. She stated she learned on 2/11/19 that the PPSV23 could be administered 8 weeks after the PCV13. She was unable to explain why the initial doses of the missing PCV13 immunizations was not completed.

During another interview on 2/14/19 at 11:54 AM, the DON stated it was her expectation that Resident #118's receive the Pneumonia Immunization as ordered and done timely.

6. Resident #74 was admitted 10/8/18 with cumulative diagnoses of Dementia, weakness and Hypertension. Review of the medical record revealed a signed consent on admission for the Pneumonia Immunization.

A review of Resident #74's medical record revealed there was no documentation to indicate whether the resident received or refused either of

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pneumococcal vaccines.

A review of Resident #74's most recent quarterly Minimum Data Set (MDS) assessment dated 1/14/19 was reviewed. Section O of the MDS assessment indicated the resident's pneumococcal vaccination was up to date.

During an interview on 2/12/19 at 1:50 PM, the Director of Nursing (DON) stated it was her expectation that residents residing at the facility that have consented to the Pneumonia Immunization receive the immunization series as ordered. She was unable to offer any explanation as to why the Pneumonia Immunizations were not administered for Resident #74. The DON stated it was ultimately responsibility of the Unit Managers and Unit Coordinator with oversight by the Infection Control Preventionist (ICP) to ensure the immunizations were administered.

During an interview on 2/12/19 at 2:30 PM, the Infection Control Preventionist (ICP) confirmed there was no information in Resident #74's medical record that reflected that the PCV13 or PPSV23 was administered. She was unable to offer any explanation as to why the consented Pneumonia Immunizations were not administered. She stated on admission, the Unit Managers and the Unit Coordinator were responsible for initiating the Pneumonia Immunization series on residents who have consented. She stated she did not routinely go behind the Unit Managers or Unit Coordinator to ensure the immunizations were completed.

During an interview on 2/12/19 at 5:04 PM, Unit Coordinator (UC) stated she administered the

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F 883	Continued From page 131 Pneumonia Immunizations to residents who had consented, and she was under the impression that the PPSV23 immunization could not be given until 1 year after the initial PCV13 dose. She stated she learned on 2/11/19 that the PPSV23 could be administered 8 weeks after the PCV13. She was unable to explain why the initial doses of the missing PCV13 immunizations was not completed. During another interview on 2/14/19 at 11:54 AM, the DON stated it was her expectation that Resident #74's receive the Pneumonia Immunization as ordered and done timely.	F 883		