STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 3/18/19 through 3/21/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #YQDZ11.	E 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		4/18/19

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

Electronically Signed | 04/04/2019

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F 550	Continued From page 1 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 provide privacy and dignity by not covering the urinary catheter drainage bag for 2 of 4 sampled residents reviewed for urinary catheter (Residents #74 & # 53). Findings included: 1. Resident #74 was admitted to the facility on 2/14/19 with multiple diagnoses including urinary retention. The admission Minimum Data Set (MDS) assessment dated 2/24/19 indicated that Resident #74 had memory and decision making problems and she had an indwelling urinary catheter. Resident #74 did not have a comprehensive care plan developed for the use of the urinary catheter. Resident #74 had a doctor's order on admission (2/14/19) for the indwelling urinary catheter. On 3/19/19 at 9:50 AM and at 4:30 PM, Resident #74 was observed in bed. She had a urinary catheter and the urinary catheter bag was facing the door and it was not covered.	F 550	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The licensed nurse placed Resident #74□s urinary drainage bag in a dignity cover bag on 3/19/19. The licensed nurse placed Resident #53□s urinary drainage bag in a dignity cover bag on 3/19/19. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Director of nursing (DON) and Assistant Director of Nursing (ADON) identified 9 current residents with catheters on 3/19/19. All identified residents were observed on 3/19/19, and a dignity bag in place covering the urinary drainage bag. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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F 550	Continued From page 2 On 3/19/19 at 4:33 PM, Nurse Aide (NA) #3 was interviewed. She stated that she just worked part time at the facility and she didn't not know why the catheter bag was not covered with a privacy bag. NA #3 also stated that she didn't notice that Resident #74's catheter bag was not in a privacy bag. On 3/19/19 at 4:35 PM, Nurse #8 was interviewed. She stated that she expected the NA to report to her that the catheter bag was not in a privacy bag. She indicated that nobody had reported that Resident #74's catheter bag was not covered with a privacy bag. On 3/21/19 at 8:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected all catheter bags to be covered with a privacy bag and NAs were supposed to report to the nurse when the catheter bag was not covered. 2. Resident #53 was originally admitted to the facility on 12/7/17 and was readmitted on 2/18/19 with multiple diagnoses including congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated 2/10/19 indicated that Resident #53's cognition was intact and she did not have an indwelling urinary catheter. Resident #53 had an order for the urinary catheter on 2/18/19 (readmission) due to urinary retention. Resident #53 did not have a comprehensive care	F 550	The DON and/or the ADON□s completed in service education for the current nursing staff on 3/27/19, regarding use of dignity bags for residents with urinary catheter bags. Education will be provided for newly hired staff during new hire orientation. The DON and/or the ADON□s will review physician orders during morning clinical meeting at least 5 days a week to identify residents with orders for catheters and validate that the catheter bag is placed in a dignity cover bag. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON and/or the ADON□s will observe 3 catheters a week for 4 weeks then 10 catheters a month for 2 months to validate that the urinary catheter bag is placed in a dignity cover bag. The DON will review audits/observations to identify patterns/trends and will adjust plan as necessary for continued compliance. The Administrator will review the plan during monthly QAPI and will continue audits at the discretion of the QAPI committee.	

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F 550	Continued From page 3 plan developed for the use of the urinary catheter after readmission (2/18/19). On 3/19/19 at 9:53 AM and at 4:31 PM, Resident #53 was observed in bed. She had a urinary catheter and the urinary catheter bag was facing the door and it was not covered. On 3/19/19 at 4:33 PM, Nurse Aide (NA) #3 was interviewed. She stated that she just worked part time at the facility and she didn't not know why the catheter bag was not covered with a privacy bag. NA #3 also stated that she didn't notice that Resident #53's catheter bag was not in a privacy bag. On 3/19/19 at 4:35 PM, Nurse #8 was interviewed. She stated that she expected the NA to report to her that the catheter bag was not in a privacy bag. She indicated that nobody had reported that Resident #53's catheter bag was not covered with a privacy bag. On 3/19/19 at 4:38 PM, Resident #53 was interviewed. She stated that it was a dignity issue to show your catheter bag in public and staff should have covered it. On 3/21/19 at 8:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected all catheter bags to be covered with a privacy bag and NAs were supposed to report to the nurse when the catheter bag was not covered.	F 550		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		4/18/19

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F 623	Continued From page 4 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 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.	F 623		

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F 623	Continued From page 5 §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 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	F 623		

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F 623	Continued From page 6 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 reviews and family, resident and staff interviews, the facility failed to provide the resident and/or resident representative written notification of the reason for transfer to the hospital for 2 of 2 residents reviewed for hospitalization. (Resident # 38 and #53). The findings included: 1) Resident #38 was admitted to the facility on 9/12/17 with diagnoses that included Multiple Sclerosis, muscle weakness, seizure disorder, diabetes mellitus, neurogenic bladder and hypertension. A medical record review revealed the resident was transferred to the hospital on 9/7/18 and on 10/4/18. There was no documentation of a written notice of transfer provided to the resident, who was her own responsible party. A review of Resident #38's most recent Minimum Data Set (MDS) coded as a Quarterly	F 623	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Social Service Director (SSD) provided a written letter of discharge/transfer on 4/01/19, to Resident # 38 for hospital transfer dates of 9/7/18 and 10/4/18. The Social Service Director (SSD) provided a written letter of discharge/transfer on 4/01/19, to Resident # 53 for hospital transfer dates of 12/4/18, 1/25/19 and 2/14/19. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Social Service Director (SSD) identified current facility residents that were discharged/transferred to the hospital from March 1, 2019 through April 1, 2019, and a written letter of	

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F 623	Continued From page 7 assessment and dated 1/24/19 revealed she was cognitively intact. During an interview on 3/21/19 at 8:20am with Nursing Supervisor #1, she explained when a hospital discharge or transfer occurred the resident was informed and if applicable, the responsible party was notified by phone. She stated she was not aware of any written notification provided to the resident and/or the responsible party. On 3/21/19 at 8:50am an interview was conducted with Resident #38. She was able to recall the reason for each of the hospital transfers and stated she had not received written notifications from the facility for any of the hospital transfers. The Director of Nursing was interviewed on 3/21/19 at 8:53am. She stated the nurses informed the residents and called the responsible party when a discharge or transfer to the hospital occurred, but not in writing. She stated she did not know the facility was to inform the resident and/or responsible party in writing of the reason for the transfer or discharge to the hospital. 2. Resident #53 was originally admitted to the facility on 12/7/17 and was readmitted on 2/18/19 with multiple diagnoses including congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated 2/10/19 indicated that Resident #53's cognition was intact.	F 623	discharge/transfer was provided to the resident and/or the resident representative by April 4, 2019. There were fifteen residents identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Regional Director of Clinical Services provided in service education to the SSD on April 1, 2019, regarding the regulation pertaining to providing written notice of transfer/discharge to the resident and/or the resident representative upon discharge/transfer to the hospital. The SSD and/or the Director of Nursing (DON) will be provided with a list of resident discharges/transfers to the hospital during morning meeting to include prior day and weekend discharges/transfers. The SSD and or DON will provide a written letter of discharge/transfer to those residents and/or resident representatives identified within 5 days of hospital discharge/transfer. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator will audit hospital transfer /discharge report weekly for four weeks then monthly for 2 months to validate that a written letter was sent/given to the resident and/or the resident representative following a transfer/discharge to the hospital. The Administrator will review audits to identify patterns/trends and will adjust	

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F 623	Continued From page 8 Resident #53's nurse's notes were reviewed. The notes revealed that Resident #53 was transferred and was admitted to the hospital on 12/4/18 due to shortness of breath, on 1/25/19 due to pain on her spine and on 2/14/19 due to diarrhea and vomiting. The notes indicated that the resident and the Responsible Party (RP) were notified of the transfer verbally but not in writing. On 3/20/19 at 9:05 AM, Resident #53 was interviewed. She stated that she was notified by the nurse when the doctor ordered to send her out to the hospital but she had not received anything in writing prior to her discharge. She added that maybe the facility was sending the information to her RP. On 3/20/19 at 9:54 AM, Nursing Supervisor #2 was interviewed. He stated that nursing staff had been notifying the resident and the RP verbally of the reason for transfer/discharge but not in writing. On 3/20/19 at 3:04 PM, the RP of Resident #53 was interviewed and she stated that she had not received anything in writing from the facility when Resident #53 was discharged/transferred to the hospital. On 3/21/19 at 8:53 AM, the Director of Nursing (DON) was interviewed. The DON stated that nursing staff were supposed to notify the resident and the RP when a resident was discharged/transferred to the hospital. The DON indicated that she didn't know that facility had to notify resident and RP in writing of the reason for discharge/transfer.	F 623	plan as necessary for continued compliance. The Administrator will review the plan during monthly QAPI and will continue audits at the discretion of the QAPI committee.	
F 636	Comprehensive Assessments & Timing	F 636		4/18/19

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F 636 SS=D	Continued From page 9 CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must	F 636		

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F 636	Continued From page 10 include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to comprehensively assess residents on the Minimum Data Set (MDS) assessment in the areas of cognition and mood for 2 of 12 interviewable residents reviewed (Residents #51 and #62). The findings included: 1. Resident #51 was admitted to the facility on 2/14/18 with diagnoses that included Wernicke ' s encephalopathy. The annual Minimum Data Set (MDS) assessment dated 2/8/19 indicated Resident #51	F 636	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Social Service Director (SSD) completed a Modified Assessment on 4/02/19 for MDS ARD dated 2/8/19 for Resident #51 to reflect sections C0100-C0500 and D0100-D0300, as comprehensively assessed. The Social Service Director (SSD) completed a Modified Assessment on 4/02/19 for MDS ARD dated 2/16/19 for Resident #62 to reflect sections C0100-C0500 and D0100-D0300, as comprehensively assessed.	

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F 636	Continued From page 11 had clear speech, was usually understood by others, and usually understood others. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #51. Question C0100 was coded to indicate a Brief Interview for Mental Status (BIMS) was to be conducted with Resident #51. The BIMS interview, questions C0200 through C0500, was coded as not assessed. Section D, the Mood section, was not comprehensively assessed for Resident #51. Question D0100 was coded to indicate a resident mood interview was to be conducted with Resident #51. The resident mood interview, questions D0200 through D0300, was coded as not assessed. Section C and D of Resident #57 ' s 8/31/18 MDS was completed by the Social Worker (SW). An observation and interview were conducted with Resident #51 on 3/18/19 at 11:50 AM. Resident #51 was lying in bed in his room with a bed sheet fully covering his head. Resident #51 initially declined an interview, but after being provided with pleasantries and encouragement he removed the bed sheet that was covering his head and he completed an interview with logical and appropriate answers. An interview was conducted with the SW on 3/20/19 at 5:00 PM. The SW indicated she completed Section C and D of Resident #51 ' s annual MDS assessment dated 2/8/19. Section C and D of the 2/8/19 MDS for Resident #51 was reviewed with the SW. She reported that Resident #51 refused to be interviewed for this 2/8/19 MDS. She stated that this was why she had coded the BIMS interview and resident mood interview as not assessed. The SW indicated she was unaware of the coding instructions	F 636	The Director of Clinical Reimbursement provided in service education on 4/2/19, for the SSD and MDS coordinator regarding MDS RAI guidelines for coding sections B, C, and D of the MDS. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents have the potential to be affected by the alleged deficient practice of inaccurate coding of sections B, C and D of the MDS assessment. The Director of Clinical Reimbursement completed an audit of current resident MDS assessments from January 1, 2019-March 31, 2019, to identify MDS assessment sections B, C, and D that were coded inaccurately and/or were not comprehensively assessed. There were six MDS assessments that were identified with inaccurate coding and/or were not comprehensively assessed in sections B, C and D. The MDS coordinator and the SSD completed modified assessments on 4/02/19 for those residents identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Clinical Reimbursement provided in service education on 4/2/19, for the SSD and MDS coordinator regarding MDS RAI guidelines for coding and assessing residents for sections B, C, and D of the MDS.	

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F 636	Continued From page 12 specified in the Resident Assessment Instrument (RAI) manual for the completion of the resident interviews in Sections C and D. An interview was conducted with the Director of Nursing (DON) on 3/21/19 at 10:21 AM. She indicated her expectation was for all residents to be comprehensively assessed in all areas of the MDS. 2) Resident #62 was admitted to the facility on 11/13/18 with diagnoses that included dementia, anxiety disorder, major depressive disorder, restless leg syndrome and polyarthritis. The quarterly Minimum Data Set (MDS) assessment dated 2/16/19 indicated Resident #62 had clear speech, was able to make self-understood at times and rarely understood others. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #62. Question C0100 was coded to indicate Resident #62 was rarely/never understood and the Brief Interview for Mental Status (BIMS-questions C0200-C0500) was not conducted. Section D, the Mood section, was not comprehensively assessed for Resident #62. Question D0100 was coded to indicate Resident #62 was rarely/never understood and the resident interview (questions D0200 through D0300) was not conducted. On 3/20/19 at 5:00pm an interview occurred with the Social Worker. She indicated she completed Sections C and D on Resident #62's quarterly MDS assessment dated 2/16/19. She stated that Resident #62 wasn't interviewable as he was not able to answer questions appropriately or follow directions. The Social Worker stated she was unaware of the coding instructions specified in	F 636	The MDS coordinator and the SSD will follow the MDS RAI guidelines for coding and assessing residents for sections B, C and D and will provide documentation in the residents medical record to support coding documentation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The MDS coordinator will audit 5 resident MDS assessments Sections B,C and D weekly for 4 weeks then 10 resident MDS assessments Sections B, C and D monthly for 2 months, to validate that the residents were assessed and Sections B, C and D are coded accurately. The MDS coordinator will review audits to identify patterns/trends and will adjust plan as necessary for continued compliance. The MDS coordinator will review the plan during monthly QAPI and will continue audits at the discretion of the QAPI committee.	

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F 636	Continued From page 13 the Resident Assessment Instrument (RAI) manual for the completion of the resident interviews in Sections C and D. On 3/21/19 at 10:25am, the Director of Nursing stated it was her expectation for all residents to be comprehensively assessed in all areas of the MDS.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set in the areas of medications (Resident #87) and diagnoses (Resident #35) for 2 of 4 residents reviewed. Findings included: 1. Resident #87 was admitted to the facility on 2/14/19 with the diagnoses of dementia and obstructive uropathy. A review of Resident #87's 5-day Minimum Data Set (MDS) dated 2/19/19 revealed cognition was unable to be completed secondary to memory deficit. The resident required minimal assistance for activity of daily living. The active diagnoses were medically complex conditions and non-Alzheimer's dementia. The resident received 1 injection. A review of Resident #87's medication administration record for February 2019 revealed documentation that the resident had not received	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The MDS coordinator completed a Modification assessment for the MDS dated 2/19/19 on 3/29/19, to correct the coding for injections for Resident # 87. The MDS coordinator completed a Modification assessment for the MDS dated 2/19/19 on 3/29/19, to include the coding of the diagnosis of dementia for Resident # 35. The Director of Clinical Reimbursement provided education for the MDS coordinator on 4/2/19, regarding accurate coding of the MDS according the MDS RAI guidelines, to include coding of injections and diagnosis of Alzheimers/dementia. Address how the facility will identify other	4/18/19

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F 641	Continued From page 14 his tuberculin injection (test for tuberculosis) because it was documented as "completed at the previous facility." The resident had no other injections ordered. A review of Resident #78's nurses' note dated 2/14/19 documented that the resident had not received his tuberculin injection. The resident was not available for an interview. On 3/20/19 at 9:20 am an interview was conducted with the MDS Coordinator who stated she mis-read Resident #87's chart and incorrectly coded for having received an injection on the 5-day MDS dated 2/19/19. On 3/20/19 at 3:30 pm an interview was conducted with the Director of Nursing who stated she expected the MDS to be coded accurately. 2. Resident #35 was admitted to the facility on 11/30/18 with diagnoses that included dementia. A physician's note dated 1/7/19 indicated that Resident #35 had a diagnosis of dementia. A psychiatric nurse practitioner's note dated 1/14/19 indicated Resident #35 was receiving Seroquel (antipsychotic medication) for vascular dementia with behavioral disturbance. The quarterly Minimum Data Set (MDS) assessment dated 1/21/19 indicated Resident #35's cognition was severely impaired, and she received antipsychotic medication on 7 of 7 days during the MDS review period. Resident #35 was not coded for a diagnosis of dementia on the 1/21/19 MDS.	F 641	residents having the potential to be affected by the same deficient practice; Current facility residents with orders for injections and diagnosis of Alzheimers/Dementia have the potential to be affected by the alleged deficient practice. The MDS coordinator completed an audit 4/04/19, of current residents MDS assessment from 01/01/19 through 3/31/19, to identify residents that were coded as receiving injections within the MDS lookback period. There were 37of residents that were coded as receiving injections during the lookback period of their MDS assessments. The MDS coordinator reviewed the MDS assessments for those residents identified to validate that the MDS was accurately coded. The MDS coordinator completed a corrected MDS for those residents identified as inaccurate coding for injections. The MDS coordinator completed an audit on 4/4/19, of current residents diagnosis, to identify residents with diagnosis of Alzheimers/dementia. The MDS coordinator completed an audit 4/4/19, for the last MDS assessment completed for the residents identified with Alzheimers/dementia diagnosis, to validate that the diagnosis was included in the MDS assessment. There 28 residents identified with diagnosis of Alzheimers/dementia and the last MDS assessment that was completed for each resident was coded correctly.	

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F 641	Continued From page 15 An interview was conducted with the MDS Coordinator on 3/19/19 at 4:50 PM. The 1/21/19 quarterly MDS for Resident #35 that included no diagnosis of dementia was reviewed with the MDS Coordinator. The MDS Coordinator revealed this MDS was coded inaccurately for Resident #35. She stated that normally, the electronic medical records system auto-populated all active diagnoses directly onto the MDS. She reported that she was not sure why this diagnosis of dementia was not auto-populated onto Resident #35's 1/21/19 quarterly MDS. The MDS Coordinator confirmed dementia was an active diagnosis for Resident #35 at the time of her 1/21/19 MDS. An interview was conducted with the Director of Nursing on 3/21/19 at 10:25 AM. She stated that she expected the MDS to be coded accurately.	F 641	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Clinical Reimbursement provided education for the MDS coordinator on 4/2/19, regarding accurate coding of the MDS according the MDS RAI guidelines, to include coding of injections and diagnosis of Alzheimers/dementia. The MDS coordinator will review physician orders, medication administration records and progress notes during the look back period of the MDS to validate when injections are given to the resident and will code accurately on the MDS. The MDS coordinator will review the residents medical record to validate that active diagnosis□ are included on the MDS assessment that is being completed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing (DON) will audit MDS assessments completed each week for 4 weeks then 20 MDS assessment monthly for 2 months , prior to submission to the state, to validate that injections are coded accurately and diagnosis of Alzheimer's/dementia is included as applicable. The DON will review audits to identify patterns/trends and will adjust plan as necessary for continued compliance. The DON will review the plan during monthly QAPI and will continue audits at the discretion of the QAPI committee.	

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F 656	Continued From page 16	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		4/18/19

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F 656	Continued From page 17 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 develop a comprehensive care plan for the indwelling urinary catheter (Residents #74 & 53) and for behavior (Residents #50 & 35). The facility also failed to implement the care plan for nutrition for Resident #35. This was evident for 4 of 17 sampled residents reviewed. Findings included: 1. Resident #74 was admitted to the facility on 2/14/19 with multiple diagnoses including urinary retention. The admission Minimum Data Set (MDS) assessment dated 2/24/19 indicated that Resident #74 had memory and decision making problems and she had an indwelling urinary catheter. Resident #74 had a doctor's order on admission (2/14/19) for the indwelling urinary catheter. The Care Area Assessment (CAA) for the indwelling urinary catheter dated 2/26/19 revealed "resident has an indwelling urinary catheter in place for end of life. Resident needs assistance with catheter care, see activity of daily living (ADL) documentation. Staff will provide catheter care per facility protocol and monitor for complications. The doctor and family will be notified of problems as needed. Will proceed to care plan".	F 656	F 656 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The MDS coordinator developed a care plan for indwelling catheter on 3/19/19, for Resident #74. The MDS coordinator developed a care plan for indwelling catheter on 3/19/19, for Resident # 53. The Social Service Director (SSD) developed a care plan on 3/19/19, for specific behaviors and interventions related to Resident #35, to include yelling out related to Behavioral and Psychological Symptoms of Dementia (BPSD). The Director of Nursing (DON) completed in service education on 3/26/19, for the certified nursing assistants (CNA) regarding following care plan interventions as noted on the resident Kardex for assistance with eating for Resident #35. The MDS coordinator had resolved the Sexual behavior care plan for Resident #50 on 11/21/18, due to resident not exhibiting sexual behaviors. The MDS coordinator initiated a History of Sexual behavior care plan on 3/29/19. The SSD	

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F 656	Continued From page 18 Resident #74 did not have a comprehensive care plan developed for the use of the urinary catheter as of 3/19/19. On 3/19/19 at 9:50 AM and at 4:30 PM, Resident #74 was observed in bed with an indwelling urinary catheter in place. On 3/19/19 at 3:49 PM, the MDS Nurse was interviewed. She verified that Resident #74 had an indwelling urinary catheter and she had missed to develop a care plan for the urinary catheter. On 3/21/19 at 8:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected a comprehensive care plan developed when a resident has a urinary catheter. 2. Resident #53 was originally admitted to the facility on 12/7/17 and was readmitted on 2/18/19 with multiple diagnoses including congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated 2/10/19 indicated that Resident #53's cognition was intact and she did not have an indwelling urinary catheter. Resident #53 had an order for the urinary catheter on 2/18/19 (readmission) due to urinary retention. Resident #53 did not have a comprehensive care plan developed for the use of the urinary catheter as of 3/19/19.	F 656	initiated a care plan on 4/04/19, for Resident #50, specific to behaviors of anger that is not easily redirected. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents with indwelling catheters, feeding assistant needs and behaviors have the risk to be affected by the deficient practice. The DON identified current facility residents with indwelling catheters on 3/22/19, to validate that a care plan had been initiated for those residents. There were 9 residents identified, and all residents had a care plan for indwelling catheter. The SSD completed an audit on 4/04/19, of current facility residents receiving psychoactive medications, to validate that a care plan for behaviors had been initiated for those residents identified. There were 35 residents identified, and 34residents had a behavior care plan to include resident specific behaviors and appropriate interventions. The SSD implemented behavior care plans for the remaining 1 resident to include resident specific behaviors and appropriate interventions. The DON completed an audit on 3/28/19, of current facility residents to identify residents that require assistance with eating. The DON validated that residents identified to need assistance with eating were included on the care plan and Kardex. There were no other discrepancies identified.	

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F 656	Continued From page 19 On 3/19/19 at 9:53 AM and at 4:35 PM, Resident #53 was observed in bed with a urinary catheter in place. On 3/19/19 at 3:49 PM, the MDS Nurse was interviewed. She verified that Resident #53 had an indwelling urinary catheter when she was readmitted from the hospital on 2/18/19 and she had missed to develop a comprehensive care plan for the urinary catheter. On 3/21/19 at 8:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected a comprehensive care plan developed when a resident has a urinary catheter. 3a. Resident #35 was admitted to the facility on 11/13/18 with diagnoses that included dementia with behavioral disturbance and anxiety disorder. A nursing note dated 11/14/18 indicated Resident #35 had anxiety, rang the call bell every 5- 10 minute, and frequently yelled out, "Nurse, Nurse". When staff entered the room to see what Resident #35 needed, she stated that she had forgotten and didn't know why she was yelling out or ringing the call bell. A nursing note dated 11/15/18 indicated Resident #35 rang the call bell every 5-10 minutes along with yelling out for staff. When staff entered room and asked Resident #35 what she needed, she would state that she didn't need anything, and she stated that she just wanted someone in the room with her. A nursing note dated 11/16/18 indicated Resident	F 656	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The DON, ADON, and/or MDS coordinator will review physician orders during morning clinical meeting at least 5 times a week, to identify orders for indwelling catheter, psychoactive medications and assistance with feeding, and will implement care plan accordingly. Care plan interventions will be included on the care Kardex for residents to enable the CNA to be aware of interventions for each resident. The CNA will review the Kardex at the beginning of each shift and the licensed nurse will notify the CNA of any changes that may occur throughout the shift. The IDT will review and update care plans quarterly, annually and significant change. The Director of Nursing (DON) completed an in-service education on 3/27/19, for the certified nursing assistants (CNA) regarding following care plan interventions as noted on the resident Kardex. The education will be provided to new hires during orientation. The Director of Clinical Reimbursement provided education for the MDS coordinator and SSD on 4/2/19, regarding implementation and updating of care plans specific to resident needs and diagnosis. Indicate how the facility plans to monitor its performance to make sure that	

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F 656	Continued From page 20 #35 was yelling out for staff this morning while the physician was in the facility. The physician was noted to order an Seroquel (antipsychotic medication) for Resident #35. A nursing note dated 11/19/18 indicated Resident #35 was yelling out that morning and was noted with visual and auditory hallucinations. A nursing note dated 11/20/18 indicated Resident #35 was yelling out and stating that the medication that was given to her was poison. The admission Minimum Data Set (MDS) assessment dated 11/20/18 indicated Resident #35' s cognition was moderately impaired. She was assessed with hallucinations during the MDS 7 day look period. Resident #35 had other behavioral symptoms on 4-6 days and no rejection of care. She was administered antipsychotic medications on 4 of 7 days and had a Gradual Dose Reduction (GDR) of the antipsychotic medication on 11/19/18. The behavioral symptom care area assessment (CAA) for Resident #35's 11/20/18 admission MDS indicated she had diagnoses of anxiety disorder and Behavioral and Psychological Symptoms of Dementia (BPSD). She was noted to yell out and then forget why she was yelling. Resident #35 was to be assisted as needed, approached calmly, offer reassurance, explain procedures, and anticipated needs. This CAA indicated a care plan was to be developed. Resident #35's comprehensive care plan included the focus area, initiated on 11/23/18 and last revised on 11/26/18, of the use of antipsychotic medications related to behavior management and	F 656	solutions are sustained; The DON, and/or ADONs will observe 5 residents weekly for 4 weeks, then 10 residents monthly for 2 months to validate that residents requiring assistance with eating are receiving assistance per the resident's care plan. The Director of nursing, Assistant Director of nursing and/or MDS coordinator will log 100% of identified incoming orders to ensure compliance within 72 hours of receipt of orders to include care plan updates and Kardex updates. Log will be presented monthly X 3 months to the QAPI program with the plan adjusted/extended as deemed necessary by QAPI Program to ensure significant compliance is maintained. Dates When The Corrective Action will be completed April 18th, 2019	

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BPSD. There were two interventions for this focus area: 1) Administer psychotropic medications as ordered by the physician and monitor for side effects and effectiveness each shift; 2) Monitor/document/report as needed any adverse reactions of psychotropic medications. These interventions were initiated on 11/26/18 and last revised on 11/28/18. This care plan had no specific behaviors noted and contained no non-pharmacological interventions. In addition, the comprehensive care plan included no other focus areas related to Resident #35 ' s behaviors and/or BPSD.

A review of nursing notes revealed Resident #35 ' s behavior of frequent yelling out occurred on 11/24/18, 11/26/18, 11/28/18, 11/29/18, 12/5/18, 12/9/18, 12/13/18, 12/27/18, 12/29/18, 1/26/19, 2/1/19, 2/10/19, 2/16/19, and 3/3/19.

An interview was conducted with Nurse #8 on 3/19/19 at 4:40 PM. Nurse #8 stated that Resident #35 yelled out all the time. She indicated that this behavior had been ongoing since Resident #35 ' s admission.

An interview was conducted with Nurse Supervisor #1 on 3/20/19 at 10:13 AM. Nurse Supervisor #1 stated that Resident #35 exhibited the behavior of screaming/yelling out for staff. She reported that when staff entered Resident #35's room in response to her yelling, the resident stated that she had not needed anything. Nurse Supervisor #1 stated that Resident #35 was ordered Seroquel for BPSD to manage the behavior.

An interview was conducted with the MDS Coordinator on 3/19/19 at 4:50 PM. She stated

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that the SW was responsible for completing care plans to address behaviors.

An interview was conducted with the Social Worker (SW) on 3/19/19 at 4:25 PM. She stated that she was auditing her care plans today (3/19/19) and noticed that there was no care plan in place to address Resident #35's behaviors. She explained that there was a care plan for Resident #35's antipsychotic medication, but this care plan had not included any non-pharmacological interventions to address behaviors.

An interview was conducted with the Director of Nursing on 3/21/19 at 10:25 AM. She stated that she expected care plans to be comprehensive based on the resident's assessed needs. She indicated that Resident #35 had been assessed with dementia-related behaviors and she expected a care plan to be in place to address these behaviors.

3b. Resident #35 was admitted to the facility on 11/13/18 with diagnoses that included dementia.

On 1/3/19 Resident #35's comprehensive care plan was updated with the initiation of the focus area of nutrition/dehydration risk. The interventions included assisting Resident #35 with meals as needed.

The quarterly Minimum Data Set (MDS) assessment dated 1/21/19 indicated Resident #35's cognition was severely impaired, and she required the supervision of 1 with eating. Resident #35 was assessed with significant

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weight loss with a current body weight of 124 pounds.

A dietary communication form dated 1/31/19 indicated a recommendation for Resident #35 to be assisted with eating for all meals.

On 2/1/19 Resident #35's care plan related to nutrition/dehydration risk was revised to indicate the resident was to be assisted with eating for all meals and snacks.

A physician's order signed on 2/5/19 indicated Resident #35 was to be assisted with eating for all meals.

A family interview was conducted for Resident #35 on 3/18/19 at 12:21 PM. She stated that Resident #35 had some weight loss over the past couple of months and she was unsure if the facility staff were providing assistance with eating.

A review was conducted of the Nursing Assistant (NA) Activities of Daily Living (ADL) documentation for the eating assistance level provided to Resident #35 from 2/6/19 through 3/19/19. There was a total of 96 NA documentations completed which revealed Resident #35 was provided with total assistance 12 out of 96 times. The remaining times ranged from independent with no set up assistance to extensive assistance of 1.

An observation was conducted of Resident #35 during the breakfast meal on 3/20/19 beginning at 8:40 AM. Resident #35's breakfast meal tray had the lid/cover removed and it was placed on her over-the-bed table within her reach. Resident #35 was sleeping and was not easily roused.

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There was no staff present in Resident #35's room to provide her assistance with eating. Resident #35's nutritional intake of the breakfast meal at this time was 0-25 percent (%).

A second observation was conducted of Resident #35 during the breakfast meal on 3/20/19 at 9:00 AM. Resident #35 was sleeping, and her breakfast meal tray remained in the same position as on the first observation at 8:40 AM. There was no staff present in Resident #35's room to provide her assistance with eating. Their appeared to be no further nutritional intake than what was observed during the 8:40 AM observation.

On 3/20/19 at 9:15 AM NA #4 was observed to remove Resident #35 ' s breakfast tray from her room. An interview was then conducted with NA #4. She stated that Resident #35 had eaten 0-25% of her breakfast meal. NA #4 stated that Resident #35 required no assistance with eating.

A second interview was conducted with NA #4 on 3/20/19 at 10:50 AM. The care plan related to nutrition/dehydration risk for Resident #35 that indicated she needed assistance with all meals and snacks was reviewed with NA #4. NA #4 revealed she had not known that Resident #35's care plan included this intervention.

An interview was conducted with the Director of Nursing on 3/21/19 at 10:25 AM. She stated that she expected the care plan interventions to be implemented.

4. Resident #50 was admitted to the facility on 12/3/13 with the diagnoses of dementia and seizure.

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A review of Resident #50's psychotherapy notes dated 12/19/18 revealed the resident had poor judgement and was confused at times. The resident's mood during therapy was anger, depression, and sadness. The resident had the diagnosis of Sexual Behavior Disorder. The psychotherapist was working to change negative thought patterns into positive (last note visit documented in the record).

A review of Resident #50's quarterly Minimum Data Set dated 2/7/19 revealed the resident wore a hearing aid and had minimal difficulty hearing. The resident had an intact cognition with no behaviors, psychosis or depression. Active diagnoses were non-Alzheimer's dementia, seizure, anxiety, and depression

Resident #50's care plan initiated on 11/2/18 and revised on 11/14/18 revealed a focus of anti-psychotic mediation administration for behavior management related to depression, anxiety, and dementia. The goal was the resident will remain free of medication complication(s). The interventions were to report medication side effects, psych services as needed, consistent approaches, and behavior symptoms not usual to the person (there were no interventions specific to behaviors documented).

On 3/20/19 at 2:00 pm an interview was conducted with Nurse #1 who stated he was familiar with and assigned to Resident #50. The resident had a history of behaviors including sexual where she kissed another resident on the mouth about a year ago. There has not been another incident. The resident was observed by staff for behaviors. Most recently the resident was having anxiety and verbal behaviors because

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she had a new roommate placed 3 weeks ago. The resident had the verbal behaviors of negative communication and anger. The resident had verbalized that she did not want a roommate. The resident had a care plan goal for no behaviors, but the nurse was not aware that interventions did not reflect the sexual behavior.

On 3/20/19 at 2:10 pm an observation was done of Resident #50 who was sleeping and not verbally aroused. The resident was clean, hair styled, wearing makeup.

On 3/21/19 at 8:30 am an interview was conducted with Resident #50 who stated she had seizures all her life. The resident appeared angry by her facial expression and tone of voice and was fixed on her body symptoms during conversation. The resident was not easily re-directed. When asked about her new roommate, the resident stated, "what is there to say" and frowned. The resident did not have any complaint and did not want to talk any further.

On 3/21/19 at 8:30 am an observation was done of the resident who was sitting at the side of her bed eating breakfast. The resident was alert and oriented to time, situation, and self. No confusion was noted. The resident appeared to be fixated on her somatic symptoms and her past.

On 3/21/19 at 8:45 am an interview was conducted with Nurse #8 who stated she was familiar with Resident #50 and commented that the resident can be negative and aggressive. Nurse #8 was aware of the resident's anger and aggression but was not aware of prior sexual behavior.

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F 656	Continued From page 27 On 3/21/18 at 8:55 am an interview was conducted with Nurse #5 who stated she was regularly assigned to the resident. Nurse #5 added that the resident was more relaxed and less angry with staff she was familiar with. Nurse #5 has not observed recent behaviors from the resident nor concerns voiced from the nursing assistants. Nurse #5 was not sure of the care plan interventions without looking. On 3/20/19 at 4:00 pm an interview was conducted with the facility physician who remembered Resident #50 and stated that the resident had received psychotherapy for her behaviors and psychiatry followed as needed. The physician was aware of the resident's behaviors, including sexual behavior sometime in the past. On 3/20/19 at 4:00 pm an interview was conducted with the Director of Nursing who stated she expected the resident's care plan to be developed to reflect their preferences and care required.	F 656		
F 657 SS=D	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. (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	F 657		4/18/19

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F 657	Continued From page 28 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff, resident, and physician interviews, the facility failed to revise the resident's care plan in the area of activities of daily living (Residents #50) for 1 of 17 residents reviewed. Findings included: Resident #50 was admitted to the facility on 12/3/13 with the diagnoses of dementia, seizure, and atrial fibrillation. A review of Resident #50's quarterly Minimum Data Set dated 2/7/19 revealed the resident wore a hearing aid and had minimal difficulty hearing. The resident had an intact cognition with no behaviors, psychosis or depression. The resident required set up and supervision for meals and dressing and physical help in part of bathing. Active diagnoses were non-Alzheimer's dementia and seizure. Resident #50's care plan initiated on 11/2/18	F 657	The MDS coordinator reviewed and revised Resident #50□s Activities of Daily Living (ADL) care plan on 3/29/19, to reflect the residents current ADL care needs. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents have the potential to be affected by the alleged deficient practice of failure to revise the residents ADL care plan to reflect the residents current ADL care needs. The Director of Nursing (DON), Assistant Director of Nursing (ADON), and MDS coordinator completed an audit on 3/28/19, of current facility residents ADL care plan to validate that the ADL care plan reflects the residents current ADL care needs. There were 4 additional ADL	

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F 657	Continued From page 29 revealed a focus for self-care performance deficit related to limitations. The goal was the resident will maintain her current level of functioning. Interventions for all activities of daily living was independent initiated on 1/3/19. On 3/20/19 at 2:00 pm an interview was conducted with Nurse #1 who stated he was familiar with and assigned to Resident #50. The resident had a care plan for activities of daily living assistance and was not completely independent. The resident required assistance with bathing and set up for meals. On 3/20/19 at 2:10 pm an observation was done of Resident #50 who was sleeping and not verbally aroused. The resident was clean, hair styled, wearing makeup. On 3/21/19 at 8:30 am an interview was conducted with Resident #50 who stated she has had seizures all her life. The resident commented that the nursing assistant helped her with "a few things." "I can do most things myself." The resident commented that she cannot take a shower by herself and staff gets her what she needs for her meal. On 3/21/19 at 8:30 am an observation was done of the resident who was sitting at the side of her bed. She was eating breakfast after staff set up. On 3/21/18 at 8:55 am an interview was conducted with Nurse #5 who was regularly assigned to Resident #50. She stated that the resident was mostly independent but required meal set up and some assistance with her shower. The resident preferred to be as independent as possible.	F 657	care plans that were revised to reflect the residents current ADL care needs. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The DON, ADON and/or the MDS coordinator will implement ADL care plans within 21 days of admission for new admissions and will review and update ADL care plans quarterly, annually and significant change, to reflect the residents current ADL care needs. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON and/or the ADON□s will audit 5 resident ADL care plans weekly for 4 weeks then 10 resident ADL care plans a month for 2 months to validate that the ADL care plan reflects the residents current ADL care needs. The DON will review audits monthly to identify patterns/trends and will adjust plan as necessary for continued compliance. The DON will review the plan during monthly QAPI and will continue audits at the discretion of the QAPI committee.	

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F 657	Continued From page 30 On 3/20/19 at 4:00 pm an interview was conducted with the Director of Nursing who stated she expected the resident's care plan to be revised to reflect their preferences and care required.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and resident and staff interviews, the facility failed to monitor and document fluid intake on resident with an order for fluid restriction for 2 of 2 residents reviewed (Resident #26 and #42). A review of the facility policy titled Encouraging and Restricting Fluids and dated October 2010, read in part, "be accurate when recording fluid intake and record fluid intake on the intake side of the intake and output record. Record fluid intake in milliliters (ml)". The findings included: 1) Resident #26 was admitted to the facility on 4/2/18 with diagnoses that included congestive heart failure (CHF) and chronic kidney disease (CKD). A review of the most recent Minimum Data Set (MDS) coded as a quarterly assessment and	F 658	F 658 F658 failed to monitor and document intake on a resident with a fluid restriction resident 26 and 42 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; In regard to the deficient practice of the facility to monitor and document intake on a resident with a fluid restriction for resident # 26 and resident # 42, the facility initiated an I and O (intake and output) monitoring system for both affected residents on 3/20/19. The facility placed monitoring parameters on the residents' medication administration record (MAR) to properly record and monitor intake of resident number 26 and resident number 42 on 3/20/19. Non-compliance of	4/18/19

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F 658	Continued From page 31 dated 1/15/19 revealed the resident was cognitively intact, received supervision with her Activities of Daily Living (ADL's) and was independent with meals. Active diagnoses were CHF, CKD and diabetes. The resident received 7 days of diuretics and insulin injections over the 7 day look back period. A review of Resident #26's care plan dated 1/15/19 revealed fluid restrictions as ordered. A review of the most recent Registered Dietician (RD) progress note dated 2/12/19 indicated the resident was to continue with the 1200ml per day fluid restriction for CHF. A review of Resident #26's February 2019 and March 2019 Medication Administration Record (MAR) revealed no monitoring and documentation of fluid intake until 3/18/19 which only accounted for the fluids provided from nursing with medications. A review of the monthly physician orders dated 3/1/19 revealed a fluid restriction of 1200 ml in a 24-hour period with dietary providing 240ml at breakfast, lunch and dinner and nursing staff providing 160ml on each shift with medications. On 3/19/19 at 9:25am an observation was made of Resident #26's breakfast tray which included a cup of coffee only. An interview occurred with Resident #26 on 3/19/19 at 2:20pm, who stated she was aware of the fluid restriction and consumed extra beverages throughout the day. A can of unopened diet Pepsi was sitting on her nightstand. She stated that the staff did not ask	F 658	resident's Intake restrictions are reported to residents' physician for adjustment and modification of the residents' plan of care as deemed necessary by resident's attending physician. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; An audit of all current residents was completed 3/19/19, by the Assistant Director of Nursing (ADON) to identify other residents who have the potential for deficient practice of monitoring and documenting fluid intake on a resident with a fluid restriction. Four were identified as having the deficient practice of failing to monitor and document fluid intake. In-service education was provided on or by 3/19/19, to all current licensed staff that upon receipt of any fluid restriction orders, resident's care plan and Medication administration record (MAR) will be reviewed and updated as necessary to include I & O(intake and output) records and fluid restriction parameters. Licensed personnel will be responsible to ensure that residents fluid intake records reflect and record of all fluid consumed by resident as reasonably able to include all fluids throughout their shifts. In-service education will be provided to newly hired licensed nursing personnel during orientation and prior to assuming care for a resident that upon receipt of any fluid restriction orders, resident's care plan and Medication administration record	

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F 658	Continued From page 32 her about the fluids she consumed daily. On 3/19/19 at 2:25pm an interview was conducted with Nursing Aide (NA) #2. She explained that she was aware Resident #26 was on a fluid restriction and that she only provided the fluids that were sent on the meal tray. She added that she didn't record any intake for the resident or provide additional fluids to her. On 3/19/19 at 2:30pm an interview occurred with Nurse #6 who was assigned to the resident. After reviewing the MAR, Nurse #6 stated she documented the 160ml of fluids provided with medications as ordered on each shift but did not document the additional amounts of fluid consumed by the resident. During an interview with the Director of Nursing (DON) on 3/20/19 at 8:15am, she stated she was aware the intake sheet was not being utilized as stated in the policy but would expect the nursing staff to document fluid intake on the MAR to include the fluid received on meal trays, provided with medications as well as any additional fluids consumed by the resident. On 3/20/19 at 1:00pm Resident #26 was observed with a cup of tea provided by dietary on her lunch tray and a big styrofoam cup of bubbly, dark fluid on her bedside table. An interview was conducted with Nurse #7 on 3/20/19 at 1:35pm. She stated she documented the 160ml of fluids provided with medications as ordered on each shift but did not document any additional amounts of fluid consumed by the resident.	F 658	(MAR) will be reviewed and updated as necessary to include I & O (intake and output) records and fluid restriction parameters. Licensed personnel will be responsible to ensure that residents fluid intake records reflect and record of all fluid consumed by resident as reasonably able to include all fluids throughout their shifts. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Physician order review will occur 5 x's per week of all newly written physician orders by Unit coordinators (ADON), DON, and/or MDS coordinator. Upon receipt of any fluid restriction orders, resident's care plan and Medication administration record (MAR) will be reviewed and updated as necessary to include I &O (intake and output) records and fluid restriction parameters. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The director of nursing, assistant director of nursing and/or MDS coordinator will log 100% of identified incoming orders to ensure compliance within 72 hours of receipt of orders. Log will be presented monthly X 3 months to the QAPI program with the plan adjusted/extended as deemed necessary by QAPI Program to ensure significant compliance is	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 33 During an interview with the DON on 3/20/19 at 2:05pm, she indicated as of today, nursing staff were to question the alert and oriented residents about fluids consumed and document all fluid intake on the MAR. On 3/21/19 at 10:25am during an interview with the DON, she stated it was her expectation for fluid intake to be monitored and documented. 2) Resident #42 was admitted to the facility on 1/23/19 with diagnoses that included Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), diabetes mellitus (DM) and lymphedema. A review of the most recent MDS coded as an admission assessment and dated 1/30/19 revealed the resident was cognitively intact, received extensive assistance from staff for Activities of Daily Living (ADL's) and was independent after setup with meals. Active diagnoses were heart failure, COPD and diabetes. The resident received 7 days of insulin injections and diuretics during the 7 day look back period. A review of Resident #42's care plan dated 2/4/19 revealed fluid restrictions as ordered. A review of Resident #42's February 2019 and March 2019 MAR revealed no monitoring and documentation of fluid intake. A review of the monthly physician orders dated 3/1/19 revealed fluid restriction of 1500 ml in a 24-hour period with dietary providing 240ml at breakfast, lunch and dinner and nursing staff	F 658	maintained. Indicate dates when corrective action will be completed; 04/18/2019	

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F 658	Continued From page 34	F 658		

providing 260ml on each shift.

On 3/19/19 at 9:20am an observation was made of Resident #42's breakfast tray which included a cup of coffee.

An interview occurred with Resident #42 on 3/19/19 at 2:15pm, who stated he was aware of the fluid restriction and did consume extra fluids throughout the day or brought in by family members.

On 3/19/19 at 2:25pm an interview was conducted with NA #2. She explained that she was aware Resident #42 was on a fluid restriction and that she assisted with the fluids that were provided on the meal tray. She added that she didn't record any intake for the resident or provide any additional fluids to him.

On 3/19/19 at 2:30pm an interview occurred with Nurse #6 who was assigned to the resident. After reviewing the MAR, Nurse #6 stated that she documented the 260ml of fluids provided with medications as ordered on each shift but did not document the additional amounts of fluid consumed by the resident or brought in by family members.

During an interview with the Director of Nursing (DON) on 3/20/19 at 8:15am, she stated that she was aware the intake sheet was not being utilized as stated in the policy but would expect the nursing staff to document fluid intake on the MAR to include the fluid received on meal trays, provided with medications as well as any additional fluids consumed by the resident.

An interview was conducted with Nurse #7 on

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F 658	Continued From page 35 3/20/19 at 1:35pm. She stated she documented the 260ml of fluids provided with medications as ordered on each shift but did not document any additional amounts of fluid consumed by the resident. During an interview with the DON on 3/20/19 at 2:05pm, she indicated as of today, the nursing staff were to question the alert and oriented residents about fluids consumed and document all fluid intake on the MAR. On 3/21/19 at 10:25am during an interview with the DON, she stated it was her expectation for fluid intake to be monitored and documented.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		4/18/19

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F 690	Continued From page 36 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide catheter care by not securing and anchoring the urinary catheter tubing to prevent excessive tension and to prevent accidental removal (Resident #74) and failed to perform a voiding trial as ordered and per hospital recommendation (Resident #53) for 2 of 4 sampled residents reviewed for indwelling urinary catheter. Findings included: 1. Resident #74 was admitted to the facility on 2/14/19 with multiple diagnoses including urinary retention. The admission Minimum Data Set (MDS) assessment dated 2/24/19 indicated that Resident #74 had memory and decision making problems and she had an indwelling urinary catheter. Resident #74 had a doctor's order on admission (2/14/19) for the indwelling urinary catheter.	F 690	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; In regard to deficient practice of properly securing and anchoring catheter tubing to prevent excessive tension and to prevent accidental removal for resident number 74, catheter tubing was secured on 03/19/19 by C.N.A assigned to resident. In regard to deficient practice of performing a toileting trial and if unable to void, refer to urology. Resident #53 declined a voiding trail, and the physician doesn□t want the catheter removed at this time. Residents care plan was updated to reflect a comprehensive plan of care for the use of a urinary catheter on 3/19/19. Education was provided to all currently working C.N.A□s on the securement of urinary catheters on 3/19/19 by Director of nursing (DON). All other C.N.A□s	

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F 690	Continued From page 37 Resident #74 did not have a comprehensive care plan developed for the use of the urinary catheter as of 3/19/19. On 3/19/19 at 9:50 AM and at 4:30 PM, Resident #74 was observed in bed. She had an indwelling urinary catheter and the catheter was not secured or anchored to her thigh. On 3/19/19 at 4:33 PM, Nurse Aide (NA) #3 was interviewed. She stated that she just worked part time at the facility. NA #3 also stated that Resident #74 had pulled her catheter out once. NA #3 indicated that she would inform the Nurse to put a securement device on the resident's catheter. On 3/19/19 at 4:35 PM, Nurse #8 was interviewed. She stated that she expected the NA to inform her if the resident's catheter had no securement device on it. She indicated that nobody had reported that Resident #74's catheter was not secured or anchored to her thigh. On 3/21/19 at 8:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected all urinary catheters to be secured or anchored by using a securement device and NAs were supposed to inform the nurse when the urinary catheter did not have a securement device. 2. Resident #53 was originally admitted to the facility on 12/7/17 and was readmitted on 2/18/19 with multiple diagnoses including congestive heart failure. The quarterly Minimum Data Set (MDS)	F 690	received in-service training and education to the securement of urinary catheters on or by 3/28/19, by the DON. Newly hired C.N.A□s will be provided with in-service education during new hire orientation prior to caring for residents who have an indwelling catheter. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; An audit was completed 3/22/19, by the DON and Assistant Director of Nursing (ADON), of all residents who currently have a catheter for current orders for voiding trials to ensure orders were properly carried out. There were no other residents identified as deficient. An audit was completed 3/22/19, by Director of Nursing (DON) and Assistant Director of Nursing (ADON) on of all residents who currently have a catheter to ensure that they were properly secured to prevent excessive tension and to prevent accidental removal. There were no other residents identified as deficient. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Education was provided to all currently working C.N.A□s on the securement of urinary catheters on 3/19/19, by the Director of Nursing (DON). All other C.N.A□s received in-service training and education to the securement of urinary catheters on or by 3/28/19, by the DON. Newly hired C.N.A□s will be provided with in-service education during new hire orientation prior to caring for residents	

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F 690	Continued From page 38 assessment dated 2/10/19 indicated that Resident #53's cognition was intact and she did not have an indwelling urinary catheter. The hospital discharge summary dated 2/18/19 revealed that in and out catheterization was performed on Resident #53 at the hospital and she continued to have residual up to 800 milliliter (ml). An indwelling urinary catheter was inserted. It was recommended to discharge the resident to the facility with the indwelling urinary catheter and to attempt voiding trials at the facility and if unable to void and to empty her bladder, to refer her to urology. Resident #53 had doctor's orders dated 2/18/19 (readmission) for the indwelling urinary catheter and recommend voiding trials and if unable to void, refer to urology. Resident #53 did not have a comprehensive care plan developed for the use of the urinary catheter as of 3/19/19. On 3/19/19 at 9:53 AM and at 4:35 PM, Resident #53 was observed in bed with a urinary catheter in place. On 3/20/19 at 11:58 AM, Nursing Supervisor #1 was interviewed. She stated that she was the nurse who wrote the orders dated 2/18/19 for the indwelling urinary catheter and the recommendation from the hospital for the voiding trials and if not voiding, to refer to urology. The Nursing Supervisor indicated that she expected the Nurse to follow through with the order for the voiding trial. The Nursing Supervisor reviewed the resident's records and reported that the voiding trial was missed, it was not performed for	F 690	who have an indwelling catheter. Education was provided to all currently working Licensed nurses on 3/19/19 by the DON, for completing voiding trials as ordered. All other licensed nursing personnel received in-service training and education for completion of voiding trials as ordered on or by 3/28/19, by the DON. Newly hired licensed nursing personnel will be provided with in-service education during new hire orientation to include ensuring resident□s orders are carried out in regards to a voiding trial prior to caring for residents who have an indwelling catheter. Physician order review will occur 5 x□s per week of all newly written physician orders and new admission orders by the Assistant Director of Nursing(ADON), DON, and/or MDS coordinator. Upon receipt of any residents identified with a catheter upon admission or a newly ordered catheter, the resident□s care plan and orders will be reviewed and updated as necessary to ensure all orders (including voiding trials and/or other catheter care) are carried out appropriately. Residents with catheters will include an order on their Medication Administration Record(MAR) for the nurses to ensure that catheter is appropriately secured to prevent excessive tension and to prevent accidental removal. Indicate how the facility plans to monitor	

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F 690	Continued From page 39 Resident #53. On 3/20/19 at 3:05 PM, Nurse #9 was interviewed. She stated that she was assigned to Resident #53 when readmitted from the hospital. Nurse #9 stated that the Nursing Supervisor wrote the admission orders and she didn't know about the order for the voiding trial. She revealed that she had not performed the voiding trial for Resident #53. On 3/21/19 at 8:45 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the nursing staff to read the hospital discharge summary and to follow the hospital recommendation and the doctor's order for the voiding trial. The DON stated that the doctor's order and the hospital recommendation for the urinary catheter and the voiding trial were written on the physician's order but was not copied into the Medication Administration Record (MAR) therefore the voiding trial was missed.	F 690	its performance to make sure that solutions are sustained; The DON, ADON and/or MDS coordinator will log 100% of identified incoming orders to ensure compliance within 72 hours of receipt of orders. Log will be presented monthly X 3 months to the QAPI program with the plan adjusted/extended as deemed necessary by QAPI Program to ensure significant compliance is maintained. The DON will audit 3 of residents who have an order for a catheter per week X 4 weeks, then 10 residents with a catheter monthly per month X 2 months to ensure that all residents have their catheter□s properly secured. Findings will be reported to QAPI committee with adjustment to plan as necessary to achieve and maintain significant compliance.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		4/18/19

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F 692	Continued From page 40 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with family, Registered Dietician, and staff, the facility failed to follow the physician's order to provide Resident #35 assistance with eating for all meals for 1 of 5 residents reviewed for nutrition. The findings included: Resident #35 was admitted to the facility on 11/13/18 with diagnoses that included dementia. On 1/3/19 Resident #35's comprehensive care plan was updated with the initiation of the focus area of nutrition/dehydration risk. The interventions included assisting Resident #35 with meals as needed. The quarterly Minimum Data Set (MDS) assessment dated 1/21/19 indicated Resident #35's cognition was severely impaired, and she required the supervision of 1 with eating. Resident #35 was assessed with significant weight loss with a current body weight of 124 pounds. A Registered Dietician (RD) quarterly note dated 1/25/19 indicated Resident #35 had a weight loss of 10 percent (%) from 12/3/18 at 138 pounds to	F 692	F 692 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Director of Nursing (DON) provided in service education beginning on 3/19/19, for the licensed nurses and certified nursing assistants (CNA) regarding following physician orders and care plan interventions and as noted on the resident Kardex for assistance with eating for Resident #35. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The DON completed an audit on 3/28/19, of current facility residents to identify residents that require assistance with eating. The DON validated that residents identified to need assistance with eating were included on the care plan and Kardex. There were no discrepancies identified. Address what measures will be put into	

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F 692	Continued From page 41 1/18/19 at 124 pounds. Resident #35's intake was noted as 0-50% and she was independent with set up assistance for eating. The RD indicated Resident #35 was receptive to nutritional supplements. A dietary communication form dated 1/31/19 indicated a recommendation for Resident #35 to be assisted with eating for all meals. On 2/1/19 Resident #35's care plan related to nutrition/dehydration risk was revised to indicate the resident was to be assisted with eating for all meals and snacks. On 2/1/19 Resident #35's Nursing Assistant (NA) care guide/kardex was updated to indicate the resident was to be assisted with eating for all meals and snacks. A physician's order signed on 2/5/19 indicated Resident #35 was to be assisted with eating for all meals. An RD note dated 3/15/19 indicated Resident #35 ' s current body weight was 120.8 pounds as of 3/14/19 (previously 124 pounds on 1/18/19). Resident #35 was noted to be totally dependent on staff for assistance with eating. A family interview was conducted for Resident #35 on 3/18/19 at 12:21 PM. The family member stated that Resident #35 had some weight loss over the past couple of months and she was unsure if the facility staff were assisting the resident to eat. A review was conducted of the NA Activities of Daily Living (ADL) documentation for the eating	F 692	place or systemic changes made to ensure that the deficient practice will not recur; The DON, ADON, and/or MDS coordinator will review physician orders during morning clinical meeting at least 5 times a week, to identify orders for indwelling catheter, psychoactive medications and assistance with feeding, and will implement care plan accordingly. Care plan interventions will be included on the care Kardex for residents to enable the CNA to be aware of interventions for each resident. The CNA will review the Kardex at the beginning of each shift and the licensed nurse will notify the CNA of any changes that may occur throughout the shift. The IDT will review and update care plans quarterly, annually and with significant change. The Director of Nursing (DON) completed in service education on 3/28/19, for the certified nursing assistants (CNA) regarding following physician orders and care plan interventions as noted on the resident Kardex. The education will be provided to new hires during orientation. The Director of Clinical Reimbursement provided education for the MDS coordinator and SSD on 4/2/19, regarding implementation and updating of care plans specific to resident needs and diagnosis. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

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F 692	Continued From page 42 assistance level provided to Resident #35 from 2/6/19 through 3/19/19. There was a total of 96 NA documentations completed for eating assistance level which revealed Resident #35 was provided with total assistance 12 out of 96 times. The remaining times ranged from independent with no set up assistance to extensive assistance of 1. An observation was conducted of Resident #35 during the breakfast meal on 3/20/19 beginning at 8:40 AM. Resident #35's breakfast meal tray had the lid/cover removed and it was placed on her over-the-bed table within her reach. Resident #35 was sleeping and was not easily roused. There was no staff present in Resident #35's room to provide her assistance with eating. Resident #35's nutritional intake of the breakfast meal at this time was 0-25%. A second observation was conducted of Resident #35 during the breakfast meal on 3/20/19 at 9:00 AM. Resident #35 was sleeping, and her breakfast meal tray remained in the same position as on the first observation at 8:40 AM. There was no staff present in Resident #35's room to provide her assistance with eating. Their appeared to be no further nutritional intake than what was observed during the 8:40 AM observation. On 3/20/19 at 9:15 AM NA #4 was observed to remove Resident #35's breakfast tray from her room. An interview was then conducted with NA #4. She stated that Resident #35 had eaten 0-25% of her breakfast meal. NA #4 was asked how she knew if a resident needed assistance with eating. She reported that this information was listed on the NA kardex if the resident	F 692	The DON, and/or ADONs will observe 5 residents weekly for 4 weeks, then 10 residents monthly for 2 months to validate that residents requiring assistance with eating are receiving assistance according to the residents care plan. The Director of nursing, Assistant Director of nursing and/or MDS coordinator will log 100% of identified incoming orders to ensure compliance within 72 hours of receipt of orders to include care plan updates and Kardex updates. Log will be presented monthly X 3 months to the QAPI program with the plan adjusted/extended as deemed necessary by QAPI Program to ensure significant compliance is maintained. Date When Corrective Action will be Completed April 18th, 2019	

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F 692	Continued From page 43 required assistance. NA #4 stated that Resident #35 had not required assistance with eating. A second interview was conducted with NA #4 on 3/20/19 at 10:50 AM. The NA kardex for Resident #35 that indicated she needed assistance with all meals was reviewed with NA #4. NA #4 revealed she had not known that Resident #35's kardex indicated she needed assistance with all meals. She reported that she was familiar with Resident #35 and that the resident had fluctuations in her eating abilities over time, but that she thought the resident was eating independently at this point in time. An interview was conducted with the RD on 3/20/19 at 11:55 AM. The 3/15/19 RD note that indicated Resident #35 was totally dependent on staff for assistance with eating was reviewed. She stated that she reviewed the NA kardex as well as the NA documentation to determine what level of assistance a resident requires with eating. The RD indicated she expected staff to provide assistance to Resident #35 with eating as ordered. An interview was conducted with the Director of Nursing on 3/21/19 at 10:25 AM. She stated that she expected physician's orders to be followed.	F 692		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and	F 698		4/18/19

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THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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F 698	Continued From page 44 the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to maintain ongoing routine communication with the hemodialysis center for 1 of 1 resident reviewed for dialysis (Resident #2). The findings included: Resident #2 was admitted to the facility on 8/30/18 and most recently readmitted on 1/28/19 with diagnoses that included End Stage Renal Disease (ESRD) and dependence on renal dialysis. The quarterly Minimum Data Set (MDS) assessment dated 1/24/19 indicated Resident #2's cognition was intact, and she received dialysis. A review of Resident #2's active care plan included the focus area of the need for dialysis related to ESRD. This area was initiated on 10/25/18 and remained active as of 3/18/19. The interventions, also initiated on 10/25/18, included dialysis as ordered by the physician. An interview was conducted with Resident #2 on 3/18/19 at 12:00 PM. She stated she went to dialysis three times a week. An interview was conducted with Nurse #5 on 3/20/19 at 3:30 PM. Nurse #5 reported she regularly worked with Resident #2 and confirmed the resident attended dialysis three times a week. Nurse #5 revealed there was no system in place for ongoing routine communication with the	F 698	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility will maintain ongoing effective communication with the hemodialysis center through written communication by utilizing a communication notebook that will accompany residents to/from dialysis center(s). This deficient practice was noted for one resident Resident #2, where the nurse was unable to verify written communication to and from the hemodialysis center had occurred. Dialysis center was contacted by the assistant director of nursing on 3/20/2019 to verify no other communication to the facility in regard to Resdient #2 had not been communicated. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All other residents who receive services provided by hemodialysis center(s) are at risk for this deficient practice. All dialysis residents will utilize written communication notebooks to communicate information, validating verbal conversations between dialysis center(s) and the facility staff. Communication notebooks are maintained and transported to and from dialysis centers by the transportation aide. All other identified residents dialysis centers were contacted on or before April 2, 2019 to verify that all information had	

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F 698	Continued From page 45 dialysis center's staff for Resident #2. She explained that the facility used to have a "communication book" that contained routine communication that was shared between the facility staff and the dialysis center's staff, but this was no longer in place. She stated she had not known why this was discontinued, but that it had been several months since it had been in place. Nurse #5 indicated that if something out of the normal occurred that the dialysis center staff called the facility staff or vice versa. An interview was conducted with Nurse #1 on 3/20/19 at 3:35 PM. Nurse #1 confirmed Nurse #5's interview that there was no system in place for ongoing routine communication with the dialysis center's staff for Resident #2. An interview was conducted with Nurse Supervisor #1 on 3/20/19 at 3:40 PM. She verified there was no system in place for ongoing routine communication with the dialysis center's staff for Resident #2. An interview was conducted with the Director of Nursing (DON) on 3/21/19 10:25 AM. The DON indicated she expected a system to be in place for ongoing communication, coordination, and collaboration between the facility staff and the dialysis staff.	F 698	been appropriately communicated to the facility and services were coordinated. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Facility transportation driver received in-service education provided by Director of Nursing in regards to the communication process to coordinate services with the dialysis centers on 3/27/19. All current licensed nursing personnel were provided in-service education on or before 3/27/19, by the Director of nursing in regards to the communication process to coordinate services with the dialysis centers. New licensed nursing personnel will be provided training to communication with dialysis provider(s) to properly coordinate services upon hire. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Administrator, Director of Nursing, or assistant director of nursing will audit dialysis communication notebooks to ensure appropriate coordination and communication occurs 5 x□s per week X 4 weeks, 2 X per week for 3 weeks and weekly X 2, reporting results to QAPI program and re-evaluating and adjusting plan to maintain compliance as needed.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		4/18/19

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F 732	Continued From page 46 §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. §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 observation and staff interview, the	F 732	Address how corrective action will be	

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F 732	Continued From page 47 facility failed to post nurse staffing information in the area of actual hours worked for 4 of 4 days during the survey. The findings included: Observation of the posted nurse staffing form on 3/18/19, 3/19/19, 3/20/19, and 3/21/19 revealed the column titled "Actual Hours Worked" was blank for licensed and unlicensed nursing staff. An interview was conducted with the Director of Nursing (DON) on 3/21/19 at 9:30 AM. The DON stated that the column titled "Actual Hours Worked" on the posted nurse staffing form was completed by the third shift nurse for all 3 previous shifts at midnight at the end of the day. She reported that after the third shift nurse filled in the column on the nurse staffing form for "Actual Hours Worked", she removed that posting for the previous day and replaced it with the current date's posting with the column for "Actual Hours Worked" again being blank. She indicated she was unaware that the posting of nurse staffing information was to be fully completed at the beginning of each shift. The DON stated that it was her expectation that the nurse staffing information be completed and posted as per the regulations.	F 732	accomplished for those residents found to have been affected by the deficient practice; The staffing sheets for dates 3/18, 3/19, 3/20 and 3/21 were updated at the end of each day to reflect actual hours worked. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; No residents were affected due to this deficient practice of failure to post nurse staffing information with actual data as it were to occur, providing actual hours worked, adjusting from those scheduled hours posted. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; To ensure that deficient practice does not reoccur, nursing personnel will adjust postings to reflect actual hours worked. This will be completed during the shift to shift transition, providing accurate information of actual hours worked. Director of nurses completed in-service training for the current licensed nursing personnel on 3/27/19,regarding the responsibility of adjusting staffing sheet to reflect actual hours worked to be completed by the designated hall(Masters) nurse when they receive a call-in that will impact the listed number of hours, thereby posting actual hours worked. All newly hired licensed nurses will receive training during new hire orientation to the process of posting hours as actual hours worked on staff postings.	

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F 732	Continued From page 48	F 732	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Director of nursing, ADON, or administrator will ensure postings are correctly adjusted reflecting actual hours worked by completing audits 5 X□s per week X 4 weeks, 3 X per week X 4 weeks, and Monthly X 1 to ensure that appropriate and timely adjustments and postings are made to reflect actual hours worked per shift. Findings will be reported to the QAPI committee and program will be re-evaluated and adjusted as needed to maintain compliance.	
F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident, staff, and physician, the facility failed to develop and implement person centered interventions to address the needs of residents with dementia for 2 of 4 residents (Residents #35 and #50) reviewed for dementia care. The findings included: 1. Resident #35 was admitted to the facility on 11/13/18 with diagnoses that included dementia with behavioral disturbance and anxiety disorder. A nursing note dated 11/14/18 indicated Resident	F 744	F 744 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Social Service Director (SSD) developed a care plan on 3/19/19, for specific behaviors and interventions related to Resident #35, to include yelling out related to Behavioral and Psychological Symptoms of Dementia (BPSD).	4/18/19

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F 744	Continued From page 49 #35 had anxiety, rang the call bell every 5- 10 minute, and frequently yelled out, "Nurse, Nurse". When staff entered the room to see what Resident #35 needed, she stated that she had forgotten and didn't know why she was yelling out or ringing the call bell. A nursing note dated 11/15/18 indicated Resident #35 rang the call bell every 5-10 minutes along with yelling out for staff. When staff entered room and asked Resident #35 what she needed, she would state that she didn't need anything, and she stated that she just wanted someone in the room with her. A nursing note dated 11/16/18 indicated Resident #35 was yelling out for staff this morning while the physician was in the facility. The physician was noted to order Seroquel (antipsychotic medication) for Resident #35. Resident #35 ' s behavior of yelling was reduced after one dose of the Seroquel. A nursing note dated 11/19/18 indicated Resident #35 was yelling out that morning and was noted with visual and auditory hallucinations. A nursing note dated 11/20/18 indicated Resident #35 was yelling out and stating that the medication that was given to her was poison. The admission Minimum Data Set (MDS) assessment dated 11/20/18 indicated Resident #35 ' s cognition was moderately impaired. She was assessed with hallucinations during the MDS 7 day look period. Resident #35 had other behavioral symptoms on 4-6 days and no rejection of care. She was administered antipsychotic medications on 4 of 7 days.	F 744	The MDS coordinator had resolved the Sexual behavior care plan for Resident #50 on 11/21/18, due to resident not exhibiting sexual behaviors. The MDS coordinator initiated a History of Sexual behavior care plan on 3/29/19. The SSD initiated a care plan on 4/04/19, for Resident #50, specific to behaviors of anger related to dementia that is not easily redirected. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The MDS coordinator completed an audit on 4/4/19, of current resident's diagnosis, to identify residents with diagnosis of Alzheimers/dementia, and validate that a Dementia specific care plan with resident centered interventions were in place. There were 28 residents identified with Alzheimers/dementia diagnosis. Dementia care plans were developed on 4/4/19 for residents identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The licensed nurse and/or the SSD will initiate a baseline care plan upon admission to identify care needs specifically related to dementia care needs. The SSD will review new admission resident records to identify diagnosis of	

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F 744	Continued From page 50 The behavioral symptom Care Area Assessment (CAA) for Resident #35 ' s 11/20/18 admission MDS indicated she had diagnoses of anxiety disorder and Behavioral and Psychological Symptoms of Dementia (BPSD). She was noted to yell out and then forget why she was yelling. Resident #35 was to be assisted as needed, approached calmly, offer reassurance, explain procedures, and anticipated needs. This CAA indicated a care plan was to be developed. Resident #35's comprehensive care plan included the focus area, initiated on 11/23/18 and last revised on 11/26/18, of the use of antipsychotic medications related to behavior management and BPSD. The goal was for Resident #35 to remain free of antipsychotic drug related complications. There were two interventions for this focus area: 1) Administer psychotropic medications as ordered by the physician and monitor for side effects and effectiveness each shift; 2) Monitor/document/report as needed any adverse reactions of psychotropic medications. These interventions were initiated on 11/26/18 and last revised on 11/28/18. This care plan had no non-pharmacological interventions to address resident #35's dementia related behaviors. In addition, the comprehensive care plan included no other focus areas related to Resident #35's behaviors, dementia, and/or BPSD. A review of nursing notes revealed Resident #35's behavior of frequent yelling out occurred on 11/24/18, 11/26/18, 11/28/18, 11/29/18, 12/5/18, 12/9/18, 12/13/18, 12/27/18, 12/29/18, 1/26/19, 2/1/19, 2/10/19, 2/16/19, and 3/3/19. An observation was conducted of Resident #35	F 744	Alzheimers/dementia and will develop a resident centered dementia care plan within 21 days of admission. The SSD will review and update as necessary, dementia care plans quarterly, annually and significant change to assure care plans remain resident centered and effective. The Director of Clinical Reimbursement provided education for the MDS coordinator and SSD on 4/2/19, regarding implementation and updating of care plans specific to resident needs and diagnosis. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The MDS coordinator and/or the DON will review new admission resident care plans weekly for 12 weeks to validate that a dementia specific care plan has been initiated as applicable within 21 days of admission and will review care plans quarterly, annually and significant change to validate that dementia care plans have been reviewed and updated. The MDS coordinator and/or the DON will review audits to identify patterns/trends and will adjust plan as necessary for continued compliance. The MDS coordinator and/or DON will review the plan during monthly QAPI and will continue audits at the discretion of the QAPI committee.	

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on 3/19/19 at 11:35 AM. Staff were present for this observation and Resident #35 was noted to be awake, but kept her eyes closed. No behaviors were observed. Resident #35 was not interviewable.

An observation was conducted of Resident #35 on 3/20/19 at 8:40 AM. She was sleeping in her bed and was not easily roused.

An observation was conducted of Resident #35 on 3/20/19 at 10:00 AM. She was sleeping in her bed and was not easily roused.

An interview was conducted with Nurse #8 on 3/19/19 at 4:40 PM. Nurse #8 stated that Resident #35 yelled out all the time. She indicated that this behavior had been ongoing since Resident #35's admission. She indicated she was not sure if Resident #35's care plan included any non-pharmacological interventions to address Resident #35's behavior of yelling.

An interview was conducted with Nurse Supervisor #1 on 3/20/19 at 10:13 AM. Nurse Supervisor #1 stated that Resident #35 exhibited the behavior of screaming/yelling out for staff. She reported that when staff entered Resident #35's room in response to her yelling, the resident stated that she had not needed anything. Nurse Supervisor #1 stated that Resident #35 was ordered Seroquel for BPSD to manage the behavior. She indicated she was not sure if Resident #35's care plan included any non-pharmacological interventions to address Resident #35's behavior of yelling.

An interview was conducted with the MDS Coordinator on 3/19/19 at 4:50 PM. She stated

Date When Corrective Action Will be Completed

4/18/19

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that the SW was responsible for completing care plans to address dementia related behaviors. She reported that her expectation was for a care plan to be developed that included person-centered, non-pharmacological interventions to address a resident's dementia related behaviors.

An interview was conducted with the Social Worker (SW) on 3/19/19 at 4:25 PM. She stated that she was auditing her care plans today (3/19/19) and noticed that there was no care plan in place to address Resident #35's dementia related behaviors. She explained that there was a care plan for Resident #35's antipsychotic medication, but this care plan had not included any non-pharmacological interventions to address the dementia related behaviors.

An interview was conducted with the Director of Nursing on 3/21/19 at 10:25 AM. She reported that her expectation was for person-centered interventions to be developed through the comprehensive care planning process to address a resident's dementia-related behaviors.
2. Resident #50 was admitted to the facility on 12/3/13 with the diagnosis of dementia.

A review of Resident #50's psychotherapy notes dated 12/19/18 revealed the resident had poor judgement and was confused at times. The resident's mood during therapy was anger, depression, and sadness. The resident had the diagnosis of Sexual Behavior Disorder. The psychotherapist was working to change negative thought patterns into positive (last note visit documented in the record).

A review of Resident #50's quarterly Minimum

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Data Set dated 2/7/19 revealed the resident wore a hearing aid and had minimal difficulty hearing. The resident had an intact cognition with no behaviors, psychosis or depression. Active diagnoses were non-Alzheimer's dementia, anxiety, and depression

Resident #50's care plan initiated on 11/2/18 and revised on 11/14/18 revealed a focus of anti-psychotic mediation administration for behavior management related to depression, anxiety, and dementia. The goal was the resident will remain free of medication complication(s). The interventions were to report medication side effects, psych services as needed, consistent approaches, and behavior symptoms not usual to the person (there were no interventions specific to behaviors documented).

On 3/20/19 at 2:00 pm an interview was conducted with Nurse Supervisor #2 who stated he was familiar with and assigned to Resident #50. The resident had a history of behaviors including sexual where she kissed another resident on the mouth about a year ago. There has not been another incident. The resident was observed by staff for behaviors. Most recently the resident was having anxiety and verbal behaviors because she had a new roommate placed 3 weeks ago. The resident had the verbal behaviors of negative communication and anger. The resident had verbalized that she did not want a roommate. The resident had a care plan goal for no behaviors, but the nurse was not aware that interventions did not reflect sexual and verbal behaviors.

On 3/20/19 at 2:10 pm an observation was done of Resident #50 who was sleeping and not

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verbally aroused. The resident was clean, hair styled, wearing makeup.

On 3/21/19 at 8:30 am an interview was conducted with Resident #50 who stated she had seizures all her life. The resident appeared angry by her facial expression and tone of voice and was fixed on her body symptoms during conversation. The resident was not easily re-directed. When asked about her new roommate, the resident stated, "what is there to say" and frowned. The resident did not have any complaint and did not want to talk any further.

On 3/21/19 at 8:30 am an observation was done of the resident who was sitting at the side of her bed eating breakfast. The resident was alert and oriented to time, situation, and self. No confusion was noted.

On 3/21/19 at 8:45 am an interview was conducted with Nurse #8 who stated she was familiar with Resident #50 and commented that the resident can be negative and aggressive. Nurse #8 was aware of the resident's anger and aggression that caused verbal behavior but was not aware of prior sexual behavior.

On 3/21/18 at 8:55 am an interview was conducted with Nurse #5 who stated she was regularly assigned to the resident. Nurse #5 added that the resident was more relaxed and less angry with staff she was familiar with. Nurse #5 has not observed recent behaviors from the resident nor concerns voiced from the nursing assistants. Nurse #5 was not sure of the care plan interventions without looking.

On 3/20/19 at 4:00 pm an interview was

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F 744	Continued From page 55 conducted with the facility physician who remembered Resident #50 and stated that the resident had received psychotherapy for her behaviors and psychiatry followed as needed. The physician was aware of the resident's current behaviors, including sexual behavior sometime in the past. On 3/20/19 at 4:00 pm an interview was conducted with the Director of Nursing who stated she expected the resident to have interventions and a plan to address individual and specific needs.	F 744		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		4/18/19

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F 756	Continued From page 56 (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 staff and Pharmacy Consultant interviews, the Pharmacy Consultant failed to identify and address an incomplete Abnormal Involuntary Movement Scale assessment (an assessment utilized to monitor involuntary movements for persons on antipsychotic medications) for 1 of 5 residents reviewed for unnecessary medications (Resident #62). The findings included: Resident #62 was admitted to the facility on 11/13/18 with diagnoses that included dementia, anxiety disorder, depression, restless leg syndrome and polyarthritis. A review of assessments revealed an incomplete Abnormal Involuntary Movement Scale (AIMS) assessment dated 11/13/18. A review of the comprehensive Minimum Data	F 756	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; An abnormal involuntary movement scale assessment (AIMS) was completed on resident number 62 on 03/20/2019 by the licensed nurse. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; An audit was conducted by the Director of Nursing and Assistant director of nurses on 04/02/2019 of all other residents who are on antipsychotic medications to ensure that their AIMS had been completed within the most recent quarter, identifying 10 residents who were affected of the deficient practice of having a complete AIMS upon admission and within the most recent quarter. The licensed nurses updated/completed AIMs	

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F 756	Continued From page 57 Set (MDS) coded as an Admission assessment and dated 11/20/18 indicated the resident had cognitive impairment and received an antipsychotic medication 7 days out of the 7 day look back period. A review of the most recent MDS coded as a quarterly assessment and dated 2/16/19 indicated the resident had cognitive impairment and received an antipsychotic medication 7 days out of the 7 day look back period. A review of Resident #62's March 2019 physician orders revealed an order for Seroquel (an antipsychotic medication) twice a day. An interview was completed with Nurse #3 on 3/20/19 at 2:55pm who stated she was unsure why the AIMS assessment was not completed at the time of admission. She further explained that the nursing staff completed an AIMS assessment for any new admission that was on an antipsychotic medication. An interview was conducted with the Director of Nursing (DON)on 3/20/19 at 3:05pm who stated the AIMS assessments are completed on admission and every six months. On 3/20/19 at 4:10pm a phone interview occurred with the Pharmacy Consultant. She stated she looks for the AIMS assessment when a resident was on an antipsychotic medication, but only looked to see if it was marked complete in the status bar on the Electronic Medical Record System. She added that the 11/13/18 AIMS assessment that was marked with an Error in the status bar was an oversight.	F 756	assessment for identified residents on 4/4/19. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The director of nursing provided education to the pharmacy consultant on 4/4/19, regarding the routine monitoring of the completion of the Involuntary movement scale assessment (AIMS), while conducting the monthly review. Additionally, the director of nursing completed inservice education to all current licensed nursing staff to the completion of the AIMS quarterly and upon admission for all applicable residents (those who receive antipsychotic medications) on 3/27/19. New licensed nursing personnel will be provided training upon hire to the completion of the AIMS assessment upon admission and quarterly for all applicable residents(Those who receive antipsychotic medications). Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of nursing will review monthly reports provided by the consultant pharmacist review and respond/complete recommendations including incomplete or missing AIMS within 30 days of receipt of recommendations. Recommendations follow up will be presented in quarterly QAPI meeting with re-evaluation and adjustment to plan to maintain compliance. Additionally, the director of nursing, assistant director of nursing or	

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F 756	Continued From page 58 On 3/21/19 at 10:25am during an interview with the DON, she stated it was her expectation for the Pharmacy Consultant to identify and address any AIMS assessments that needed to be completed.	F 756	MDS coordinator will conduct audits to ensure the completion of the Involuntary movement scale Assessment (AIMS) of 3 residents per week X 4 weeks, followed by 4 residents per month X 3 months verifying the completion of the AIMS to be done upon admission and quarterly. Findings will be presented to the monthly QAPI meeting to review and adjust plan to maintain compliance.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (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;	F 758		4/18/19

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F 758	Continued From page 59 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and Physician and staff interview, the facility failed to try non pharmacological interventions/approaches prior to the initiation and prior to the increase in dosage of an antipsychotic medication (Residents #54 & #35), failed to monitor and to document the target behavior and side effects of medication for a resident on antipsychotic medication (Resident #54) and failed to assess a resident on antipsychotic medication for extrapyramidal symptoms (EPS), a drug induced movement disorder (Resident # 62) for 3 of 5 sampled residents reviewed for unnecessary medications. Findings included:	F 758	Monitor and document target behavior and side effects of medications on antipsychotic medication (54) and failed to and assess for EPS for resident # 62 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; In regard to deficient practice of non-pharmacological interventions/approaches prior to initiation or increase in dosage of antipsychotic medications for resident number 54 and 35; the residents physician was notified on 3/20/19 by the Director of Nursing (DON), to review current orders for	

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F 758	Continued From page 60 1a. Resident # 54 was admitted to the facility on 7/14/17 with multiple diagnoses including dementia with behaviors. The significant change in status Minimum Data Set (MDS) assessment dated 2/8/19 indicated that Resident #54 had memory and decision making problems and had received antipsychotic medication for 7 days during the assessment period. Resident #54's care plan dated 2/8/19 was reviewed. One of the care plan problems was the resident was at risk for adverse reaction related to "polypharmacy". The goal was the resident would be free of adverse drug reactions through the next review date. The approaches included to monitor for possible signs and symptoms of adverse drug reaction, review resident's medications with the physician and consulting pharmacist for duplicate medications or prescriptions, proper dosing, timing and frequency of administration, adverse reactions, supporting diagnoses and review as needed (PRN) in the process. A doctor's progress note dated 2/26/18 revealed that Resident #54 was referred to the doctor due to altered in mental status. The note indicated that Resident #54 continued to express behavioral issues. She has had hallucinatory issues of seeing people who were not there. She was not hearing any voices apparently. At times, she appeared to be possibly at harm to herself. The plan was to add Seroquel (antipsychotic medication) and follow up for results. On 2/26/18, a new order for Seroquel 25 milligrams (mgs) by mouth twice a day was started for progressive dementia with behaviors and for Behavioral and Psychological Symptoms	F 758	antipsychotic medications. At that time the physician chose to maintain current dosage of prescribed antipsychotic medications. On 3/19/19, care plan was added by the Social Service Director (SSD) to monitor for increased or changed targeted behaviors specific to resident # 54 and resident #35 with non-pharmacological interventions specific to resident # 54 and resident # 35 to prevent, improve or intercede with targeted behaviors. Instructions to record affects of non-pharmacological interventions for targeted behaviors to be recorded in the resident medical record to review with resident□s physician prior to initiation or increase in dosage of antipsychotic medication. The Director of nursing (DON) completed inservice training for all current licensed personnel on 3/27/19, for introducing resident specific care plans which provide targeted behavior documentation and non-pharmacological interventions prior to the initiation or increase dosage of antipsychotic medications. Education and training to all newly hired licensed nursing staff will occur during orientation to include introducing resident specific care plans which provide targeted behavior documentation and non-pharmacological interventions and reviewing with the resident physician prior to the initiation or increase dosage of antipsychotic medications. In Regards to the deficient practice of Monitor and document target behavior and side effects of medications on antipsychotic medication (54) and failed to	

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F 758	Continued From page 61 of Dementia (BPSD). Review of Resident #54's nurse's notes for February 2018 was conducted. There was no documentation that non pharmacological intervention had been tried prior to the initiation of Seroquel. A nurse's note dated 4/3/18 at 8 PM revealed that Resident #54 continued with Seroquel as ordered. She was noted to have episodes of agitation/anxiety. She was screaming out when incontinence care was provided, when she was being transferred and when she was being turned. She noted to dig in her stools when attempting to have a bowel movement. She was noted to have emotional lability more so in the evening. She was laughing in one minute and then crying and calling out for "mama/granny". She has had as needed (PRN) Ativan (antianxiety medication) and Xanax (antianxiety medication) in the past, both were effective for anxiety/agitation. The physician was aware and to address in the morning. A doctor's progress note dated 4/4/18 revealed that Resident #54 was referred due to behaviors. The note revealed that Resident #54 with end stage dementia had been having issues with behavior outburst. She required close supervision so as to prevent her from harm. She also was getting extremely anxious when these episodes occur. The assessment indicated altered mental status probably secondary to ongoing dementia. The plans were treatment as ordered and to continue to monitor with recheck in one week. On 4/4/18, there was an order to discontinue	F 758	assess for EPS for resident # 62; On 3/21/19, the director of nursing assessed resident # 54 and resident # 62 for side effects of medications and (no) side effects were noted. Physician was contacted 3/21/19, by the DON, and no changes to current medication regimen were received. On 4/1/19 director of nursing and assistant director of nursing placed on each residents Medication administration record (MAR) to monitor for targeted behaviors and monitoring of adverse effects of use of antipsychotic medications to include extrapyramidal symptoms(EPS). Inservice training to all current licensed staff was completed by the director of nursing on 3/27/19, to include the daily monitoring for target behaviors on the Medication administration record(MAR) and monitoring of adverse effects of use of antipsychotic medications to include extrapyramidal symptoms(EPS). All newly hired licensed nursing staff will receive education during new-hire orientation to include the daily monitoring for target behaviors on the Medication administration record(MAR) and monitoring of adverse effects of use of antipsychotic medications to include extrapyramidal symptoms(EPS). Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All current facility residents who receive antipsychotic medications were identified to be at risk for the deficient practice of	

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F 758	Continued From page 62 Seroquel 25 mgs twice a day and to start Seroquel 25 mgs in AM and 50 mgs in PM. Review of Resident #54's medical records including the nurse's notes revealed no documentation to indicate that non pharmacological intervention/approach had been tried on 4/4/18 prior to the increase in dosage of Seroquel. A doctor's progress note dated 4/5/18 revealed that Resident #54 was referred due to altered in mental status. She was becoming more confused and disoriented and was becoming more agitated with hallucinatory behavior. She had no fever, sweats or chills, no cough, no shortness of breath or wheezing, no abdominal pain, no nausea or vomiting and no frequency, dysuria or urgency. The plan was to increase Seroquel, would like to try to avoid sedation and further treatment pending response to above. On 4/5/18, there was another order to discontinue the Seroquel 25 mgs in AM and 50 mgs in PM and to start Seroquel 50 mgs twice a day. Review of Resident #54's medical records including the nurse's notes revealed no documentation to indicate that non pharmacological intervention/approach had been tried on 4/5/18 prior to the increase in dosage of Seroquel. An interview with the Director of Nursing (DON) was conducted on 3/20/19 at 8:50 AM. The DON stated that she expected the nurses to try non pharmacological approaches and to document in the nurse's notes the approaches that had been tried prior to the initiation and prior to the increase	F 758	not having non-pharmacological interventions/approaches prior to initiation or increase in dosage of antipsychotic medication and failure to monitor and document target behavior and side effects of medications on antipsychotic medication and failed to and assess for EPS for resident. An audit was completed on 3/28/19 by the DON and/or ADON to identify residents who receive antipsychotic medications were identified to be at risk for the deficient practice of not having non-pharmacological interventions/approaches prior to initiation or increase in dosage of antipsychotic medication and failure to monitor and document target behavior and side effects of medications on antipsychotic medication and failed to and assess for EPS for resident. 17 residents were affected by deficient practice. In regard to deficient practice of non-pharmacological interventions/approaches prior to initiation or increase in dosage of antipsychotic medications the residents□ physician was notified on 4/01/19 by the DON to review current orders for antipsychotic medications. At that time the physician reviewed dosage of prescribed antipsychotic medications. On 4/04/19, care plan was added by MDS Coordinator to monitor for increased or changed targeted behaviors specific to residents with non-pharmacological interventions specific to prevent, improve or intercede with targeted behaviors. Instructions to record affects of non-pharmacological	

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F 758	Continued From page 63 in the dose of any psychotropic medications. An interview was conducted with Nurse #5 on 3/20/19 at 2:50 PM. The Nurse stated that she was assigned to Resident #54 and she had known her since her admission. Resident #54 was quiet when left alone. She yelled out "mama/mama" only when staff was providing care (incontinent care, turning, bathing). Nurse #5 indicated that Resident #54 was on PRN Ativan (antianxiety drug) and PRN Xanax (antianxiety drug) in the past and they were effective, but the doctor had discontinued them. She also stated that nurses were supposed to try non pharmacological interventions and to document these interventions in the nurse's notes when residents were displaying behaviors. Nurse #5 had reviewed the Resident #54's medical records including the nurse's notes and she was unable to find documentation of any non pharmacological interventions that were tried prior to the initiation or to the increase in dosage of Seroquel. She further revealed that the Nurse who carried out the order to increase the Seroquel on 4/4/18 and 4/5/18 was no longer an employee of the facility. An interview with Resident #54's physician was conducted on 3/21/19 at 9:58 AM. He stated that he was made aware of Resident #54's behavior by the nursing staff. He indicated that Resident #54 was having hallucinations and outburst in behavior, so he started the Seroquel. He also stated that he was aware of the increase in dosage of Seroquel in one day (4/4/18 and 4/5/18). He indicated that the nursing staff had called him that resident's behavior was out of control. A follow up interview with the DON was	F 758	interventions for targeted behaviors to be recorded in the resident medical record to review with resident□s physician prior to initiation or increase in dosage of antipsychotic medication. On 3/27/19, director of nursing completed inservice training to all current licensed personnel for introducing resident specific care plans which provide targeted behavior documentation and non-pharmacological interventions prior to the initiation or increase dosage of antipsychotic medications. Education and training to all newly hired licensed nursing staff will occur during orientation to include introducing resident specific care plans which provide targeted behavior documentation and non-pharmacological interventions and reviewing with the resident physician prior to the initiation or increase dosage of antipsychotic medications. In Regards to the deficient practice of Monitor and document target behavior and side effects of medications on antipsychotic medication and failing to assess for EPS for resident On 3/28/19, the director of nursing assessed 17, of identified resident for side effects of medications and any side effects were noted. Physician was contacted 4/1/19, by the DON, to review medication regimen were received. On 4/1/19, the director of nursing and assistant director of nursing placed an order on each residents Medication administration record (MAR) to monitor for targeted behaviors and monitoring of adverse effects of use of antipsychotic medications	

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F 758	Continued From page 64 conducted on 3/21/19 at 10:31 AM. The DON stated that she didn't expect dose increase of Seroquel to happen the next day and she expected the Nurse to clarify the order with the Physician or Practitioner. She also indicated that she expected the nurses to try non pharmacological interventions and to document these interventions in the nurse's notes before calling the doctor for orders for any psychotropic medications. 1b. Resident # 54 was admitted to the facility on 7/14/17 with multiple diagnoses including dementia with behaviors. The significant change in status Minimum Data Set (MDS) assessment dated 2/8/19 indicated that Resident #54 had memory and decision making problems and had received antipsychotic medication for 7 days during the assessment period. Resident #54's care plan dated 2/8/19 was reviewed. One of the care plan problems was the resident was at risk for adverse reaction related to "polypharmacy". The goal was the resident would be free of adverse drug reactions through the next review date. The approaches included to monitor for possible signs and symptoms of adverse drug reaction, review resident's medications with the physician and consulting pharmacist for duplicate medications or prescriptions, proper dosing, timing and frequency of administration, adverse reactions, supporting diagnoses and review as needed (PRN) in the process. A doctor's progress note dated 2/26/18 revealed that Resident #54 was referred to the doctor due to altered in mental status. The note indicated	F 758	to include extrapyramidal symptoms(EPS). Inservice training to all current licensed staff was completed by the director of nursing on 3/27/19 to include the daily monitoring for target behaviors on the Medication administration record(MAR) and monitoring of adverse effects of use of antipsychotic medications to include extrapyramidal symptoms(EPS). All newly hired licensed nursing staff will receive education during new-hire orientation to include the daily monitoring for target behaviors on the Medication administration record(MAR) and monitoring of adverse effects of use of antipsychotic medications to include extrapyramidal symptoms(EPS). Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Physician order review will occur 5 x□s per week of all newly written physician orders by Unit coordinators(ADON), DON, and/or MDS coordinator. Upon receipt of any antipsychotic medication orders, resident□s care plan and Medication administration record (MAR) will be reviewed and updated as necessary to include targeted behavior monitoring, non-pharmacological interventions of targeted behaviors and review of unnecessary medication or duplicative therapy. Any findings will be reported to resident physician. Indicate how the facility plans to monitor	

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F 758	Continued From page 65 that Resident #54 continued to express behavioral issues. She has had hallucinatory issues of seeing people who were not there. She was not hearing any voices apparently. At times, she appeared to be possibly at harm to herself. The plan was to add Seroquel and follow up for results. On 2/26/18, a new order for Seroquel 25 milligrams (mgs) by mouth twice a day was started for progressive dementia with behaviors and for Behavioral and Psychological Symptoms of Dementia (BPSD). A nurse's note dated 4/3/18 at 8 PM revealed that Resident #54 continued with Seroquel as ordered. She was noted to have episodes of agitation/anxiety. She was screaming out when incontinence care was provided, when she was being transferred and when she was being turned. She noted to dig in her stools when attempting to have a bowel movement. She was noted to have emotional lability more so in the evening. She was laughing in one minute and then crying and calling out for "mama/granny". She has had as needed (PRN) Ativan (antianxiety medication) and Xanax (antianxiety medication) in the past, both were effective for anxiety/agitation. The physician was aware and to address in the morning. A doctor's progress note dated 4/4/18 revealed that Resident #54 was referred due to behaviors. The note revealed that Resident #54 with end stage dementia had been having issues with behavior outburst. She required close supervision so as to prevent her from harm. She also was getting extremely anxious when these episodes occur. The assessment indicated	F 758	its performance to make sure that solutions are sustained; The director of nursing, assistant director of nursing and/or MDS coordinator will log 100% of identified incoming orders as they occur to ensure compliance within 72 hours of receipt of orders. Log will be presented monthly X 3 months to the QAPI program with the plan adjusted/extended as deemed necessary by QAPI Program to ensure significant compliance is maintained.	

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altered mental status probably secondary to ongoing dementia. The plans were treatment as ordered and to continue to monitor with recheck in one week.

A doctor's progress note dated 4/5/18 revealed that Resident #54 was referred due to altered in mental status. She was becoming more confused and disoriented and was becoming more agitated with hallucinatory behavior. She had no fever, sweats or chills, no cough, no shortness of breath or wheezing, no abdominal pain, no nausea or vomiting and no frequency, dysuria or urgency. The plan was to increase Seroquel, would like to try to avoid sedation and further treatment pending response to above.

On 4/4/18, there was an order to discontinue Seroquel 25 mgs twice a day and to start Seroquel 25 mgs in AM and 50 mgs in PM.

On 4/5/18, there was another order to discontinue the Seroquel 25 mgs in AM and 50 mgs in PM and to start Seroquel 50 mgs twice a day.

Review of the Resident #54's medical records including the nurse's notes for the last 6 months (October 2018, November 2018, December 2018, January 2019, February 2019 and March 2019)revealed no documentation to indicate that resident's behavior or side effects of medication had been monitored.

An interview was conducted with Nurse #5 on 3/20/19 at 2:50 PM. The Nurse stated that she was assigned to Resident #54 and she had known her since her admission. Resident #54 was quiet when left alone. She yelled out "mama/mama" only when staff was providing

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care (incontinent care, turning, bathing). She also stated that nurses were supposed to monitor and to document behaviors and side effects of medication in the nurse's notes. Nurse #5 had reviewed the resident's medical records including the nurse's notes and she was unable to find documentation to indicate that resident's behavior and side effects of medication had been monitored for the last 6 months.

An interview with the DON was conducted on 3/21/19 at 10:31 AM. The DON stated that she expected the nurses to monitor and to document resident's behaviors and side effects of medication in the nurse's notes for all residents on psychotropic medications. The DON had reviewed the medical records including the nurse's notes of Resident #54. The DON was able to find one behavior documented in the nurse's note dated 11/8/18 for the last 6 months. The DON was unable to find documentation to indicate that side effects of medication had been monitored.

2. Resident #35 was admitted to the facility on 11/13/18 with diagnoses that included dementia with behavioral disturbance and anxiety disorder.

A nursing note dated 11/14/18 indicated Resident #35 had anxiety, rang the call bell every 5- 10 minute, and frequently yelled out, "Nurse, Nurse". When staff entered the room to see what Resident #35 needed, she stated that she had forgotten and didn't know why she was yelling out or ringing the call bell.

A nursing note dated 11/15/18 completed by Nurse #11 indicated Resident #35 was calling out names of her family members throughout the

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night. She was noted with anxiety and frequent "screaming" of family members' names or calling for the nurse. When staff entered Resident #35's room and asked what she needed she replied, "oh not much" or "nothing important".

A nursing note dated 11/15/18 indicated Resident #35 rang the call bell every 5-10 minutes along with yelling out for staff.
When staff entered room and asked Resident #35 what she needed, she would state that she didn't need anything, and she stated that she just wanted someone in the room with her. The physician was aware of Resident #35's behaviors and he ordered Namenda cognition-enhancing medication) 10 milligrams (mg) twice daily for dementia. The nurse indicated she contacted Resident #35's Responsible Party (RP) and made her aware of Resident #35's behaviors and the new order for Namenda. The RP indicated Resident #35 had these behaviors in the past and that she had previously taken Xanax (antianxiety medication) for anxiety.

A physician's order dated 11/15/18 indicated Namenda 10 mg twice daily for Resident #35.

A nursing note dated 11/16/18 indicated Resident #35 was yelling out for staff this morning while the physician was in the facility. The physician was noted to order Seroquel (antipsychotic medication) 25 mg now and then twice daily for Behavioral and Psychological Symptoms of Dementia (BPSD). Resident #35 was noted to be quieter and stopped yelling out after one dose of Seroquel.

A physician's order dated 11/16/18 indicated Seroquel 25 mg now and then twice daily for

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BPSD for Resident #35.

A nursing note dated 11/17/18 indicated Resident #35 had a decrease in behaviors since starting Seroquel on 11/16/18. She had yelled out 2 -3 times that shift.

A nursing note dated 11/19/18 indicated Resident #35 was yelling out that morning and was noted with visual and auditory hallucinations. Resident #35 was educated several times by staff to use the call bell when she needed assistance, but she had not done so.

A physician's note dated 11/19/18 indicated Resident #35 continued to have constant crying out to staff. She was noted with confusion and disorientation. The physician's assessment of Resident #35 included severe dementia with behavioral issues. Resident #35 was noted with a trial of Seroquel with follow up pending the response.

A physician's order dated 11/19/18 indicated the discontinuation of Seroquel for Resident #35.

A psychotherapy note dated 11/20/18 indicated Resident #35 was seen for an initial psychiatric evaluation. Resident #35 was assessed with the symptoms of anxiety, depression/hopelessness/sad, and adjusting to new community. She was noted to have severe cognitive impairment, she was alert and oriented to person only, her mood was assessed as anxious and her attitude/behavior was assessed as irritable. Resident #35 was noted to not be appropriate for psychotherapy.

A nursing note dated 11/20/18 indicated Resident

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#35 was yelling out, her words were not making sense, and she was stating that the medicine that was given to her was poison.

The admission Minimum Data Set (MDS) assessment dated 11/20/18 indicated Resident #35's cognition was moderately impaired. She was assessed with hallucinations during the MDS 7 day look period. Resident #35 had other behavioral symptoms on 4-6 days and no rejection of care. She was administered antipsychotic medications on 4 of 7 days and had a Gradual Dose Reduction (GDR) of the antipsychotic medication on 11/19/18.

The behavioral symptom care area assessment (CAA) for Resident #35's 11/20/18 admission MDS indicated she had diagnoses of anxiety disorder and BPSD. She was noted to yell out and then forget why she was yelling. Resident #35 was to be assisted as needed, approached calmly, offer reassurance, explain procedures, and anticipated needs.

The psychotropic drug use CAA for Resident #35's 11/20/18 admission MDS indicated she was ordered Seroquel for BPSD on 11/16/18, but the medication was causing "severe side effects" so the physician discontinued the Seroquel on 11/19/18.

Resident #35's comprehensive care plan included the focus area, initiated on 11/23/18 and last revised on 11/26/18, of the use of antipsychotic medications related to behavior management and BPSD. The goal was for Resident #35 to remain free of antipsychotic drug related complications. There were two interventions for this focus area: 1) Administer psychotropic medications as

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ordered by the physician and monitor for side effects and effectiveness each shift; 2) Monitor/document/report as needed any adverse reactions of psychotropic medications. These interventions were initiated on 11/26/18 and last revised on 11/28/18. This care plan had no non-pharmacological interventions.

A physician's note dated 11/21/18 indicated Resident #35 continued to be confused, disoriented, and shouting out. She was noted to be placed on Seroquel which caused some sedation and was subsequently discontinued. The Seroquel was noted to have worn off and Resident #35 again was yelling and screaming. The physician indicated a small dose of Seroquel was to be initiated.

A physician's order dated 11/21/18 indicated Seroquel 12.5 mg twice daily for BPSD for Resident #35.

A nursing note dated 11/24/18 completed by Nurse #11 indicated Resident #35 had episodes where she became anxious, demanding, and called out "nurse" repeatedly. There was noted improvement with her behaviors from the previous week.

A nursing note dated 11/26/18 completed by Nurse #11 indicated Resident #35 was yelling out "nurse, nurse" at the beginning of the shift. She had requested the nurse to turn the volume up on her television and/or turn the television on.

A nursing note dated 11/28/18 indicated Resident #35 yelled out sporadically throughout the shift. When staff entered the room to ask what she needed she stated either that she didn't

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remember or that she just wanted someone to stay in the room with her.

A nursing note dated 11/29/18 completed by Nurse #11 indicated Resident #35 was extremely agitated, screaming out for the nurse and attempting to get out of bed. She requested to call the police and stated that she was being kept at the facility against her will. Resident #35 was noted to be very confused and not easily redirected. Nurse #11 indicated that several other residents and family members had been disrupted by Resident #35 ' s behavior.

A physician's note dated 11/29/18 indicated Resident #35 continued with outbursts throughout the day and night, constantly calling out for staff. Namenda was noted with no benefit. The physician indicated Seroquel at 25 mg twice daily had been tried but had caused "excessive sedation". The current Seroquel dose of 12.5 mg twice daily was noted to not be of any benefit. The physician indicated a trial of increased Seroquel of 25 mg twice daily was to be initiated.

A physician's order dated 11/29/18 indicated an increase in Seroquel 12.5 mg twice daily to 25 mg twice daily for Resident #35.

A physician's note dated 12/3/18 indicated a discussion was had with Resident #35's family. The family reported that Resident #35 called them throughout the night. The family member reported that they were not getting any rest and were becoming increasingly frustrated. The physician indicated it was his goal to control the resident ' s behavior so that she was able to have more rest, be calmer, and have a better quality of life. He additionally indicated he wanted to

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reduce the amount of disruption Resident #35's behaviors were causing the staff and other residents in the facility. The physician wrote that he was going to continue to adjust medications accordingly in order to have the resident calm down and not be do so disruptive. He indicated that this would require a probable increase in Seroquel and adjustments in Ativan (antianxiety medication).

A review of the medical record indicated Resident #35 was not ordered Ativan at the time of the 12/3/18 physician's note nor had she received Ativan while at the facility.

A nursing note dated 12/5/18 indicated Resident #35 was yelling out and pressing the call light immediately after staff exited her room. When Resident #35 was asked what she needed she stated either that she didn't need anything or that she just wanted the person in the room.

A physician note dated 12/5/18 indicated Resident #35 continued to have outbursts of behaviors, called her family member all night long, and yelled out for staff. The physician wrote that he was attempting to control this behavior with a combination of Namenda, Seroquel, and "judicious" Ativan, but was not having a lot of success. He indicated the plan was to adjust Seroquel and noted that other medications may be necessary.

A review of the medical record indicated Resident #35 was not ordered Ativan at the time of the 12/5/18 physician's note nor had she received Ativan while at the facility.

A physician's order dated 12/5/18 indicated an

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increase in Seroquel from 25 mg twice daily to 25 mg in the morning and 50 mg at night for Resident #35.

A nursing note dated 12/9/18 completed by Nurse #11 indicated Resident #35 was very upset, crying, and was yelling out of for the nurse. She stated she wanted to call her daughter and expressed that she had not known why her daughter put her in the facility. Resident #35 was not easily redirected, and she was difficult to console. Nurse #11 indicated she sat with Resident #35 for about 30 minutes providing reassurance until the she calmed down and was able to fall asleep.

A nursing note dated 12/10/18 indicated Resident #35 was heard yelling "help me" and when the nurse entered the room she was found on the floor on the side of the bed. She stated that someone was in her room and had taken her keys.

A physician's note dated 12/10/18 indicated Resident #35 continued to act out with continuous screaming and attempting to phone her family non-stop. The physician wrote that medication changes were made in an attempt to deal with these behavior issues. He indicated he was going to continue to adjust medications in an attempt to keep her behaviors down and not cause sedation.

A nursing note dated 12/13/18 indicated Resident #35 continued to yell out for staff. She rang the call bell and then started yelling. Resident #35 was gotten up into her wheelchair, but then yelled that she wanted to go to bed.

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A physician's note dated 12/23/18 indicated Resident #35 continued to be confused, disoriented, and had behaviors of continually shouting out and calling her family. He wrote that he would continue to modify medications to make Resident #35 less anxious.

A nursing note dated 12/29/18 indicated Resident #35 was yelling out for staff and family.

A physician's note dated 1/7/19 indicated Resident #35 ' s family member requested a psychiatric consultation. They indicated they believed Resident #35 was depressed over the events that led to her being admitted to the facility and needed a psychological evaluation. They also indicated they believed she needed one on one compassion visiting to help her deal with loss. The physician indicated this family member was resistant to accepting that Resident #35 had dementia.

A physician's order dated 1/9/19 indicated a psychiatric consultation was ordered for Resident #35.

A Psychiatric Nurse Practitioner (PNP) note dated 1/14/19 Resident #35 was seen for an initial psychiatric medication management visit for stabilization of dementia with behavior of yelling out, and possible depression and anxiety. Nursing staff reported that Resident #35 had no change in mental status and that she had yelled out since her admission to the facility whenever she was left alone. She was noted with poor memory and repetitive questions. Resident #35's current psychiatric medications included Seroquel 25 mg in the morning and 50 mg at night. This was noted to have helped with some of her

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distressing delusions but had not helped with yelling out. The PNP's diagnosis was vascular dementia with behavioral disturbance. She indicated Resident #35 was not responding as expected to the Seroquel. She noted a plan to start Remeron (antidepressant medication) at 7.5 mg at night for sleep and appetite noting that the sleep difficulties were likely due to dementia. A regular sleep/wake cycle was to be encouraged with naps during the day being discouraged. The PNP indicated that follow up was to be continued in 4-5 weeks and if Remeron was helping, the Seroquel would be reduced to the lowest dose possible to manage delusions. Resident #35's family and nursing staff reported that the yelling out behavior was the biggest concern, rather than delusions. Delusions were noted to not distress the resident.

A physician's order dated 1/17/19 indicated Remeron 7.5 mg at night for disordered sleep for Resident #35.

The quarterly MDS assessment dated 1/21/19 indicated Resident #35's cognition was severely impaired. She had no symptoms of psychosis, no behaviors, and no rejection of care. She was administered antipsychotic medication and antidepressant medication on 7 of 7 days.

A physician's order dated 1/25/19 indicated a discontinuation of Seroquel 25 mg in the morning and 50 mg at night and the initiation of Seroquel 50 mg in the morning for Resident #35.

A nursing note dated 1/26/19 indicated Resident #35 was yelling out for family and for staff. She was reminded to use her call bell, but she had not done so.

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A physician's order dated 1/31/19 indicated a discontinuation of Seroquel.

A behavioral note dated 2/1/9 indicated that since Seroquel was discontinued, and Resident #35 had an increase in behaviors and had continuously yelled out for staff. When Resident #35 was asked what she needed she stated she had not remembered. She was also noted with an increase anxiety and was easily agitated.

A physician's note dated 2/1/19 indicated Resident #35's family had reported she was increasing sleepy/drowsy, but staff had reported otherwise indicating that she continued to have bouts of behaviors throughout the day and night despite medications. The physician wrote he was going to reduce sedating type medications, but staff were to monitor and report if behaviors increased which were both disruptive to Resident #35 as well as others in the facility.

A nursing note dated 2/10/19 indicated Resident #35 yelled out for help rather than using her call bell. She was provided with education to use the call bell, but after about 20 minutes she yelled out again.

A behavior note dated 2/16/19 completed by Nurse #11 indicated Resident #35 was yelling out for staff continuously. She was noted to be disruptive to other residents and their family members. When Resident #35 was asked what she needed, she requested to call her family member. She was crying and yelling at the family member on the phone asking, "how could you do this to me".

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A physician's order dated 2/19/19 indicated Seroquel 50 mg twice daily for BPSD for Resident #35.

A nursing note dated 3/3/19 indicated Resident #35 was continuously hollering out for staff, most of the time not needing any assistance. Resident #35 was noted to become angry and accused staff of ignoring her.

An observation was conducted of Resident #35 on 3/19/19 at 11:35 AM. Staff were present for this observation and Resident #35 was noted to be awake, but kept her eyes closed. No behaviors were observed. Resident #35 was not interviewable.

An observation was conducted of Resident #35 on 3/20/19 at 8:40 AM. She was sleeping in her bed and was not easily roused.

An observation was conducted of Resident #35 on 3/20/19 at 10:00 AM. She was sleeping in her bed and was not easily roused.

An interview was conducted with MDS Coordinator on 3/20/19 at 10:04 AM. The psychotropic drug use CAA for Resident #35's 11/20/18 admission MDS that indicated she was ordered Seroquel for BPSD on 11/16/18, but the medication was causing "severe side effects" so the physician discontinued the Seroquel on 11/19/18 was reviewed with the MDS Coordinator. She reported that Resident #35 initially had a decrease in yelling behaviors when the Seroquel was started, but then on 11/19/18 she was yelling out and hallucinating. The Seroquel was also noted to sedate Resident #35. The MDS Coordinator was unable to explain why

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the Seroquel was re-initiated despite its noted "severe side effects".

An interview was conducted with Nurse #8 on 3/19/19 at 4:40 PM. Nurse #8 stated that Resident #35 yelled out all the time. She indicated that this behavior had been ongoing since Resident #35's admission. She reported that Resident #35's behavior of yelling out normally ceased if someone sat with her and talked to her. She explained that she believed Resident #35 needed companionship with verbal interaction for her yelling to stop.

A phone interview was conducted with Nurse #11 on 3/20/19 at 4:28 PM. She stated that she was familiar with Resident #35 and had worked with her since admission. She reported that Resident #35 moved to the facility from a different state to be closer to family. She indicated she believed Resident #35 had the early stages of dementia at the time of admission and that she became disoriented, confused, anxious, and fearful after admission. She stated that generally, Resident #35 was able to be redirected or calmed with companionship, but occasionally there were times where she became very angry with her family members for placing her in the facility and she was unable to be redirected during those times. Nurse #11 indicated that there were times when the Seroquel had sedated Resident #35. She also stated that the Seroquel had not completely ceased the yelling behaviors.

An interview was conducted with Nurse Supervisor #1 on 3/20/19 at 10:13 AM. Nurse Supervisor #1 stated that Resident #35 exhibited the behavior of screaming/yelling out for staff. She reported that when staff entered Resident

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#35's room in response to her yelling, the resident stated that she had not needed anything or that she just wanted someone to stay in the room with her. Nurse Supervisor #1 stated that Resident #35 was ordered Seroquel for BPSD to manage the behavior. She reported that the Seroquel had caused some sedation and that there were instances when hallucinations occurred even when she was on the Seroquel. Nurse Supervisor #1 was unable to explain why the Seroquel was re-initiated despite its noted "severe side effects". She stated that staff reported behaviors to the physician and it was up to him how to proceed with pharmacological approaches.

A phone interview was conducted with Resident #35's physician on 3/20/19 at 3:50 PM. The physician indicated he was out of the country and was unable to review his records, but that he was familiar with Resident #35. He stated that he was made aware of Resident #35's behavior of frequent yelling out by staff and was informed by her family members that she called them on the phone all night long and that she had hallucinations that she was working at her former job as a school bus driver. He stated he initiated Seroquel for Resident #35 to manage the behaviors and hallucinations. The discontinuation of the Seroquel on 11/19/19, the 11/21/19 physician ' s note that indicated the Seroquel had been discontinued due to sedation, and the re-initiation of the Seroquel on 11/21/19 was reviewed with the physician. He indicated the nursing staff had informed him the yelling behavior had increased when the Seroquel was discontinued so he re-initiated it. He was asked if staff had implemented any non-pharmacological interventions for Resident #35 prior to the re-initiation of the Seroquel and he indicated he

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was not sure if non-pharmacological interventions had been implemented by the staff. He reported that staff informed him Resident #35 was constantly yelling, she had hallucinations, and she was disrupting her living environment as well as other residents and family members and this behavior had to be addressed. The physician's notes dated 12/3/18 and 12/5/18 that indicated Resident #35 was being treated with Ativan were reviewed with the physician. He indicated that he was not able to review his records to see why he had noted Resident #35 was on Ativan when she was not, but that he generally preferred not to utilize benzodiazepine medications such as Ativan.

An interview was conducted with the Director of Nursing (DON) on 3/21/19 at 10:25 AM. The DON stated that she expected the nurses to try non-pharmacological approaches prior to the initiation and/or increase in an antipsychotic medication. She reported that she expected that medications that caused side effects of sedation to not be utilized.

3) Resident #62 was admitted to the facility on 11/13/18 with diagnoses that included dementia, anxiety disorder, depression, restless leg syndrome and polyarthritis.

A review of assessments revealed an incomplete Abnormal Involuntary Movement Scale (AIMS) assessment dated 11/13/18.

A review of the most recent comprehensive Minimum Data Set (MDS) coded as an Admission assessment and dated 11/20/18 indicated the resident had cognitive impairment and received an antipsychotic medication 7 days out of the 7 day look back period.

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F 758	Continued From page 82 A review of the most recent MDS coded as a quarterly assessment and dated 2/16/19 indicated the resident had cognitive impairment and received an antipsychotic medication 7 days out of the 7 day look back period. A review of Resident #62's March 2019 physician orders revealed an order for Seroquel (an antipsychotic medication) twice a day. An interview was completed with Nurse #3 on 3/20/19 at 2:55pm who stated she was unsure why the AIMS assessment was not completed at the time of admission. She further explained that the nursing staff completed an AIMS assessment for any new admission that was on an antipsychotic medication. An interview was conducted with the Director of Nursing (DON)on 3/20/19 at 3:05pm who stated the AIMS assessments are completed on admission and every six months. On 3/21/19 at 10:25am during an interview with the DON, she stated it was her expectation for the AIMS assessments to be completed correctly.	F 758		
F 849 SS=B	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with	F 849		4/18/19

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a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility

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F 849	Continued From page 84 for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property	F 849		

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by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the

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F 849	Continued From page 86 hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and review of nursing facility hospice agreement and hospice and facility staff interview, the facility coordinator failed to obtain resident care information from hospice for 1 of 2 sampled residents reviewed for hospice (Resident #54). Findings included:	F 849	One resident was affected by this alleged deficient practice of not having physician signed documentation of hospice services during the time of survey. This information is expected to be received by the facility no later than 5 days from initiation of hospice services. This information was received and placed on	

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F 849	Continued From page 87 Resident # 54 was admitted to the facility on 7/14/17 with multiple diagnoses including dementia with behaviors. The significant change in status Minimum Data Set (MDS) assessment dated 2/8/19 indicated that Resident #54 had memory and decision making problems and she had received hospice care. Resident #54 had a doctor's order dated 2/1/19 for hospice services. Resident #54's care plan dated 2/8/19 was reviewed. One of the care plan problems was the resident has a terminal prognosis. The goal was the resident's comfort would be maintained through review date. The approaches included to observe resident closely for signs of pain and administer pain medication as ordered, notify physician immediately for breakthrough pain, to work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs were met and to work with nursing staff to provide maximum comfort for the resident. Review of the nursing facility hospice services agreement dated 8/3/2018 was conducted. The agreement indicated that hospice should provide nursing facility with the most recent hospice plan of care specific to the hospice resident, the hospice election form and any advance directives specific to the hospice resident, Physician certification and recertification of terminal illness specific to the hospice resident and the hospice medication list specific to the hospice resident. Review of Resident #54's medical records on 3/19/19 revealed no hospice information filed in	F 849	the resident #54□s medical record on March 25,2019. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; An audit was completed on March 28, 2019 of the 3 other residents receiving Hospice services by the Director of Nursing to ensure that all other residents receiving Hospice services had appropriate and signed certifications, recertifications, medication lists, hospice election form and plan of care were signed and received by the facility as part of the resident medical record. No other residents were found to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Director of nurses provided notification to all hospice providers that the facility would expect all hospice documentation to be signed by the provider within 5 days of initiation of services on or before April 2, 2019. Social services director and assistant director(s) of nursing were in-serviced on 3/21/19, by director of nursing to ensure that appropriate and complete documentation of the hospice services are completed within 5 days of initiation of hospice services. This will be monitored through audits of new physician orders of Hospice referrals are reviewed in morning standup meeting by Assistant directors of nursing and social service director to ensure that once order is received, appropriate and signed	

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F 849	Continued From page 88 the records including the most recent hospice plan of care, hospice election form, Physician certification and recertification of terminal illness and hospice medication list. On 3/19/19 at 3:40 PM, the Hospice Nurse was interviewed. She stated that she had not filed the required forms in Resident #54's medical records because the Physician had not signed the forms yet. On 3/20/19 at 2:21 PM, the Social Worker (SW) was interviewed. She stated that she was the facility coordinator with hospice. The SW stated that the hospice staff was responsible for filing the required forms in the resident's medical records. She indicated that she was not aware the required information/forms were not in Resident #54's medical records. On 3/21/19 at 10:31 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the hospice staff to file the required forms in resident's medical records as soon as the Physician had signed the forms and the hospice care had started but not after a month the hospice care had started.	F 849	paperwork is received within 5 days and placed on residents medical record. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Director of nursing or administrator will monitor audits monthly X 3 months to ensure substantial compliance is achieved. Findings will be reported to the QAPI committee and program will be re-evaluated and adjusted as needed to maintain compliance.	