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	345534	A. BUILDING _____ B. WING _____	C 12/13/2019

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F 000	INITIAL COMMENTS The survey team entered the facility on 12/9/19 to conduct a complaint survey and exited on 12/11/19. Additional information was obtained on 12/12/19 and 12/13/19. Therefore, the exit date was changed to 12/13/19. Two of the seventeen allegations were substantiated.	F 000		
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 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, resident interview, and staff interviews the facility failed to provide an ordered nutritional supplement for one (Resident # 6) of three sampled residents who had experienced weight loss. The findings	F 692	Preparation and/or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement f deficiencies. The plan is	1/7/20

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

Electronically Signed | 12/27/2019

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F 692	Continued From page 1 included: Resident # 6 was admitted to the facility on 10/11/19. The resident had diagnoses of Alzheimer's disease, chronic kidney disease, coronary artery disease, diabetes, and vitamin B12 deficiency. Resident #6's admission Minimum Data Set Assessment, dated 10/19/19, coded the resident as cognitively intact. The resident's weight was listed as 112 pounds and her height was 58 inches. Resident # 6's weights were recorded as the following. 10/11/19 111.5 pounds 10/24/19-110 pounds 10/30/19-107 pounds 11/3/19-107 pounds 11/11/19-107 pounds 11/19/19-106 pounds 11/25/19-109 pounds 12/6/19-103.8 pounds 12/9/19-106 pounds On 10/30/19 at 4:06 PM the RD (Registered Dietician) documented the following in the medical record. The resident had lost 4% of her weight since admission. She had variable intake which ranged from 25 % to 75%. The resident was being given Medpass three times per day for weight maintenance. She was having antibiotic treatment for a Clostridium Difficile infection and continued to have some loose stools. The resident might benefit from adding a Magic Cup supplement to her meal at lunch and supper. On 11/1/19 an order was written to provide a	F 692	prepared and executed solely because it is required by the provisions of the State and Federal Law. On 11/01/2019 a physician order was received for Resident #6 to receive Magic Cup related to weight loss. However, magic cup did not come out on meal tray on 12/10/19 due to a missing dietary slip. Diet order verified & dietary communication slip was completed by Regional Clinical Manager (RCM) and then Certified Dietary Manager (CDM) entered order into Tray Card System on 12/10/19. Also, on 12/10/19 Resident #6 was given Magic Cup and resident consumed half of the Magic Cup. However, on 12/16/19 Resident was offered Magic Cup again and resident refused the supplement and snacks. Medical Director, Registered Dietitian, and family made aware of refusals. Magic Cup was discontinued 12/16/19 per order. RD recommended fortified food at breakfast and ice cream at lunch and dinner. A new physician order was received and put in place for 12/16/19 related to the RD recommendations. On 12/24/19 an order was implemented for an appetite stimulant for the resident due to her lack of desire to eat. 100% Audit of all Magic Cup orders in Matrix Care System and tray cards system was completed by Administrative nurses and Certified Dietary Manager 12/10/19. Of 112 Residents 39 have orders for Magic cup. Out of the 39 with orders dietary had 31 in the tray card	

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F 692	Continued From page 2 Magic Cup at lunch and dinner meals. On 12/10/19 at 12:50 PM, NA # 1 was observed to serve Resident # 6 her lunch tray. The resident did not have a Magic Cup on her lunch tray. When asked if the resident usually received one, Resident # 6 stated she never had done so and was not familiar with the item. NA # 1 stated she routinely cared for Resident # 6 and the resident had never received a Magic Cup with her meals. NA # 1 pointed to Resident # 6's tray card and stated if the resident was supposed to receive one then it would appear on her tray card. It was observed that Resident # 6's tray card did not list Magic Cup as an item to be served. NA # 2 was also helping pass lunch trays on Resident # 6's hall on 12/10/19. NA # 2 was interviewed on 12/10/19 at 12:58 PM. She stated she routinely helped serve Resident # 6's trays, and the resident had never received a Magic Cup. The facility's RD was interviewed on 12/9/19 at 3:55 PM and again on 12/11/19 at 10:25 AM. The RD reported the following. The Magic Cup provided 300 calories and also protein. Therefore, the RD stated it was a great way to help residents who were losing weight. Resident # 6's weight was trending downwards, but she did not think the 103.8 weight was accurate. Therefore, she felt the resident's weight had fallen from 111.5 pounds to 106 pounds; but not further. She confirmed the resident had not been receiving the Magic Cup since it had been ordered on 11/1/19. This was because the order had been put into the computer by a nurse who entered it as a separate order and not part of the diet order. Therefore, the order did not show up in the dietary	F 692	system the other 8 were missing Dietary Communicator Slips. All dietary communication slips were completed by Regional Clinical Manager and Staff Development Coordinator 12/11/19. Certified Dietary Manager entered all missing Magic cups on tray card into the Tray card system on 12/11/19. 100% In service to all Licensed Nurses, Certified Dietary Manager, and Dietitian was initiated by Regional Clinical Manager on 12/11/19 and will be completed on 12/31/19 in regards to What to do when you receive an order for a Magic Cup and completing Dietary Communication slip to ensure magic cup is entered in tray card system. Director of Nursing (DON) and administrative nurses will review new orders daily to ensure all Magic Cup orders have a dietary communication slip and have been provided to Dietary Manager. The Director of Nursing (DON) will complete five random tray audits of Magic Cup ordered weekly X 8 weeks, then monthly x 1 to verify residents are receiving Magic Cups as ordered on their tray for consumption. The Director of Nursing will review the audit tools and bring the results of the audit to the Quality Assurance Committee Meeting Monthly x 3 Months.	

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F 692	Continued From page 3 department's computer system, and the dietary department had not known they needed to send the Magic Cup to Resident # 6. Prior to 11/1/19, communication between nursing and dietary was handwritten. On 11/1/19, the facility went to a new system in which supplement orders were entered directly into the computer. The facility had not identified prior to 12/10/19 that supplement orders, which were not tied to a computer diet order, were not showing up in the dietary department's computer system. It had not affected all residents who had been ordered supplements since 11/1/19 because at times she took care of the communication herself. She always did both a handwritten communication slip and entered it into the computer, but nursing staff no longer did this.	F 692		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		1/7/20

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F 757	Continued From page 4 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, staff interview, Hospice Clinical Care Manager interview, Physician Assistant interview, and Geriatric Neuropsychiatry Nurse Practitioner interview for one (Resident # 4) of three sampled residents whose drug regimen was reviewed, the facility failed to assure psychotropic drug monitoring occurred for a resident with long term mental illness who experienced a significant change in status. The findings included: Resident # 4 resided at the facility from 5/16/19 to 11/12/19. He was 67 years of age at the time of his residency. The resident had a history of Schizophrenia, traumatic brain injury, frontotemporal cognitive disorder, and peripheral artery disease. According to records, prior to his facility residency the resident had a history of setting his feet on fire due to voices he heard telling him to do so and which were part of his mental illness. According to hospital records, Resident # 4 was hospitalized for pneumonia in August 2019 and returned to the facility on 8/9/19. During the hospitalization it was found the resident's pneumonia was likely due to aspiration and he was diagnosed with moderate to severe dysphagia. The resident was readmitted to the facility with orders for a diet change based on his dysphagia diagnosis.	F 757	Preparation and/or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement f deficiencies. The plan is prepared and executed solely because it is required by the provisions of the State and Federal Law. On 8/9/19 Resident #4 admitted to facility with an order to “follow up with psychiatry asap to evaluate need for medication. However, resident discharged 11/12/19 to hospital before receiving the service. 100% Audit of all anti-psychotic medications orders was completed on 12/13/19 to ensure all residents currently on anti-psychotic are being managed by psychiatry services. Those identified as not receiving services at this time were reviewed and placed on Psych consult list. 100% In service to all Licensed Nurses was initiated by Regional Clinical Manager (RCM) on 12/14/19 and will be completed 12/31/19 regarding the process of “What to do when a nurse receives an order for stat psychiatric consults.” The nurse receiving the physician order will contact the Psychiatric Nurse Practitioner via	

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F 757	Continued From page 5 According to records the resident was placed on hospice services on 8/30/19 due to senile degenerative disease of the brain with associated significant weight loss and decline in communication abilities and physical status. On 9/6/19 a significant change in status Minimum Data Set assessment was completed. The resident was unable to complete a brief interview for mental status at the time. He was coded as needing total assistance with his activities of daily living and was not coded as having behaviors. The resident's care plan information included a notation that the care plan was updated on 9/6/19. On this date a notation was entered which read, "resident has a history of above behaviors." According to the care plan the "above behaviors" were sexually and/or socially inappropriate behavior, refusal of care, refusal of therapy, and cursing at staff. These behaviors had originally been added to the care plan on 5/29/19. The facility also included on the care plan, "Resident receives psychotropic medication for insomnia, depression, neurocognitive disorder with history of TBI (traumatic brain injury) and dementia." Interventions listed on the care plan included that the pharmacist and physician would monitor for the continued need of the psychotropic drugs, and a psychological provider would evaluate and follow as needed and indicated. These interventions had originally been added to the care plan on 5/17/19 and continued to be part of his care plan at the time of the resident's final discharge. Review of Resident # 4's regularly scheduled medications revealed the following medications.	F 757	telephone to alert her of the resident's need and condition. The notification will be documented in the resident's electronic medical record. The licensed nurse will then provide the Social worker with a copy of the physician's order for additional follow up. Director of Nursing (DON) will review psychiatric consults, discharge summaries, and resident orders daily in the Clinical Meeting to verify completion. The Director of Nursing (DON) will complete 5 random audits a week of stat psychiatric consults and resident's orders to verify consults are completed timely X 8 weeks, then monthly X 1. The Director of Nursing (DON) will review audit tools and bring the results of audits to Quality Assurance Committee Meeting Monthly X 3 months.	

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Lithium Carbonate 150 mg (milligrams) three times per day (ordered 6/7/19 to time of final discharge)
Haloperidol 2 mg three times per day (ordered 8/16/19 to time of final discharge)
Zoloft 100 mg once per day (ordered 8/9/19 to time of final discharge)
Trazodone 25 mg once per day ((ordered 8/2/19 to time of final discharge)
Depakote 125 mg give three capsules (375 mg dose) three times per day (ordered 8/9/19 to time of final discharge)

According to notations by the orders, the Lithium was used for neurocognitive disorder, the Depakote was used for a mood disorder, the Haloperidol was used for dementia with behavior disturbance, the Zoloft was used for depression, and the Trazodone was used for insomnia.

On 12/13/19 at 1:59 PM it was validated with the Administrator that there was no documentation the resident's scheduled psychotropic medications were ever held from 8/9/19 to 11/12/19. They had been administered as ordered.

On 12/9/19 at 11:55 AM the resident's family member was interviewed. The family member stated when he visited the resident in the last few months of his residency, the resident was generally sleeping and he had shared with staff he was concerned the resident's sleeping was leading to him not eating.

Nurse Aide (NA) # 3 was interviewed on 12/9/19 at 5:10 PM. NA # 3 reported she routinely cared for the resident on the 3:00 to 11:00 PM shift. She did not know of any behaviors the resident had

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ever displayed while at the facility and had not witnessed any. When she reported to work at 3:00 PM he was generally sleeping but would easily awaken when his name was called. He generally slept the majority of the second shift in the last month of his residency.

Nurse # 1 was interviewed on 12/9/19 at 5:19 PM. The nurse reported she routinely worked with Resident # 4 from 7:00 AM to 7:00 PM. The nurse reported the resident would curse at caregivers if he seemed aggravated with them. The nurse stated other than that she, "wouldn't say he had any behaviors."

NA # 4 was interviewed on 12/10/19 at 11:35 AM. NA # 4 reported the following. She helped take care of Resident # 4 on the 7:00 AM to 3:00 PM shift. The resident needed help to get up, and after lunch she usually laid him down to rest. The resident would curse a great deal, but he was never combative with her. He was anxious and did fidget in his chair a great deal. At times he would get angry and start yelling out loud. This did not happen as much after he was placed on hospice, but it still did happen some. For the last week and one half of his residency, the resident would open his eyes and close them right back. She could not really engage him in conversation for the last week and one half as she normally could.

The Consultant Pharmacist was interviewed on 12/9/19 at 4:00 PM and reported the resident was seen by psychiatric services and she relied on their recommendations regarding continued use of psychotropic medications given his mental illness.

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Interview with the Physician Assistant (PA) on 12/10/19 at 4:00 PM revealed the following. The resident had a history of long-term mental illness, yelling out, agitated behavior, and trying to walk when he was not able to do so. The PA stated she manages residents who do not have a complicated mental illness and who might receive only one or two psychotropic medications. A resident, such as Resident # 4 with a more complicated history and multiple psychotropics such as Lithium and Haldol, would need to be managed by a psychiatric provider. It was her understanding that the Geriatric Neuropsychiatry Nurse Practitioner (NP) was seeing the resident and monitoring the continued necessity of his psychotropic medications, and if the Geriatric Neuropsychiatry NP had stopped doing so, the PA did not know why.

The Hospice Clinical Care Manager was interviewed on 12/11/19 at 12:00 PM and reported the following. She validated the resident had been under their services since 8/30/19 and during that time they did no management of his psychotropic medications. The Case Manager stated they only managed pain for the resident, and his psychotropic medications would have been continued to be assessed and managed by a psychiatric physician or his medical physician.

The Geriatric Neuropsychiatry Nurse Practitioner was interviewed on 12/9/19 at 4:50 PM and reported the following. Resident # 4 had been on her caseload to see prior to his August hospitalization. He needed to be seen every four weeks because he was on Lithium. She was never aware he had returned from the hospital on 8/9/19 and resided in the facility again. She never saw him between the dates of 8/9/19 and his

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discharge on 11/12/19 to evaluate the continued need and effectiveness of his psychotropic medications. The GNP looked in the computer during the interview, and stated her notes showed she asked a nurse on 8/13/19 about the resident when she was at the facility that day and was told the resident was in the hospital. She was never made aware he returned. The Geriatric NP stated if the resident had been sleeping more during the end of his residency, she might have potentially decreased his Depakote dosage. She noted that the last time she had evaluated him he was able to verbalize to her how he felt, and prior drug changes had been based on her speaking to him and evaluating him. She could not say for sure if she would have decreased the Depakote because she had not known he was in the facility and had not evaluated his needs.

During the interview with the Physician Assistant (PA) on 12/10/19 at 4:00 PM the PA stated it was her opinion the resident's decline was a progression of his underlying disease. The resident's frontotemporal dementia predisposed him to multiple other medical problems such as his risk for aspiration, weight loss, and continued cognitive decline, but his psychotropic medications should have continued to be assessed to determine necessity during his decline.