STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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 000	INITIAL COMMENTS An unannounced standard Medicare/Medicaid survey was conducted 6/20/17 through 6/22/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 64 certified bed facility was 59 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #1 through #13) and 3 closed record reviews (Residents #14 through #16).	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 225		8/5/17

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

Electronically Signed | 07/07/2017

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F 225	Continued From page 1	F 225		

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and

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F 225	Continued From page 2 if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to check references for 4 of 5 employees. The findings included: On 6/22/17, review of the facility's employee files was conducted. References were not available for 4 of 5 employees for the review. On 6/22/17 at 10:45 AM, an interview was conducted with the Human Resources Director (other A). He stated, "I call and get the information, but I don't write it down." Review of the facility's abuse policy revised on 3/3/17 revealed the following: "The facility will do the following prior to hiring a new employee: Generally attempt two references from 2 prior employees for an applicant." On 6/22/16 at approximately 11:45 AM, the Administrator was notified of above findings.	F 225	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. 1. References were obtained and/or attempted with results documented for all employees that were found to be deficient and placed in the employee file. 2. All current employee files will be reviewed to ensure documentation of two references were attempted and/or obtained. Those employees found to be deficient will have two references obtained and/or attempted. Results will be documented and placed in the employee file. 3. A list of required information will be utilized for all new hires to ensure all information has been obtained including reference checks. All new hires will have two reference checks obtained and/or attempted with documentation before hiring. All hiring managers will be educated on regulation and protocol. 4. Administrator will review all new hires for documentation of attempt and/or obtaining two reference checks prior to	

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F 225	Continued From page 3	F 225	hire date for three months. Results will be reviewed in monthly QAPI meeting for three months then reviewed for on-going auditing. 5. August 5, 2017	
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The	F 280		8/5/17

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F 280	Continued From page 4 planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 280		

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F 280	Continued From page 5 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 staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed for 1 resident (Resident #7) in the survey sample of 16 residents, to implement her care plan. For Resident #7, the facility staff failed to implement her care plan to prevent an elopement. The Findings included: Resident #7 was an 89 year old who was admitted to the facility on 2/2/16. Resident #7's diagnoses included a History of Falling, Wandering, Cerebrovascular Disease, Generalized Muscle Weakness, Epilepsy, Insomnia, Hypertension, Arteriosclerotic Heart Disease, Pacemaker, Glaucoma, and Anxiety Disorder. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 6/2/17 coded Resident #7 as having a Brief Interview of Mental Status Score of 9, indicating	F 280	1. Care plan was reviewed and revised to ensure that all care plan components were implemented for resident #7. 2. All current residents care plan will be reviewed to ensure implementation of care plan components. 3. The interdisciplinary team will be in-serviced on ensuring care plan interventions are implemented. All current resident care plans will be audited for implementation of care plan components. Clinical staff will be in-serviced on implementation of resident care plan by DON or designee. All doors with Wander Guard system will be assessed for proper functioning weekly. Outside company will assess Wander Guard system for proper functioning and any service needed will be provided.	

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F 280	Continued From page 6 moderately impaired cognition. On 6/20/17 at 4:00 P.M. an observation was made of Resident #7 in the activity room. She was in a regular wheelchair with her legs on footrests. She was responsive to her name being called but was not interviewable. On 6/20/17 a review was conducted of facility documentation, revealing a Facility Reported Incident dated 7/14/16. The report stated Resident #14 was observed by staff to use her walker to walk the hallways on 7/14/16 at 3:45 A.M.. At 4:30 A.M. facility staff was making rounds and recognized that Resident #7 was not in her room, or in the hallway. Resident #7 was found outside of the facility at 5:00 A.M. by a dietary aide Resident #7 was found on her knees, holding on to her walker. She was assessed to have a bruise on top of her left hand, a bruise on her left elbow, and a skin tear measuring 0.1 x 0.3 on her left elbow. Resident #7 communicated that her right ankle was sore. Her ankle was X - rayed negative results. The facility stated that Resident #7's Wander Guard was tested, as well as the Wander Guard System in the facility, and that they were working properly. On 8/7/16, which was over 1 month after Resident #7's elopement, the facility had the Wanderguard serviced by an outside company. The invoice read, "8/17/16. Wander Guard Unit is not working properly, 4 hours labor/travel charge for service." On 6/21/17 at approximately 11:00 A.M. an observation was conducted of a test of the	F 280	4. 10% of current residents care plans will be audited weekly for four weeks then monthly for two additional months to ensure implementation of all interventions by MDS Coordinator. The results of the audit will be taken to the QAPI committee monthly for three months for review and revision as needed. 5. August 5, 2017	

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F 280	Continued From page 7	F 280		

Wanderguard System, which was conducted by the facility Director of Nursing (DON-Administration B). The Wanderguard system was on 4 of the 6 doors in the facility. The 2 doors without the system were locked, and could only be unlocked by pressing a button (which was located about 4 feet up from the floor), and pushing a bar shaped handle on the door simultaneously. The Wanderguard system worked properly on 3 of the 4 remaining doors. The alarm didn't work on the West Wing hall. The DON stated, "It not working. Maybe the staff didn't close the door fully after leaving." She then manipulated the door until it closed fully. The alarm then worked correctly. Resident #7 may have eloped from the West Wing door because it had not been fully closed. Facility staff did not know which door Resident #7 had eloped from.

On 6/22/17 at 11:00 A.M. an interview was conducted in the Conference Room with the DON. When asked about the importance of staff providing adequate supervision, and asked to describe the facility's location on the bank of the Rappahannock River, the DON stated, "Wandering residents we try to keep visual checks on them frequently to know where they are. You don't want them to be trying to get outside. We're close to water. We're beside a road that leads to an apartment building. There's not a fence."

Resident #7 had worn a Wander Guard since 2/3/16, the day after her admission to the facility. Her care plan read, "2/10/16. The resident is an elopement risk/wanderer. Impaired safety awareness. History of attempts to leave facility unattended. Goal: The resident will not leave facility unattended. Interventions: Distract resident

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F 280	Continued From page 8 from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Redirect as needed. Wander device if applicable. Check all doors for proper closure." On 6/22/17 at approximately 11:30 A.M. the facility Administrator (Administration A) was notified of the findings and no further information was received.	F 280		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		8/5/17

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F 323	Continued From page 9 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review and in the course of a complaint investigation, the facility staff failed for 1 resident (Resident #7) in the survey sample of 16 residents, to provide adequate supervision to prevent elopement and injury. For Resident #7, the facility staff failed to prevent an elopement and injury of unknown origin. The Findings included: Resident #7 was an 89 year old who was admitted to the facility on 2/2/16. Resident #7's diagnoses included a History of Falling, Wandering, Cerebrovascular Disease, Generalized Muscle Weakness, Epilepsy, Insomnia, Hypertension, Arteriosclerotic Heart Disease, Pacemaker, Glaucoma, and Anxiety Disorder. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 6/2/17 coded Resident #7 as having a Brief Interview of Mental Status Score of 9, indicating moderately impaired cognition. On 6/20/17 at 4:00 P.M. an observation was made of Resident #7 in the activity room. She was in a regular wheelchair with her legs on footrests. She was responsive to her name being called but was not interviewable.	F 323	1. An Elopement Assessment was completed on resident #7. The Wander Guard bracelet was assessed for placement and proper functioning. The care plan was reviewed and revised for resident #7. 2. All current residents will have an Elopement Assessment completed. Any resident with risk of elopement will have interventions to prevent elopement and the care plan will be reviewed and updated with interventions. 3. All current residents with MD orders to apply Wander Guard bracelets will be checked for placement and proper functioning as well as every shift. All doors with Wander Guard System will be assessed for proper functioning. All current residents will have elopement risk assessment completed on admission, quarterly and with any change of condition. All residents with behaviors and/or triggering for risk of elopement will have interventions for preventing elopement	

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F 323	Continued From page 10 On 6/20/17 a review was conducted of facility documentation, revealing a Facility Reported Incident dated 7/14/16. The report stated the Resident #14 was observed by staff to use her walker to walk the hallways on 7/14/16 at 3:45 A.M.. At 4:30 A.M. facility staff was making rounds and recognized that Resident #7 was not in her room, or in the hallway. Resident #7 was found outside of the facility at 5:00 A.M. by a dietary aide Resident #7 was found on her knees, holding on to her walker. She was assessed to have a bruise on top of her left hand, a bruise on her left elbow, and a skin tear measuring 0.1 x 0.3 on her left elbow. Resident #7 communicated that her right ankle was sore. Her ankle was X - rayed negative results. The facility stated that Resident #7's Wander Guard was tested, as well as the Wander Guard System in the facility, and that they were working properly. On 8/7/16, which was over 1 month after Resident #7's elopement, the facility had the Wanderguard serviced by an outside company. The invoice read, "8/17/16. Wander Guard Unit is not working properly, 4 hours labor/travel charge for service." On 6/21/17 at approximately 11:00 A.M. an observation was conducted of a test of the Wanderguard System, which was conducted by the facility Director of Nursing (DON-Administration B). The Wanderguard system was on 4 of the 6 doors in the facility. The 2 doors without the system were locked, and could only be unlocked by pressing a button (which was located about 4 ft up from the floor), and pushing a bar shaped handle on the door	F 323	implemented. Outside company will assess Wander Guard system for proper functioning and any service needed will be provided. An Elopement drill will be conducted immediately as well as quarterly. Staff will be educated on policy and procedure of elopement prevention and protocol for missing resident. Doors with Wander Guard system will be assessed for proper functioning weekly. All residents that trigger for elopement risk will be reviewed weekly in Resident Review meeting. 4. DON or designee will review the 24 hour report for any residents with behaviors and/or triggering for risk of elopement to ensure interventions for preventing elopement are in place. Administrator and/or designee will review weekly assessment of doors on Wander Guard System for completion weekly for four weeks then twice a month for two additional months. Results will be reviewed in monthly QAPI meeting for three months then reviewed for on-going auditing. 5. August 5, 2017	

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F 323	Continued From page 11	F 323		

simultaneously. The Wanderguard system worked properly on 3 of the 4 remaining doors. The alarm didn't work on the West Wing hall. The DON stated, "It not working. Maybe the staff didn't close the door fully after leaving." She then manipulated the door until it closed fully. The alarm then worked correctly. Resident #7 may have eloped from the West Wing door because it had not been fully closed. Facility staff did not know which door Resident #7 had eloped from.

On 6/22/17 at 11:00 A.M. an interview was conducted in the Conference Room with the DON. When asked about the importance of staff providing adequate supervision, and asked to describe the facility's location on the bank of the Rappahannock River, the DON stated, "Wandering residents we try to keep visual checks on them frequently to know where they are. You don't want them to be trying to get outside. We're close to water. We're beside a road that leads to an apartment building. There's not a fence."

Resident #7 had worn a Wander Guard since 2/3/16, the day after her admission to the facility. Her initial care plan read, "2/10/16. The resident is an elopement risk/wanderer. Impaired safety awareness. History of attempts to leave facility unattended. Goal: The resident will not leave facility unattended. Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Redirect as needed. Wander device if applicable. Revision: Check all doors for proper

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F 323	Continued From page 12 closure." On 6/22/17 at approximately 11:30 A.M. the facility Administrator (Administration A) was notified of the findings. no further information was received.	F 323		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 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-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the	F 329		8/5/17

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	495422	A. BUILDING _____ B. WING _____	C 06/22/2017

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DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 329	Continued From page 13 medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility failed for one resident, Resident #3, in a survey sample of 16 residents, to ensure the resident was free from un- necessary medications. Resident #3 failed to have a GDR (gradual dose reduction) as recommended by pharmacy. The findings included: Resident #3, was admitted to the facility on 6/7/16. Diagnoses included Dementia with Lewy bodies, epilepsy and kidney cancer. Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/11/17 was coded as a quarterly assessment. Resident #3 was coded as having a BIMS (brief interview of mental status) score of "3" out of a possible 15, or severe cognitive impairment. Resident #3 was also coded as requiring assistance of one staff member to perform activities of daily living, such as bed mobility and transfer. The resident is currently on Hospice for end stage dementia.	F 329	1. Provider was notified of pharmacy recommendation, order was obtained and GDR was implemented per MD order for resident #3. 2. All pharmacy recommendations for previous six months will be reviewed to ensure MD notification and implementation of any new orders. 3. Pharmacist and DON will utilize "Pharmacy Tracking Log" monthly to ensure MD has been notified of all GDR's, as well as implementation of orders or denial. All LPN's/RN's, Pharmacist and MD will be educated on process of "Pharmacy Tracking Log" and procedure of unnecessary drugs. Social Worker, DON and Administrator will be provided any GDR recommendations for follow up. 4. 100% of GDR recommendations will be audited for MD notification and implementation of orders or denial	

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F 329	Continued From page 14 On 6/20/17 at 3:40 PM, Resident #3 was observed in her bed with call bell in reach. On 6/21/17 at 8:10 AM, Resident #3 was observed in a low bed, being fed breakfast. The resident had consumed 75 % of her breakfast. On 6/22/17 at 9:50 AM, Resident #3 was observed in the wheelchair in front of the nursing station. She was clean and well groomed. Review of the clinical record revealed the resident is currently on Seroquel 25 mg (milligrams) twice daily for psychosis. Review of the behavior monitoring records revealed no behaviors documented in the last 2 months. Saunders Nursing Drug Handbook, 2001 (page 985) contains the following information on Seroquel: A black box warning for use in the elderly with dementia, "Elderly with dementia related psychosis are at increased risk for death." Further review revealed a pharmacy recommendation dated 2/16/17 which read: "If clinically appropriate, please consider a gradual dose reduction (GDR) to Seroquel 12.5 mg every am, and 25 mg every night." The recommendation was signed by the DON (director of nursing) but had not been signed or acted upon by the physician. It had been faxed on the same date. Review of the care plan dated 5/4/17 read as followed: "At risk for adverse effects related to psychoactive medication use: psychosis." Interventions included: Reduction in medication doses when indicated and pharmacy review per routine." The resident was also care planned for	F 329	monthly for three months by Administrator or designee. Results will be reviewed in monthly QAPI meeting for three months then reviewed for on-going auditing. 5. August 5, 2017	

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F 329	Continued From page 15 the following behaviors: "cursing, sexual comments, throwing food." Interventions included: "Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed." There were no precipitating factors or triggers in the care plan. On 6/21/17 at 3:05 PM, the DON was questioned about the process of the pharmacy recommendations. The DON stated, "The pharmacy sends the recommendations to the DON. The DON gives these out to the different physicians. The physician brings them back to the facility when they come in." On 6/22/17 at 9:00 AM, the MDS coordinator was interviewed. She stated, "She fights care and curses and will swing at staff." She went on to state she was not aware of any triggers for the behaviors. On 6/22/17 at 10:00 AM, CNA (certified nursing assistant) A was interviewed about Resident #3's behaviors. She stated, "she curses a lot. She will hit, but not often." On 6/221/7 at approximately 11:45 AM, the Administrator and DON were notified of above findings.	F 329		
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be	F 428		8/5/17

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F 428	Continued From page 16	F 428		

reviewed at least once a month by a licensed pharmacist.

(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.

(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

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

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F 428	Continued From page 17 (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 observation, staff interview, facility documentation and clinical record review, the facility failed for one resident, Resident #3, in a survey sample of 16 residents, to ensure the the pharmacy recommendation was acted upon. Resident #3 failed to have a GDR (gradual dose reduction) as recommended by pharmacy. The physician did not address the recommendation. The findings included: Resident #3, was admitted to the facility on 6/7/16. Diagnoses included Dementia with Lewy bodies, epilepsy and kidney cancer. Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/11/17 was coded as a quarterly assessment. Resident #3 was coded as having a BIMS (brief interview of mental status) score of "3" out of a possible 15, or severe cognitive impairment. Resident #3 was also coded as requiring assistance of one staff member to perform activities of daily living, such as bed mobility and transfer. The resident is currently on Hospice for end stage dementia. On 6/20/17 at 3:40 PM, Resident #3 was observed in her bed with call bell in reach.	F 428	1. Provider was notified of pharmacy recommendation, order was obtained and GDR was implemented for resident #3. 2. All pharmacy recommendations for previous six months will be reviewed to ensure MD notification and implementation of orders. 3. Pharmacist and DON will utilize "Pharmacy Tracking Log" monthly to ensure MD has been notified of all recommendations as well as implementation of any new orders. All LPN's/RN's, Pharmacist and MD will be educated on process of "Pharmacy Tracking Log" and process of pharmacy recommendations. Social Worker, DON and Administrator will be provided any GDR recommendations for follow up. 4. 100% of GDR recommendations will be audited for MD notification and implementation of orders or denial monthly for three months by Administrator or designee.	

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F 428	Continued From page 18 On 6/21/17 at 8:10 AM, Resident #3 was observed in a low bed, being fed breakfast. The resident had consumed 75 % of her breakfast. On 6/22/17 at 9:50 AM, Resident #3 was observed in the wheelchair in front of the nursing station. She was clean and well groomed. Review of the clinical record revealed the resident is currently on Seroquel 25 mg (milligrams) twice daily for psychosis. Review of the behavior monitoring records revealed no behaviors documented in the last 2 months. Saunders Nursing Drug Handbook, 2001 (page 985) contains the following information on Seroquel: A black box warning for use in the elderly with dementia, "Elderly with dementia related psychosis are at increased risk for death." Further review revealed a pharmacy recommendation dated 2/16/17 which read: "If clinically appropriate, please consider a gradual dose reduction (GDR) to Seroquel 12.5 mg every am, and 25 mg every night." The recommendation was signed by the DON (director of nursing) but had not been signed or acted upon by the physician. It had been faxed on the same date. Review of the care plan dated 5/4/17 read as followed: "At risk for adverse effects related to psychoactive medication use: psychosis." Interventions included: Reduction in medication doses when indicated and pharmacy review per routine." The resident was also care planned for the following behaviors: "cursing, sexual comments, throwing food." Interventions	F 428	10% of all other pharmacy recommendations will be audited for MD notification and implementation of orders or denial monthly for three months by DON or designee. Results will be reviewed in monthly QAPI meeting for three months then reviewed for on-going auditing. 5. August 5, 2017	

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F 428	Continued From page 19	F 428		

included: "Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed." There were no precipitating factors or triggers in the care plan.

On 6/21/17 at 3:05 PM, the DON was questioned about the process of the pharmacy recommendations. The DON stated, "The pharmacy sends the recommendations to the DON. The DON gives these out to the different physicians. The physician brings them back to the facility when they come in."

On 6/22/17 at 9:00 AM, the MDS coordinator was interviewed. She stated, "She fights care and curses and will swing at staff." She went on to state she was not aware of any triggers for the behaviors.

On 6/22/17 at 10:00 AM, CNA (certified nursing assistant) A was interviewed about Resident #3's behaviors. She stated, "she curses a lot. She will hit, but not often."

On 6/221/7 at approximately 11:45 AM, the Administrator and DON were notified of above findings.