STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495421	A. BUILDING _____ B. WING _____	05/04/2017

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F 000	INITIAL COMMENTS	F 000		

An unannounced initial Medicare/Medicaid standard survey was conducted 05/2/17 through 5/4/17. Corrections are required for compliance with the following Federal Long Term Care requirements. The Life Safety Code survey/report has been completed

The census in this 120 bed facility was 103 at the time of the survey. The survey sample consisted of18 current Resident reviews (Residents #1 through #18) and 3 closed records (Resident #19 through #21).

F 278 SS=D — 483.20(g)-(i) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED — F 278

(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

(h) Coordination
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(i) Certification
(1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for Falsification
(1) Under Medicare and Medicaid, an individual who willfully and knowingly-

(i) Certifies a material and false statement in a

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

Administrator — 5/29/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1	F 278		

resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT Is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to maintain a complete and accurate Minimum Data Set (MDS) assessment for 1 or 21 residents in the survey sample (Resident #12).

Resident #12 was admitted to the facility on 11/19/16 with diagnoses including end stage renal disease, generalized muscular weakness, diabetes mellitus type II with complications affecting kidneys, circulation, and eyes, pain, and hypertension. On the most recent MDS assessment with assessment reference date 1/30/17, the resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others.

During clinical record review on 5/3/17, the surveyor noted physician orders dated 4/27 for Quetiapine Fumarate Tablet 50 mg(milligram) by mouth at bedtime for psychosis, and for Clonazepam tablet 0.5 mg by mouth one time a day for @HS (hour of sleep) anxiety and Clonazepam Tablet 0.5 mg by mouth every 12 hours as needed for anxiety. The Quetiapine

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F 278	Continued From page 2 order was a dosage increase from Quetiapine Fumarate 25 mg Give 1 tablet by mouth at bedtime for psychosis dated 11/19/16. The Clonazepam was a new medication. The surveyor was unable to locate documentation of symptoms requiring the medications. There were no orders for behavior monitoring of symptoms or of potential side effects of the medications. Nurse's notes for April and May 2017 did not mention symptom of psychosis or of anxiety. The surveyor was unable to locate physician notes documenting diagnoses of anxiety or psychosis. Psychosis was not listed on the diagnosis list in the clinical record or in the MDS dated 1/30/17. Pharmacy review notes for January, February, March, and April 2017 requested a psychiatric evaluation for necessity of antipsychotic medications. The physician agreed with all four recommendations. The Medication Administration Record (MAR) for April 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 4/29/17 at 0442. The MAR for May 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 5/2/2017 at 0507. The surveyor was unable to locate nursing documentation of the symptoms for which the medication was administered or whether the resident was offered non-pharmacologic interventions. The surveyor discussed concerns with the director of nursing (DON) on 5/4/16. After investigation, the DON reported that the physician was diagnosing psychosis when signing the monthly order summary. The DON obtained a Geriatric Psychiatry Consult Note dated 4/26/17. Under Nursing Report, the physician	F 278	F 278 Accuracy/Coordination/Certified 1. Facility Residents #12 had revisions made to her two MDS assessments to include psychotic diagnosis for use of antipsychotic medication use, in accordance to the Centers for Medicare & Medicaid Services. (October 2016) *Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual,* Section I: Active Diagnosis, page I-2. Revisions made to facility Resident #12's MDS assessments were shared with onsite health inspectors at time of completion prior to exit conference. 5/4/2017 2. All facility residents with antipsychotic medication use have the potential to be affected by this deficient practice. 5/4/2017 3. Facility's MDS nurses were educated on Section I: Active Diagnosis in accordance to the Centers for Medicare & Medicaid Services. (October 2016) *Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual,* Section I: Active Diagnosis. 5/23/2017	

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F 278	Continued From page 3	F 278		

wrote"Depressed. Patient currently on Seroquel with no supporting diagnosis. Anxious with transportation to dialysis". Under the Chief Complaint/reason for visit section, the physician wrote "f/u (followup) for chronic depression. Under the section HPI, the physician wrote "Pt's current TX reviewed. C/O staying bed "depressed', worrying, tired, and Also c/o being unable to sleep at night. States she still experiences auditory hallucinations (including her husband's voices). Trazodone not helping at all. Klonopin worked well previously. Under Medication Changes "1) d/c Trazodone 2)Clonazepam 0.5 mg qhs 3) [change] Zoloft to 150 mg qd (every day) 4) [change] seroquel to 50 mg qhs.

The surveyor was unable to determine when the physician ordered the Clonazepam 0.5 mg every 12 hours as needed for anxiety which the resident received on 4/29/17 and 5/2/17.

The facility policy titled Behavior Monitoring Policy (antipsychotic medications) stated under PROCEDURE: Nursing 6. Evaluation by a mental health professional will be completed for all residents that are: a. Admitted on an antipsychotic mediation used to control behavior 7. "A mental health profession will determine the proper diagnosis for antipsychotic medications. The diagnosis "will be sent to medical records and to the pharmacy."

Concerns were discussed with the administrator and DON during a summary meeting on 5/4/17. The DON stated there was no further information to offer concerning the lack of a psychiatric diagnosis on the MDS.

4. RAI Manager or designee will audit all residents with use of anti-psychotic medication will have the diagnosis for use of medication reflected in the current active diagnosis list in section I of their current MDS assessment. Findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.

5/25/2017

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F 309 SS=E	Continued From page 4 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309 F 309		

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(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 the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:

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F 309	Continued From page 5 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for 5 of 21 residents (Resident #11, Resident #8, Resident #20, Resident #12, and Resident #5). The findings included: 1. The facility staff failed to complete a pain assessment with non-pharmacological interventions for pain for Resident #11. The clinical record of Resident #11 was reviewed 5/2/17 and 5/3/17. Resident #11 was admitted to the facility 11/17/16 with diagnoses that included but not limited to lower limb cellulitis, anemia, morbid obesity, dysthymic disorder, hypertension, cardiomyopathy, ventricular tachycardia, lymphedema, diverticulosis of large intestine, constipation, and long term use of anticoagulants. Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/18/17 assessed the resident with a cognitive summary score of 12 and without evidence of behaviors, delirium or psychosis. Section G Functional Status was reviewed. Resident #11 was assessed to need extensive assistance of two people for bed mobility and transfers and had impairment in both lower extremities. Section J Health Conditions was reviewed for pain management. Resident #11 was assessed to have received scheduled and prn pain medications within the last 5 days of the ARD. Resident #11 was assessed to have not	F 309	F309 Provide Care/Services For Highest Well being #1 1. Facility Resident #11 will be interview to determine non-medication interventions that relieve her pain. Her care plan will be updated to address her preferences and unit staff will be notified of these interventions to attempt prior to medication. 5/25/2017 2. All facility residents have the potential to be affected by this deficient practice. 5/25/2017 3. Facility nursing staff will be educated on Pain Assessment and Management Policy in particular regards to non-medication interventions per the residents preference prior to use of medication as reflected on care plan. 6/9/2017	

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F 309	Continued From page 6 received non-medication interventions for pain during the 5 day look back period. The current comprehensive care plan initiated 12/2/16 and revised 5/2/17 for Resident #11 identified the focus area that read "Resident #11 had acute pain r/t (related to) arthritis, peripheral vascular disease, wounds ...Interventions: Administer analgesia as per orders. Give ½ hour before treatments or care prn, anticipate my need for pain relief and respond immediately to any complaint of pain, monitor/record pain characteristics every shift and prn: quality severity (1 to 10 scale); anatomical location; onset; duration, aggravating factors; relieving factors. Identify, record and treat my existing conditions which may increase pain and or discomfort- arthritis, neuropathies, osteoporosis, peripheral vascular disease, ulcers; I am able to call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increases or alleviates pain, and monitor/record/report to Nurse any s/sx (signs/symptoms) of non-verbal pain." The April 2017 electronic physician orders included an order that read "Oxycodone HCl Tablet 5 mg (milligrams) Give 0.5 mg tablet by mouth every 4 hours as needed for pain" and an order that read "Oxycodone HCl Tablet 5 mg (milligrams) Give 1 tablet by mouth every 4 hours as needed for pain." The April 2017 electronic medication administration records (eMARs) were reviewed. Resident #11 received Oxycodone 2.5 mg prn (as needed) pain medications nine (9) times in April 2017 on 4/14/17, 4/15/17, 4/17/17, 4/18/17 (x2), 4/25/17, 4/26/17, 4/27/17, and 4/29/17. Resident	F 309	4. DON or designee will audit 100% of residents for use of medications for pain management to ensure non-medication interventions were attempted first per the resident's preference weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter. 6/24/2017	

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#11 received Oxycodone 5 mg three times (3) in April 2017 on 4/16/17, 4/17/17, and 4/28/17.

The April 2017 progress notes did not reveal non-pharmacological interventions prior to medication administration on any of the above listed dates in April 2017. The clinical record did not reveal pain assessments were done to include anatomical location; onset; duration, aggravating factors; relieving factors. The only pain assessment documented was the numerical pain scale on the April 2017 eMARS.

The surveyor observed wound care with licensed practical nurse #2 on 5/3/17 beginning at 9:25 a.m. L.P.N. #2 asked Resident #11 about her pain level. The resident stated she needed something for pain. L.P.N. #2 stated she would inform Resident #11's nurse of the complaints of pain so the nurse could give her a pill. There were no non-pharmacological interventions offered during the observation.

The surveyor informed the director of nursing of the above concern on 5/3/17 at 9:20 a.m. and asked what her expectations for pain management included. The DON stated she would expect the staff to offer non-pharmacological interventions prior to giving pain medication and document those interventions.

The surveyor informed the administrator and the director of nursing of the failure of the facility to complete pain assessments and to offer and/or use non pharmacological interventions for resident complaints of pain on 5/3/17 at 2:12 p.m. and again on 5/4/17 at 11:20 a.m. The surveyor requested the facility policy on pain management.

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The surveyor reviewed the facility policy on pain management titled "Pain Assessment and Management" on 5/4/17. The policy read in part "Assessing Pain: 4. During the comprehensive pain assessment gather the following information as indicated from the resident (or legal representative): a. History of pain and its treatment, including pharmacological and non-pharmacological interventions. Implementing Pain Management Strategies: 15. Non-pharmacological interventions may be appropriate alone or In conjunction with medications."

No further information was provided prior to the exit conference on 5/4/17.

2. The facility staff failed to follow physician orders for TED hose for Resident #8.

The clinical record of Resident #8 was reviewed 5/3/17. Resident #8 was admitted to the facility 11/1/16 with diagnoses that included but not limited to chronic pain, dysphagia, cognitive communication deficit, hypothyroidism, dysthymic disorder, insomnia, sensorlneural hearing loss, atherosclerotic heart disease, angina pectoris, non-rheumatic aortic stenosis, gastroesophageal reflux disease, constipation, osteoarthritis, urinary tract infections, and long term use of aspirin.

Resident #8's current comprehensive care plan initiated 11/17/16 read "Resident #8 was admitted from our sister facility for LTC (long term care). Resident #8 is alert and oriented and can make her needs known. Interventions: TED (thromboembolic disease) hose as tolerated. C.N.A. (certified nursing assistant) to wash in sink

F309

#2

1. Facility Resident #8's TED Hose were applied by facility staff. 5/4/2017

2. All facility residents with orders for TED Hose have the potential to be affected by this deficient practice.

5/4/2017

3. Facility nursing staff will be educated on following practitioner orders and notification to practitioner if resident chooses not to accept order.

6/9/2017

4. DON or designee will audit 100% of residents for application of TED hose weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter. 6/24/2017

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every noc (night)."

The May 2017 physician orders were reviewed. The physician order read "TED hose as resident allows. On in am (morning), off at hs (bedtime). Rinse & dry at hs and perform skin check for skin integrity one time a day Place on in AM" and "TED hose as resident allows. On in am (morning), off at hs (bedtime). Rinse & dry at hs and perform skin check for skin integrity one time a day Take off in PM".

The surveyor observed Resident #8 on 5/3/17 at 11:05 a.m. The resident was sitting in her wheelchair in her room. The surveyor observed white socks on both feet and asked the resident if she had her elastic stockings (TED hose) on under the socks. Resident #8 stated no one had helped her put those socks on for over a month. Resident #8 rolled the wheelchair into the bathroom and got a clean pair of TED hose from the bottom drawer of the vanity. C.N.A. #1was asked about the TED hose. C.N.A. #1 stated this was the first day she was assigned to Resident #8 and she was not aware of the TED hose. Resident #8 stated she couldn't put them on by herself.

The surveyor interviewed Resident #8's nurse for 5/3/17 and 5/4/17 licensed practical nurse #3 on 5/4/17 at 9:00 a.m. L.P.N. #3 stated she had been informed about the TED hose not placed on Resident #8. She was asked who was responsible for making sure they were on the resident. L.P.N. #3 stated the nurse was responsible for making sure they were on and she also stated between the nurses and the aides, she made sure they were on Resident #8.

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The surveyor informed the administrator and the director of nursing of the above concern on 5/3/17 at 2:12 p.m. and again on 5/4/17 at 11:20 a.m.

No further information was provided prior to the exit conference on 5/4/17.

3. The facility staff failed to follow physician orders for daily weights for Resident #20.

The clinical record of Resident #20 was reviewed 5/3/17 and 5/4/17. Resident #20 was admitted to the facility 1/18/17 with diagnoses that included but not limited to chronic diastolic heart failure, displaced intertrochanteric fracture of right femur, fall from chair, methicillin resistant staphylococcus aureus (MRSA), type 2 diabetes mellitus, obesity, major depressive disorder, hypertensive heart and chronic kidney disease with heart failure, stage 4 chronic kidney disease, chronic obstructive pulmonary disease, atrial fibrillation, atherosclerotic heart disease, aortocoronary bypass graft, and dependence on oxygen.

Resident #20's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/25/17 assessed the resident with a cognitive summary score of 10 out of 15. Resident #20 was without any signs of delirium, psychosis, or behaviors directed toward others. Resident #20 required extensive assistance of 2 people for bed mobility, transfers and toileting, and extensive assistance of one person for personal hygiene.

Resident #20's current comprehensive care plan created 1/26/17 identified a focus area for weight concerns. Interventions: weights as ordered.

#3

1. Facility Resident #20 discharged from facility on 3/27/2017.
5/4/2017
2. All facility residents with orders for daily weights with parameters have the potential to be affected by this deficient practice.
5/4/2017
3. Facility nursing staff will be educated on following practitioner orders, 5 Rights to a medication administration, and notification to practitioner if resident chooses not to follow order.
6/9/2017
4. DON or designee will audit 100% of residents for daily weights and notification to practitioner per parameters weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.
6/24/2017

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Monitor changes and notify MD/RD (medical doctor/registered dietician) as needed.

The January 2017 physician orders had an order that read "Daily weights one time a day start date 1/19/17 End date 2/8/17."

The surveyor reviewed the weights and vitals summary sheet and the January 2017 eMARs. There were no recorded weights for 4 days in January 2017-1/19/17, 1/21/17, 1/24/17, and 1/26/17.

The initial order for daily weights was changed on 2/8/17 to this order that read "Daily weights Notify MD for weight gain > (greater than) 3 pounds in 24 hours or > 5 pounds in 1 week 150.23 Acute on chronic systolic (congestive) heart failure one time a day. Start date 2/9/17."

The February 2017 eMAR was reviewed. There was an "x" in the 2/12/17 box and then a "5" in the box with the nurse's initials. The legend at the bottom of the eMAR read "5=Hold/See nurses Notes". There was no progress note or physician order for 2/12/17.

The weight on 2/14/17 was documented as 232 pounds. On 2/15/17, the weight was documented as 239.2 pounds. Resident #11 had a 7.2 weight gain in 24 hours. Based on the physician order, the nurse should have informed the physician of the weight difference. The clinical record did not contain a progress note for 2/15/17.

The weight obtained on 2/16/17 was documented as 130.1 pounds- a difference of 109.1 pounds from the previous day (2/15/17).

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There was no recorded weight for 2/17/17 on the February 2017 eMAR or the weights and vitals summary.

The weights recorded on the eMAR for 2/18/17 and 2/19/17 were 130.1 pounds.

There was no recorded weight on the February 2017 eMAR or weight and vitals summary for 2/20/17, 2/24/17 and 2/26/17.

There were no recorded weights for 3/15/17, 3/24/17 and 3/26/17 on the March 2017 eMAR or the weights and vitals summary.

The surveyor informed the director of nursing of the missing weights on 5/4/17 at 9:00 a.m. The director of nursing stated the weights were usually obtained early in the mornings by the nurses or certified nursing assistants but did not specify any particular shift responsible for obtaining weights. The director of nursing stated she had nothing else for the surveyor.

The surveyor informed the administrator and the director of nursing of the failure to follow the physician orders for Resident #20's weights on 5/4/17 at 11:20 a.m.

No further weights were provided prior to the exit conference on 5/4/17.

4. For Resident #12, facility staff failed to obtain a psychiatric consult as ordered by the physician in January, February, and March 2017, and in compliance with facility policy, when the resident was admitted to the facility with orders for antipsychotic medication.

Resident #12 was admitted to the facility on

#4

1. Facility Resident #12 was seen by psychiatrist on 4/26/2017, which was provide to onsite health inspectors prior to exit conference. 5/4/2017
2. All facility residents with an order for a psychiatrist evaluation have the potential to be affected by this deficient practice. 5/4/2017

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F 309	Continued From page 13 11/19/16 with diagnoses including end stage renal disease, generalized muscular weakness, diabetes mellitus type II with complications affecting kidneys, circulation, and eyes, pain, and hypertension. On the most recent MDS assessment with assessment reference date 1/30/17, the resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others. During clinical record review on 5/3/17, the surveyor noted physician orders dated 4/27 for Quetiapine Fumarate Tablet 50 mg(milligram) by mouth at bedtime for psychosis, and for Clonazepam tablet 0.5 mg by mouth one time a day for @HS (hour of sleep) anxiety and Clonazepam Tablet 0.5 mg by mouth every 12 hours as needed for anxiety. The Quetiapine order was a dosage increase from Quetiapine Fumarate 25 mg Give 1 tablet by mouth at bedtime for psychosis dated 11/19/16. The Clonazepam was a new medication. The surveyor was unable to locate documentation of symptoms requiring the medications. There were no orders for behavior monitoring of symptoms or of potential side effects of the medications. Nurse's notes for April and May 2017 did not mention symptom of psychosis or of anxiety. The surveyor was unable to locate physician notes documenting diagnoses of anxiety or psychosis. Psychosis was not listed on the diagnosis list in the clinical record or in the MDS dated 1/30/17. Pharmacy review notes for January, February, March, and April 2017 requested a psychiatric evaluation for necessity of antipsychotic medications. The physician agreed with all four recommendations.	F 309	3. Facility nursing staff will be educated on following practitioner orders. Facility has contracted for additional psychiatric in house visits. 6/9/2017 4. DON or designee will audit 100% of residents with orders for psychiatric evaluation and that the resident is seen timely, weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter. 6/24/2017	

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The Medication Administration Record (MAR) for April 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 4/29/17 at 0442. The MAR for May 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 5/2/2017 at 0507. The surveyor was unable to locate nursing documentation of the symptoms for which the medication was administered or whether the resident was offered non-pharmacologic interventions.

The surveyor discussed concerns with the director of nursing (DON) on 5/4/16. After investigation, the DON reported that the physician was diagnosing psychosis when signing the monthly order summary. The DON obtained a Geriatric Psychiatry Consult Note dated 4/26/17. Under Nursing Report, the physician wrote"Depressed. Patient currently on Seroquel with no supporting diagnosis. Anxious with transportation to dialysis". Under the Chief Complaint/reason for visit section, the physician wrote "f/u (followup) for chronic depression. Under the section HPI, the physician wrote "Pt's current TX reviewed. C/O staying bed "depressed', worrying, tired, and Also c/o being unable to sleep at night. States she still experiences auditory hallucinations (including her husband's voices). Trazodone not helping at all. Klonopin worked well previously. Under Medication Changes "1) d/c Trazodone 2)Clonazepam 0.5 mg qhs 3) [change] Zoloft to 150 mg qd (every day) 4) [change] seroquel to 50 mg qhs.

The surveyor was unable to determine when the physician ordered the Clonazepam 0.5 mg every 12 hours as needed for anxiety which the resident

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F 309	Continued From page 15 received on 4/29/17 and 5/2/17. The facility policy titled Behavior Monitoring Policy (antipsychotic medications) stated under PROCEDURE: Nursing 6. Evaluation by a mental health professional will be completed for all residents that are: a. Admitted on an antipsychotic mediation used to control behavior 7. "A mental health profession will determine the proper diagnosis for antipsychotic medications. The diagnosis "will be sent to medical records and to the pharmacy." Concerns were discussed with the administrator and DON during a summary meeting on 5/4/17. The DON stated there was no further information to offer concerning the delay in obtaining a psychiatric evaluation as ordered by the physician. 5. For Resident #5, facility staff failed to follow physician ordered parameters for administering antihypertensive medications. Resident #5 was admitted to the facility on 8/13/16 with diagnoses including hypertension, anxiety, and pathological fracture of right femur. On the quarterly minimum data set assessment with assessment reference date 2/20/17, the resident scored 14/15 on the brief interview for mental status and was assessed as without signs of delirium, behavior, or psychosis. During clinical record review on 5/3/17, the surveyor noted a physician order dated 9/21/16 for clonidine 0.1 mg (milligram) Give 1 tablet every 8 hours as needed for antihypertensive Give 1 tab PO Q 8 hrs if SBP>170 (systolic blood pressure greater than).	F 309 F309 #5	1. Facility Resident #5 order for blood pressure parameters were reviewed for clarification to ensure compliance of the practitioner order. 5/17/2017 2. All facility residents with an order for blood pressure medication with parameters have the potential to be affected by this deficient practice. 5/17/2017 3. Facility nursing staff will be educated on following practitioner orders. 6/9/2017 4. DON or designee will audit 100% of residents with orders for blood pressure medication with parameters to ensure compliance, weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter. 6/24/2017	

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The Medication administration record (MAR) for April 2017 documented 5 dates when the systolic blood pressure was greater than 170 and clonidine was not administered. On 4/27/17 at 6 AM, SBP was 180, at 10 PM on 4/9/17 SBP= 180; 4/14/17, SBP=179; 4/18/17, SBP=180; 4/29/17, SBP=213. Neither nursing notes or MAR indicated the medication had been administered.

The administrator and director of nursing (DON) were notified of the concern during a summary meeting on 5/4/17.

F 319 SS=D 483.40(b)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES — F 319

483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that-

(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to obtain a psychiatric assessment recommended by the pharmacist and ordered by the physician for 1of 21 residents in the survey sample (Resident #12).

Resident #12 was admitted to the facility on 11/19/16 with diagnoses including end stage renal

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disease, generalized muscular weakness, diabetes mellitus type II with complications affecting kidneys, circulation, and eyes, pain, and hypertension. On the most recent MDS assessment with assessment reference date1/30/17, the resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others.

During clinical record review on 5/3/17, the surveyor noted physician orders dated 4/27 for Quetiapine Fumarate Tablet 50 mg(milligram) by mouth at bedtime for psychosis, and for Clonazepam tablet 0.5 mg by mouth one time a day for @HS (hour of sleep) anxiety and Clonazepam Tablet 0.5 mg by mouth every 12 hours as needed for anxiety. The Quetiapine order was a dosage increase from Quetiapine Fumarate 25 mg Give 1 tablet by mouth at bedtime for psychosis dated 11/19/16. The Clonazepam was a new medication.

The surveyor was unable to locate documentation of symptoms requiring the medications. There were no orders for behavior monitoring of symptoms or of potential side effects of the medications. Nurse's notes for April and May 2017 did not mention symptom of psychosis or of anxiety. The surveyor was unable to locate physician notes documenting diagnoses of anxiety or psychosis. Psychosis was not listed on the diagnosis list in the clinical record or in the MDS dated 1/30/17. Pharmacy review notes for January, February, March, and April 2017 requested a psychiatric evaluation for necessity of antipsychotic medications. The physician agreed with all four recommendations.

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F 319	Continued From page 18 The Medication Administration Record (MAR) for April 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 4/29/17 at 0442. The MAR for May 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 5/2/2017 at 0507. The surveyor was unable to locate nursing documentation of the symptoms for which the medication was administered or whether the resident was offered non-pharmacologic interventions. The surveyor discussed concerns with the director of nursing (DON) on 5/4/16. After investigation, the DON reported that the physician was diagnosing psychosis when signing the monthly order summary. The DON obtained a Geriatric Psychiatry Consult Note dated 4/26/17. Under Nursing Report, the physician wrote"Depressed. Patient currently on Seroquel with no supporting diagnosis. Anxious with transportation to dialysis". Under the Chief Complaint/reason for visit section, the physician wrote "f/u (followup) for chronic depression. Under the section HPI, the physician wrote "Pt's current TX reviewed. C/O staying bed "depressed', worrying, tired, and Also c/o being unable to sleep at night. States she still experiences auditory hallucinations (including her husband's voices). Trazodone not helping at all. Klonopin worked well previously. Under Medication Changes "1) d/c Trazodone 2)Clonazepam 0.5 mg qhs 3) [change] Zoloft to 150 mg qd (every day) 4) [change] seroquel to 50 mg qhs. The surveyor was unable to determine when the physician ordered the Clonazepam 0.5 mg every 12 hours as needed for anxiety which the resident received on 4/29/17 and 5/2/17.	F 319	F319 Mental/Psychosocial Difficulties 1. Facility Resident #12 was seen by psychiatrist on 4/26/2017, which was provide to onsite health inspectors prior to exit conference. 5/4/2017 2. All facility residents with an order for a psychiatrist evaluation have the potential to be affected by this deficient practice. 5/4/2017 3. Facility nursing staff will be educated on following practitioner orders. Facility has contracted for additional psychiatric in house visits. 6/9/2017 4. DON or designee will audit 100% of residents with order for psychiatric evaluation to ensure the resident is seen timely, weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter. 6/24/2017	

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The facility policy titled Behavior Monitoring Policy (antipsychotic medications) stated under PROCEDURE: Nursing 6. Evaluation by a mental health professional will be completed for all residents that are: a. Admitted on an antipsychotic mediation used to control behavior 7. "A mental health profession will determine the proper diagnosis for antipsychotic medications. The diagnosis "will be sent to medical records and to the pharmacy."

Concerns were discussed with the administrator and DON during a summary meeting on 5/4/17. The DON stated there was no further information to offer concerning delay of the psychiatric assessment.

F 328 SS=D 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS — F 328

(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:

(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and

(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments

(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with

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professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, staff interview and facility document review, it was

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determined that the facility staff failed to maintain suction equipment in a clean and sanitary manner for 1 of 21 in the sample survey, Resident # 3.

The Findings Included:

For Resident #3 the facility staff failed to maintain suction machine equipment in a clean and sanitary manner. The facility staff also failed to ensure that a physician's order was contained in the clinical record to suction Resident #3.

Resident #3 was an 84 year old female who was admitted on 12/02/16. Admitting diagnoses included, but were not limited to: diaphragmatic hernia with gangrene, dysphagia, cognitive communication deficit, acute renal failure, major depression, breast cancer, hypothyroidism, cataracts and glaucoma.

The most current Minimum Data Set (MDS) located in the clinical record was a 14 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 3/19/17. The facility staff coded that Resident #3 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #3 required extensive assistance (3/3) with Activities of Daily Living (ADL's).

On May 2, 2017 at 3 p.m. the surveyor observed Resident #3 lying in bed. Resident #3 had a suction machine at the side of the bed with 700cc's of frothy yellowish- white secretions in the suction canister.
On May 2, 2017 at 3:05 p.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced signed physician orders dated 4/19/17. Signed physician orders

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did not include a physician's order for the facility staff to suction Resident #3.

Continued review of the clinical record produced the Comprehensive Care Plan (CCP) that identified the following "Focus" and "Interventions." "Focus (name of Resident #3 withheld) had altered respiratory stalus/Dyspnea r/t (related to) history of respiratory failure, heart failure, allergies." "Interventions ... Maintain a clear airway by encouraging me to clear own secretions with effective coughing. If secretions cannot be cleared, suclion as ordered/requlred to clear secretions." (sic)

On May 3, 2017 at 8:25 a.m. lhe surveyor observed Resident #3 lying in bed. Resident #3 had a suction machine at the side of the bed with 700cc's of frolhy yellowish-white secretions in lhe suction canister.

On May 3, 2017 at 10:25 a.m. the surveyor observed Resident #3 lying in bed. Resident #3 had a suction machine al the side of the bed with 700 cc's of frothy yellowish-white secretions in the suclion canister.

On May 3, 2017 at 2:05 p.m. the surveyor observed Resident #3's room once again. Resident #3 had a suction machine at the side of the bed with 700 cc's of frothy yellowish-white secretions in the suction canister.

On May 3, 2017 at 2:15 p.m. the surveyor notified the Adminlstrator (Adm) and Direclor of Nursing (DON) that Resident #3 had had a dirty suction machine/canister at the side of her bed since 5/2/17 at 3 p.m. The surveyor notified the Administrative Team (AT) that the suction canister

F328 Treatment/Care For Special Needs

1. Facility Resident #3's orders were obtained to reflect the need for suctioning on 5/3/2017 and suctioning equipment was cleaned per policy. 5/4/2017
2. All facility residents with suctioning needs have the potential to be affected by this deficient practice. 5/4/2017
3. Facility nursing staff will be educated on Oropharyngeal Suctioning policy and procedure, which includes cleaning or disposing of equipment. 6/9/2017
4. DON or designee will audit 100% of residents with suction needs for order and equipment care weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.

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F 328	Continued From page 23 contained 700 cc's of frothy yellowish- white secretions since 5/2/17 at 3 p.m. The surveyor requested a copy of the facility policy and procedure for maintaining suction equipment. The surveyor also notified the AT that review of the clinical record failed to produce a physician's order to suction Resident #3. On May 4, 2017 at 7:50 a.m. the surveyor observed Resident #3 lying in bed. The surveyor also observed the suction canister at the side of the bed with 700 cc's of frothy yellow-whitish secretions. On May 4, 2017 at 8:15 a.m. the DON hand delivered a policy and procedure titled, "Respiratory. Oxygen Administration and Oropharyngeal Suctioning." The policy and procedure read in part ... "Oropharyngeal Suctioning The purpose of this procedure is to clear the upper airway of mucous secretions and prevent the development of respiratory distress. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or the facility protocol for suctioning. ... Equipment ... 46. Empty and rinse the collection container if necessary or as indicated by facility protocol ...." No additional information was provided prior to exiting the facility as to why the facility staff failed to maintain suction equipment in a clean and sanitary manner for Resident #3. Furthermore the facility staff did not provide any additional information as to why they failed to obtain a physician's order prior to suctioning Resident #3.	F 328		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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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 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:

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Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure that 8 of 21 Residents in the sample survey were free from unnecessary medications, Resident #2, Resident #3, Resident #8, Resident #11, Resident #1, Resident #12, Resident #13, Resident #4 and Resident #13.

The Findings included:

1. For Resident #2 the facility staff failed to monitor for psychotropic drug use, Seroquel, and failed to monitor for antidepressant drug use, Celexa, to include monitoring for specific behaviors, side effects, interventions and effectiveness

Resident #2 was an 84 year old female who was admitted on 12/6/16. Admitting diagnoses included, but were not limited to: pulmonary emboli, cognitive communication deficit, hypothyroidism, diabetes mellitus, major depression, atrial fibrillation and breast cancer.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 4/5/17. The facility staff coded that Resident #2 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #2 required set up (1/1) to extensive assistance (3/2) with Activities of Daily Living (ADL's).

On May 2, 2017 at 2:40 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced signed physician orders. Signed physician orders included, but were not limited to "CeleXA Tablet 10 MG

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(Citalopram Hydrobromide) Give 1 tablet by mouth one time a day for depression Celexa 10mg by mouth every day for depression. SEROquel Tablet 25MG (QUEtiapine Fumarate) 0.5 tablet by mouth one time a day for Psychosis Seroquel 12.5 mg (and Seroquel 25mg to total 37.5 mg) by mouth every day at QHS (bedtime). SEROquel Tablet 25 MG (QUEtiapine Fumarate) Give 1 tablet by mouth one time a day for Psychosis Take Seroquel 25mg and Seroquel 12.5mg for total dose of 37.5mg QHS." (sic)

Continued review of the clinical record produced the April and May 2017 Medication Administration Records (MAR's). Review of the April and May 2017 MAR's documented that Resident #2 was receiving Seroquel 37.5 mg at bedtime and Celexa 10 mg every morning.

Further review of the clinical record failed to produce medication/behavior monitoring for specific behaviors, interventions, side effects and effectiveness of the Seroquel and Celexa.

On May 2, 2017 at 3:45 p.m. the surveyor notified the Director of Nursing (DON) that Resident #2 was receiving Seroquel 37.5 mg every night at bedtime and Celexa 10 mg every morning. The surveyor notified the DON that medication/behavior monitoring for the use of the Seroquel and Celexa could not be located in the clinical record. The surveyor and DON reviewed Resident #2's clinical record. The surveyor pointed out the specific physician orders for the Seroquel and Celexa. The surveyor also reviewed the April and May 2017 MAR's with the DON. The DON reviewed the clinical record and was unable to locate any medication/behavior monitoring for the use of the Seroquel and

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Celexa.

On May 3, 2017 at 2:15 p.m. the surveyor notified the Administrator (Adm) and DON that Resident #2 was receiving a psychotropic medication, Seroquel, and an antidepressant, Celexa. The surveyor notified the Administrative Team (AT) that review of the clinical record failed to produce monitoring for the use of the psychotropic and antidepressant drug use to include specific behaviors, interventions, side effects and effectiveness.

No additional information was provided prior to exiting the facility as to why the facility staff failed to monitor for Seroquel and Celexa drug use for Resident #2.

2. For Resident #3 the facility staff failed to monitor for antidepressant drug use, Lexapro, to include monitoring for specific behaviors, side effects, interventions and effectiveness

Resident #3 was an 84 year old female who was admitted on 12/02/16. Admitting diagnoses included, but were not limited to: diaphragmatic hernia with gangrene, dysphagia, cognitive communication deficit, acute renal failure, major depression, breast cancer, hypothyroidism, cataracts and glaucoma.

The most current Minimum Data Set (MDS) located in the clinical record was a 14 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 3/19/17. The facility staff coded that Resident #3 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #3 required extensive assistance (3/3) with Activities of Daily Living

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(ADL's).

On May 2, 2017 at 3:05 p.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced signed physician orders. Signed physician orders included, but were not limited to "Lexapro Tablet 10 MG (Escitalopram Oxalate) Give 1 tablet by mouth one time a day for depression." (sic)

Continued review of the clinical record produced the April and May 2017 Medication Administration Records (MAR's). Review of the April and May 2017 MAR's documented that Resident #3 was receiving Lexapro 10 mg every morning.

Further review of the clinical record failed to produce medication/behavior monitoring for specific behaviors, interventions, side effects and effectiveness of the Lexapro.

On May 3, 2017 at 10:55 a.m. the surveyor notified the Director of Nursing (DON) that Resident #3 was receiving Lexapro 10 mg every morning. The surveyor notified the DON that medication/behavior monitoring for the use of the Lexapro could not be located in the clinical record. The surveyor and DON reviewed Resident #3's clinical record. The surveyor pointed out the specific physician orders for the Lexapro. The surveyor also reviewed the April and May 2017 MAR's with the DON. The DON reviewed the clinical record and was unable to locate any medication/behavior monitoring for the use of the Lexapro.

On May 3, 2017 at 2:15 p.m. the surveyor notified the Administrator (Adm) and DON that the Resident #3 was receiving an antidepressant,

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Lexapro. The surveyor notified the Administrative Team (AT) that review of the clinical record failed to produce monitoring for the use of the antidepressant drug use to include specific behaviors, interventions, side effects and effectiveness.

No additional information was provided prior to exiting the facility as to why the facility staff failed to monitor for Lexapro drug use for Resident #3. 3. The facility staff failed to ensure Resident #8 was free of unnecessary medications. The facility staff failed to monitor the use of Xanax (an antianxiety medication) and Zoloft (a medication used for depression) for effects and side effects.

The clinical record of Resident #8 was reviewed 5/3/17. Resident #8 was admitted to the facility 11/1/16 with diagnoses that included but not limited to chronic pain, dysphagia, cognitive communication deficit, hypothyroidism, dysthymic disorder, insomnia, sensorineural hearing loss, atherosclerotic heart disease, angina pectoris, non-rheumatic aortic stenosis, gastroesophageal reflux disease, constipation, osteoarthritis, urinary tract infections, and long term use of aspirin.

Resident #8's current comprehensive care plan initiated 11/17/16 read "I have a diagnosis of depression and anxiety. I am medicated with an antidepressant and antianxiety medication. I am at risk for SOB (shortness of breath), isolation, and mood swings. I also have insomnia. I am at risk for being sleepy, lethargic during the day. Interventions: Monitor for s/s (signs/symptoms) of depression-decreased appetite, changes in sleeping pattern, mood swings, anxiety, unexplained crying and isolation; monitor for side effects of antipsychotic medication-somnolence,

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insomnia, orthostatic hypotension, tachycardia, peripheral edema, amblyopia, constipation, thirst, increased sallvation, UTI (urinary tract infection), joint pain, sweating, leukopenia, weight gain, increased cough, flu like syndrome and back pain; monitor side effects of antidepressant-somnolence, insomnia, anxiety, tachycardia, N/V (nausea/vomiting), behavior changes, abdominal pain, changes in weight, increased sweating; monitor symptoms from antianxiety medication-drowsiness, sedation, amnesia, insomnia, agitation, dizziness, weakness, depression, and headache. Pharmacist/MD (medical doctor) to provide a GDR (gradual dose reduction) as needed."

The surveyor reviewed the April 2017 electronic medication administration records (eMARs). There were entries for Xanax Give 0.25 mg (milligrams) by mouth every 24 hours as needed for anxiety and Zoloft 25 mg give q1 tablet by mouth one time a day for depression.

Resident #8 had not received any prn Xanax during the month of April 2017. Resident #8 had received Zoloft 25 mg every day during April 2017; however, both the April 2017 progress notes and the April eMARs had no evidence of the monitoring of the antidepressant's effects or side effects.

The surveyor interviewed the unit manager licensed practical nurse #1 on 5/3/17 at 1:30 p.m. The unit manager stated the staff monitored medications monthly and completed a TBOS (targeted behavior observation sheet) when specific behaviors occurred.

The surveyor informed the administrator and the

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director of nursing of the lack of monitoring of psychotropic medication during the end of the day meeting on 5/3/17 at 2:12 p.m. and again on 5/4/17 at 11:20 a.m.

No further information was provided prior to the exit conference on 5/4/17.

4. The facility staff failed to ensure Resident #11 was free of unnecessary medications. The facility staff failed to monitor the use of the physician ordered mediations Celexa hydrobromide (an antidepressant) and Quetiapine fumarate [Quetiapine (Seroquel) belongs to a class of medications called atypical antipsychotics].

The clinical record of Resident #11 was reviewed 5/2/17 and 5/3/17. Resident #11 was admitted to the facility 11/17/16 with diagnoses that included but not limited to lower limb cellulitis, anemia, morbid obesity, dysthymic disorder, hypertension, cardiomyopathy, ventricular tachycardia, lymphedema, diverticulosis of large intestine, constipation, and long term use of anticoagulants.

Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/18/17 assessed the resident with a cognitive summary score of 12 and without evidence of behaviors, delirium or psychosis.

Resident #11's current comprehensive care plan initiated 12/2/16 had a focus area for the use of psychotropic medications r/t (related to) anxiety disorder, depression. Interventions: Monitor for non-pharmacological methods of relieving anxiety: changing temperature, 1:1 time with staff, food, check for incontinence, slow breathing, psych consult per order, administer

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medications as ordered. Monitor/document side effects and effectiveness.

Resident #11's April 2017 physician orders read Celexa 20 mg one time a day for depression and Buspar 7.5 mg twice a day for anxiety. These medications were discontinued upon Resident #11's admission to the acute care hospital on 4/4/17 but were documented to be administered daily in April 2017 from 4/1/17 through 4/4/17. Readmission physician orders read "Celexa 20 mg one time a day for depression and Quetiapine Fumarate 25 mg tablet at bedtime for general anxiety disorder/depression." Both of these medications had been entered on the April 2017 and May 2017 electronic medication administration records (eMARs) and nursing staff have documented that the resident received them as ordered from 4/12/17 through 5/2/17. However, the surveyor was unable to locate the monitoring of the Celexa and Buspar prior to hospitalization and the current order for Celexa and Seroquel. The surveyor reviewed the April 2017 and May 2017 progress notes and found no evidence that the use of Celexa, Buspar and Seroquel had been monitored for effects and side effects.

The surveyor interviewed the unit manager licensed practical nurse #1 on 5/3/17 at 1:30 p.m. The unit manager stated the staff monitored medications monthly and completed a TBOS (targeted behavior observation sheet) when specific behaviors occurred. The unit manager licensed practical nurse #1 stated the only one completed was from 5/2/17.

The surveyor informed the administrator and the director of nursing of the above issue during the

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end of the day meeting on 5/3/17 at 2:12 p.m. and again on 5/4/17 at 11:20 a.m.

No further information was provided prior to the exit conference on 5/4/17.

5. For Resident #1, facility staff failed to document indication and effectiveness for administering a PRN(as needed) antipsychotic medication.

Resident #1 was admitted to the facility on 11/22/16 with diagnoses including generalized weakness, cognitive communication deficit, coronary artery disease, anxiety, cardiopulmonary disease, vascular dementia, and peripheral vascular disease. On the quarterly Minimum Data Set assessment with assessment reference date 3/1/17, the resident scored 10/15 on the brief interview for mental status. The resident was assessed as without signs of delirium. The resident was scored as having hallucinations, behaviors, and delusions.

Clinical record review revealed no nurse's notes in April or May 2017 documented behaviors indicating hallucinations, delusions, or behaviors affecting others. The resident's orders did not include monitoring of antipsychotic side effects or symptoms of psychosis.

The Targeted Behavior Observation Summary(TBOS) dated 4/15/17 documented physical behavior occurred daily, but did not document the behaviors that occurred, or whether they placed the resident or others at or risk or could be easily directed. Verbal behavior symptom, yelling out, was documented daily, but was not documented as placing the resident or others at risk, or whether it was easily redirected.

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The section for Socially Disruptive behaviors was blank. The section for Refusal of care, shower, was marked "None exhibited". The section for Wandering was blank. The section for Psychosis was blank for whether the resident exhibited any listed behaviors, other behaviors, whether behaviors affected the resident, and whether the behavior affected other. How often those behaviors were exhibited was marked 1-3 days. Interventions listed "sometimes a sandwich and TV program will redirect resident. The sections Medication Review/Side effects, Evaluation, Review of plan of care/ Recommendations, and Additional Comments sections were blank. The TBOS dated 4/11/17 documented daily occurrence of Physical Behavior Symptoms, Verbal Behavior Symptoms, Socially Inappropriate/Disruptive Behavior, Refusal of Care, Psychosis. No descriptions of any of those symptoms were documented. The sections Medication Review/Side effects, Evaluation, Review of plan of care/ Recommendations, and Additional Comments sections were blank.

The surveyor reported to the administrator and director of nursing the concern that indications supporting the use of antipsychotic medications were not documented during a summary meeting on 5/4/17.

6. For Resident #12, facility staff failed to initiate behavior monitoring and medication side effect monitoring for a resident on antipsychotic and anxiolytic medications.

Resident #12 was admitted to the facility on 11/19/16 with diagnoses including end stage renal disease, generalized muscular weakness, diabetes mellitus type II with complications

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affecting kidneys, circulation, and eyes, pain, and hypertension. On the most recent MDS assessment with assessment reference date1/30/17, the resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others.

During clinical record review on 5/3/17, the surveyor noted physician orders dated 4/27 for Quetiapine Fumarate Tablet 50 mg(milligram) by mouth at bedtime for psychosis, and for Clonazepam tablet 0.5 mg by mouth one time a day for @HS (hour of steep) anxiety and Clonazepam Tablet 0.5 mg by mouth every 12 hours as needed for anxiety. The Quetiapine order was a dosage increase from Quetiapine Fumarate 25 mg Give 1 tablet by mouth at bedtime for psychosis dated 11/19/16. The Clonazepam was a new medication.

The surveyor was unable to locate documentation of symptoms requiring the medications. There were no orders for behavior monitoring of symptoms or of potential side effects of the medications. Nurse's notes for April and May 2017 did not mention symptom of psychosis or of anxiety. The surveyor was unable to locate physician notes documenting diagnoses of anxiety or psychosis. Psychosis was not listed on the diagnosis list in the clinical record or in the MDS dated 1/30/17. Pharmacy review notes for January, February, March, and April 2017 requested a psychiatric evaluation for necessity of antipsychotic medications. The physician agreed with all four recommendations.

The Medication Administration Record (MAR) for April 2017 documented the resident received

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Clonazepam 0.5 mg for anxiety on 4/29/17 at 0442. The MAR for May 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 5/2/2017 at 0507. The surveyor was unable to locate nursing documentation of the symptoms for which the medication was administered or whether the resident was offered non-pharmacologic interventions.

The surveyor discussed concerns with the director of nursing (DON) on 5/4/16. After investigation, the DON reported that the physician was diagnosing psychosis when signing the monthly order summary. The DON obtained a Geriatric Psychiatry Consult Note dated 4/26/17. Under Nursing Report, the physician wrote"Depressed. Patient currently on Seroquel with no supporting diagnosis. Anxious with transportation to dialysis". Under the Chief Complaint/reason for visit section, the physician wrote "f/u (followup) for chronic depression. Under the section HPI, the physician wrote "Pt's current TX reviewed. C/O staying bed "depressed', worrying, tired, and Also c/o being unable to sleep at night. States she still experiences auditory hallucinations (including her husband's voices). Trazodone not helping at all. Klonopin worked well previously. Under Medication Changes "1) d/c Trazodone 2)Clonazepam 0.5 mg qhs 3) [change] Zoloft to 150 mg qd (every day) 4) [change] seroquel to 50 mg qhs.

The surveyor was unable to determine when the physician ordered the Clonazepam 0.5 mg every 12 hours as needed for anxiety which the resident received on 4/29/17 and 5/2/17.

The facility policy titled Behavior Monitoring Policy

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(antipsychotic medications) stated under PROCEDURE: Nursing 7. Evaluation by a mental health professional will be completed for all residents that are: a. Admitted on an antipsychotic mediation used to control behavior 7. "A mental health profession will determine the proper diagnosis for antipsychotic medications. The diagnosis "will be sent to medical records and to the pharmacy."

Concerns were discussed with the administrator and DON during a summary meeting on 5/4/17. The DON stated there was no further information to offer concerning the lack of routine monitoring or lack of knowledge of symptoms for which the medications were administered.
7. The facility staff failed to provide non-pharmacological interventions for anxiety for Resident #4. Resident #4 was administered Lorazepam PRN (as needed) without any indication of the attempt to use non-pharmacological interventions prior to the administration. The facility staff failed to provide, evidence of monitoring when the anxiolytic was administered.

The clinical record of Resident #4 was reviewed 5/03/17 through 5/04/17. Resident #4 was admitted to the facility on 5/24/16 with diagnoses that included but not limited to: high blood pressure, stroke, osteoporosis, anxiety, asthma, dysphagia and heart failure.

A review of Resident #4's clinical record revealed on the quarterly minimum data set (MDS) with an assessment reference date of 3/3/17. Section C (cognitive patterns) of this assessment scored the resident 14 out of a possible 15 indicating the resident was cognitively intact. Section B coded

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the resident to understand and to be understood. In section N she was coded to have received antianxiety medication.

Resident #4's comprehensive care plan with a review date of 3/10/17 included anxiety as a focus issue. However, the surveyor did not see any non-pharmacologlcal interventions for anxiety listed as an intervention on lhe care plan.

The April and May 2017 physician order sheet read in part: "Lorazepam tablet 0.5 mg give 1 tablet by mouth as needed for anxiety tid (three times a day) PRN as needed" the start date for the order was 7/23/16.

The April and May 2017 medication administration records were reviewed. Resident #4 was administered the PRN Lorazepam in April as follows: 4/2/17, 4/6/17, 4/8/17, 4/9/17, 4/15/17, 4/19/17, 4/23/17, 4/24/17 4/26/17, 4/27/17, and 4/29/17. The PRN Lorazepam was administered also on 5/1/17.

The progress notes for April and May did not have any documentation related to the administration of the Lorazepam. There were no non-pharmacological interventions prior to the administration of the Lorazepam documented.

The surveyor informed the administrative staff of the above finding on 5/4/17 at 11:20 a.m.

On 5/4/17 at 11:20 a.m., the administration staff was informed of the failure to monitor and document behaviors and the non-pharmacologlcal interventions for anxiety.

No further information was provided to the

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surveyor prior to exit.
8. The facility staff failed to monitor specific behaviors, side effects , and effectiveness of the antipsychotic medication, Seroquel , for Resident #13.

Resident#13 was admitted to the facility on 10/27/16 with diagnoses of Parkinson's disease, psychosis, depression, hypertension, insomnia, and gastro-esophageal reflux disease.

The current quarterly Minimum Data Set (MDS) with a reference date of 2/3/17 assessed the resident with a cognitive score of "10" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers, dressing, toileting, bathing, and hygiene.

The clinical record was reviewed. The physciain ordered the resident to receive the antipsychotic medication, Seroquel 25 mg daily dated 11/8/16. The resident was given a new diagnosis of psychosis on 4/27/17.

The comprehensive care plan was reviewed. The plan contained a problem listed the resident was medicated with a antipsychotic and antidepressant medication with a new diagnosis of psychosis dated 4/27/17. The interventions included to monitor for signs/symptoms of depression- decreased appetite, changes in sleep pattern, mood swings, anxiety, unexplained crying and isolation.

The clinical record did not contain any documentation of behavior monitoring, effectiveness of the medication, or side effects.

F 329 Drug Regimen is from unnecessary drugs

1. Facility Resident's #2, #3, #8, #11, #1, #12, #13, #3, and #13 had monthly review of psychotropic medication completed with target behavior observation assessment. 5/25/2017
2. All facility residents receiving Psychotropic medications have the potential to be affected by this deficient practice. 5/25/2017
3. Facility nursing staff will be educated on Behavior Monitoring Policy, including documentation requirements when prn medications are provided. 6/9/2017
4. DON or designee will audit 100% of residents on psychotic medications for behavior monitoring program weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter. 6/24/2017

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F 329	Continued From page 40 The adminstrator and director of nursing were informed of the concern during a meeting with the survey team on 5/4/17 at 11:00 a.m.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to label and date food items when opened and failed to obtain and record tray line temperatures. The findings included:	F 371		

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The surveyor toured the kitchen on 5/2/17 beginning at 1:00 p.m. with the dietary manager other #1. The surveyor observed a bag of croissants (approximately 25- 30) in the walk in refrigerator. The bag had been opened; however, the bag was not labeled as to the contents or dated when opened. The dietary manager stated the staff must have taken a sleeve from the opened box of croissants. Also observed in the walk-in refrigerator were three covered Styrofoam cups. The dietary manager stated the cups contained homemade milkshakes. The cups were not labeled as to their contents or dated when made.

The surveyor observed in the reach-in refrigerator a Styrofoam container that contained coleslaw. The container was black in color, unlabeled and undated. The dietary manager stated the container must have been brought in from the outside. The dietary manager removed the container from the reach-in refrigerator.

The surveyor returned to the kitchen on 5/2/17 at 4:15 p.m. for tray line temperatures. After observing the tray line temperatures for cooked foods, the surveyor requested to check the temperatures of cold items served. The dietary manager checked the temperature of a carton of milk (40 degrees), a bowl of applesauce, a bowl of mandarin oranges and a cup of yogurt. The applesauce temperature was 46 degrees, the mandarin oranges temperature was taken multiple times with the dietary manager stating the mandarin oranges were "airy" and a good temperature was unable to be taken, and the temperature of the yogurt was 44 degrees. None of the cold food temperatures were 41 degrees or

F371 – Food Procure, Store/Prepare/Serve – Sanitary

1. Facility food storage was reviewed to make sure items were appropriately labelled and dated. 5/3/17
2. All facility residents that consumed the unlabeled items had a potential to be affected by this deficient practice. 5/3/17
3. Dining staff was educated on temperature logs and checking for dates for food storage. 5/3/17
4. Dining Service Director, RD, or Designee will audit temperature logs and food storage, weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.

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colder. The surveyor asked the dietary manager what the process was when food item temperatures did not reach the minimum temperature for serving. The dietary manager stated the cold items would be put back in and chilled and temperatures retaken.

The surveyor and the dietary manager reviewed the temperature logs for April 2017 and May 2017. The surveyor noted on the April and May 2017 temperature logs that there were no recorded cold food temperatures. The 4/1/17 dinner tray line temperatures were reviewed. The cook had recorded temperatures for chicken and dumplings and green beans. The alternatives for Saturdays are cheeseburgers and French fries. There were no recorded temperatures for the alternates. There were no recorded temperatures for milk, fruit or any dessert. The 4/6/17 dinner temperature log had one recorded temperature for peppers. There were no recorded cold food item temperatures. The food items on the menu for 4/6/17 included yeast roll, lemon meringue pie, whole milk and beverage of choice. The 4/11/17 lunch tray line temperatures had no temperatures recorded for either cold or hot food items. The only temperature recorded was from the alternate list and that was coleslaw. The 4/14/17 lunch tray line temperatures had no documented temperatures. The 4/18/17 lunch tray line temperatures had no temperatures recorded for either cold or hot food items. The 4/28/17 lunch food log did not have any recorded temperatures for hot or cold foods. The only recorded temperatures were the alternates. The 5/1/17 lunch tray line temperatures had no documented tray line temperatures. The 5/2/17 dinner meal had no documented cold temperatures. Milk was on the menu. The 5/2/17

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lunch tray line temperatures had no documented tray line temperatures.

The dietary manager stated the cooks are to obtain the tray line temperatures and record the temperatures in the food log. The dietary manager stated by taking the temperatures that was how the cooks determine if the foods are hot enough or cold enough to serve. The dietary manager stated he would expect temperatures to be obtained of cold food items as well.

The surveyor informed the administrator and the director of nursing of the above concern on 5/3/17 at 2:12 p.m. and again on 5/4/17 at 11:20 a.m. and requested the job description for the cook and the facility policy on storing, labeling, and dating food items and on obtaining food temperatures.

The surveyor reviewed the facility policy titled "Scope of Dietary Services" on 5/3/17. The policy read in part "Food Preparation 2) Prepared and perishable food shall be maintained at a proper/safe temperature until served. Cold items shall be kept with an internal temperature of 41 degrees and below. Hot food to be kept at a temperature of 135 degrees and above. Any food items that are within the temperature danger zone of 42 degrees to 134 degrees would need to be discarded. 5) All Food Items shall be dated with an opening date and a use by date."

The surveyor also received the facility policy from the registered dietician on 5/4/17 at 8:00 a.m. titled "Thermometer Use & Safe Food Temperatures". The policy read in part "2) The temperature of all TTS foods (foods that require time and temperature control for safety) will be

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F 371	Continued From page 44 checked and recorded prior to the start of each meal service. The holding temperature of all hot foods during meal service will be maintained at > (greater than) 135 degrees F (Fahrenheit). The holding temperature of cold foods during meal service will be < (less than) 41 degrees F. The cook is responsible for recording the temperatures on the temp logs." The surveyor interviewed the registered dietician other #2 on 5/4/17 at 8:05 a.m. The RD stated she would expect temperatures to be obtained on cold food items especially milk before served to the residents. No further information was provided prior to the exit conference on 5/4/17.	F 371		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure physician ordered medications were available for use for 1 of 21 residents (Resident	F 425		

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#8).

The findings included:

The facility staff failed to ensure Natural Balance Tears solution was available for administration to Resident #8 on 4/23/17.

The clinical record of Resident #8 was reviewed 5/3/17. Resident #8 was admitted to the facility 11/1/16 with diagnoses that included but not limited to chronic pain, dysphagia, cognitive communication deficit, hypothyroidism, dysthymic disorder, insomnia, sensorineural hearing loss, atherosclerotic heart disease, angina pectoris, non-rheumatic aortic stenosis, gastroesophageal reflux disease, constipation, osteoarthritis, urinary tract infections, and long term use of aspirin.

Resident #8's current comprehensive care plan initiated 11/17/16 read "Resident #8 was admitted from our sister facility for LTC (long term care). Resident #8 is alert and oriented and can make her needs known. Interventions: Administer natural tears as ordered."

The clinical record of Resident #8 was reviewed 5/3/17. Resident #8 had physician orders that read "Natural Balance Tears Solution (Artificial Tear Solution) Instill 1 drop in both eyes at bedtime for dry eyes QHS (every bedtime)" and "Natural Balance Tears Solution (Artificial Tear Solution) Instill 1 drop in both eyes three times a day for dry eyes 9a, 1p, 5p."

The April 2017 progress notes were reviewed. The progress notes for 4/23/17 at 13:21 (1:21 p.m.), 19:41 (7:41 p.m.) and 19:42 (7:42 p.m.) read "Natural Balance Tears Solution Instill 1 drop

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F 425	Continued From page 46 in both eyes three times a day for dry eyes 9a, 1p, 5 p Medication unavailable; on order from pharmacy" and "Natural Balance Tears Solution Instill 1 drop in both eyes at bedtime for dry eyes QHS Medication unavailable; on order from pharmacy". The surveyor and the unit manager licensed practical nurse #2 reviewed the April 2017 eMAR on 5/3/17 at 1:30 p.m. The entry for Natural Balance Tears for three times a day was reviewed. The box for 4/23/17 at bedtime had the number "5" and the nurse's initials. The legend at the bottom read "5=Hold/See Nurses Notes". The entry for Natural Balance Tears at bedtime was reviewed. The box for 4/23/17 at mid-day (1pm) and evening (5pm) had the number "5" and the nurse's initials. The legend at the bottom read "5=Hold/See Nurses Notes". The unit manager L.P.N. #1 stated medications are delivered from the main pharmacy Monday through Friday around noon and again from a carrier between 8:30 p.m. and 9:00 p.m. L.P.N. #1 stated the medication was not here to be given. The surveyor informed the director of nursing on 5/4/17 at 8:28 a.m. of the above concern that Resident #8's eye drops were not available for three administration times on 4/23/17. The surveyor asked the DON the process for obtaining medications on the weekend. The DON stated the nursing staff call the on-call pharmacist for the facility then go by those prompts. Walgreens is the back-up pharmacy. The surveyor informed the administrator and the director of nursing of the above concern on 5/4/17	F 425	F425 Pharmaceutical CSVC- Accurate Procedures 1. Facility Resident #8 received Natural tears as ordered. 4/24/2017 2. All facility residents have the potential for this deficient practice. 5/4/2017 3. Facility nursing staff will be educated on Pharmacy policy for after hour's medication assistance, including pharmacy on call schedule. 6/9/2017 4. DON or designee will audit 100% of residents weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter. 6/24/2017	

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F 425	Continued From page 47 at 11:20 and requested the facility policy on obtaining medications. No further information was provided prior to the exit conference on 5/4/17.	F 425		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be 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	F 428		

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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.

(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 staff interview and clinical record review it was determined that the facility staff failed to follow up on a pharmacy recommendation for 2 of 21 Residents in the sample survey, Resident #2 and Resident #12.

The Findings Included:

Resident #2 was an 84 year old female who was admitted on 12/6/16. Admitting diagnoses included, but were not limited to: pulmonary emboli, cognitive communication deficit, hypothyroidism, diabetes mellitus, major depression, atrial fibrillation and breast cancer.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 4/5/17. The facility staff

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F 428	Continued From page 49 coded that Resident #2 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #2 required set up (1/1) to extensive assistance (3/2) with Activities of Daily Living (ADL's). On May 2, 2017 at 2:40 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced a pharmacy recommendation dated 4/18/17. The pharmacy recommendation requested for Resident #2's Seroquel 37.5 mg at bedtime to be decreased to Seroquel 25 mg at bedtime. The physician documented ... "I agree: Please write order(s)" (sic) The physician signed and dated the pharmacy recommendation on 4/26/17. Continued review of the clinical record produced the April and May 2017 Medication Administration Records (MAR's). Review of the April and May 2017 MAR's documented that Resident #2 was still receiving Seroquel 37.5 mg at bedtime and not the pharmacy recommended and physician ordered Seroquel 25 mg at bedtime. On May 2, 2017 at 3:55 p.m. the surveyor notified the Director of Nursing (DON) that Resident #2 had a pharmacy recommendation dated 4/18/17 that recommended for the Seroquel 37.5 mg at bedtime to be decreased to Seroquel 25 mg at bedtime. The surveyor notified the DON that the physician approved and signed off for the Seroquel to be reduced to 25 mg at bedtime on 4/26/17. The surveyor notified the DON that Resident #2 was still receiving Seroquel 37.5 mg at bedtime. The surveyor and DON reviewed Resident #2's clinical record. The DON verified that Resident #2 had a pharmacy recommendation on 4/18/17 to decrease the	F 428	F 428 Drug Regimen Review, Report Irregular #1 1. Facility Resident #2 received practitioner orders to follow pharmacy recommendations for gradual dose reduction and copy provided to onsite health inspectors exiting the facility. 5/2/2017 2. All facility residents have the potential to be affected by this deficient practice. 5/4/2017 3. Facility nursing staff will be educated on pharmacy recommendations having to be noted by the nurse prior to filing and night shift nurses will review charts for any new orders every night 6/9/2017 4. DON or designee will audit 100% of residents weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter. 6/24/2017	

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F 428	Continued From page 50 Seroquel to 25 mg at bedtime. The DON also verified that the physician had approved the pharmacy recommendation on 4/26/17. Lastly, the DON verified that the April and May 2017 MAR's documented that Resident #2 was still receiving Seroquel 37.5 mg at bedtime. On May 3, 2017 at 2:15 p.m. the surveyor notified the Administrator (Adm) and DON that the facility staff failed to follow up on a pharmacy recommendation. The surveyor notified the Administrative Team (AT) that the pharmacy recommended that Resident #2's Seroquel 37.5 mg at bedtime be decreased to 25 mg at bedtime on 4/18/17. The surveyor notified the AT that the physician approved and signed off on the pharmacy recommendation on 4/26/17. The surveyor notified the AT that Resident #2 was still receiving Seroquel at 37.5 mg at bedtime. No additional information was provided prior to exiting the facility as to why the facility staff failed to follow up on a pharmacy recommendation for Resident #2. 2. For Resident #12, facility staff failed to follow pharmacy recommendations for psychotropic medications after the physician agreed to the recommendations. Resident #12 was admitted to the facility on 11/19/16 with diagnoses including end stage renal disease, generalized muscular weakness, diabetes mellitus type II with complications affecting kidneys, circulation, and eyes, pain, and hypertension. On the most recent MDS assessment with assessment reference date 1/30/17, the resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or	F 428 #2	1. Facility Resident #12 was seen by psychiatrist on 4/26/2017, which was provided to onsite health inspectors prior to exit conference. 5/4/2017 2. All facility residents with an order for a psychiatrist evaluation have the potential to be affected by this deficient practice. 5/4/2017 3. Facility nursing staff will be educated on following practitioner orders. Facility has contracted for additional psychiatric in house visits. 6/9/2017 4. DON or designee will audit 100% of residents with order for psychiatric evaluation to ensure the resident is seen timely, weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter. 6/24/2017	

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behaviors affecting others.

During clinical record review on 5/3/17, the surveyor noted physician orders dated 4/27 for Quetiapine Fumarate Tablet 50 mg(milligram) by mouth at bedtime for psychosis, and for Clonazepam tablet 0.5 mg by mouth one time a day for @HS (hour of sleep) anxiety and Clonazepam Tablet 0.5 mg by mouth every 12 hours as needed for anxiety. The Quetiapine order was a dosage increase from Quetiapine Fumarate 25 mg Give 1 tablet by mouth at bedtime for psychosis dated 11/19/16. The Clonazepam was a new medication.

The surveyor was unable to locate documentation of symptoms requiring the medications. There were no orders for behavior monitoring of symptoms or of potential side effects of the medications. Nurse's notes for April and May 2017 did not mention symptom of psychosis or of anxiety. The surveyor was unable to locate physician notes documenting diagnoses of anxiety or psychosis. Psychosis was not listed on the diagnosis list in the clinical record or in the MDS dated 1/30/17. Pharmacy review notes for January, February, March, and April 2017 requested a psychiatric evaluation for necessity of antipsychotic medications. The physician agreed with all four recommendations.

The Medication Administration Record (MAR) for April 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 4/29/17 at 0442. The MAR for May 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 5/2/2017 at 0507. The surveyor was unable to locate nursing documentation of the symptoms for which the medication was administered or

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whether the resident was offered non-pharmacologic interventions.

The surveyor discussed concerns with the director of nursing (DON) on 5/4/16. After investigation, the DON reported that the physician was diagnosing psychosis when signing the monthly order summary. The DON obtained a Geriatric Psychiatry Consult Note dated 4/26/17. Under Nursing Report, the physician wrote"Depressed. Patient currently on Seroquel with no supporting diagnosis. Anxious with transportation to dialysis". Under the Chief Complaint/reason for visit section, the physician wrote "f/u (followup) for chronic depression. Under the section HPI, the physician wrote "Pt's current TX reviewed. C/O staying bed "depressed', worrying, tired, and Also c/o being unable to sleep at night. States she still experiences auditory hallucinations (including her husband's voices). Trazodone not helping at all. Klonopin worked well previously. Under Medication Changes "1) d/c Trazodone 2)Clonazepam 0.5 mg qhs 3) [change] Zoloft to 150 mg qd (every day) 4) [change] seroquel to 50 mg qhs.

The surveyor was unable to determine when the physician ordered the Clonazepam 0.5 mg every 12 hours as needed for anxiety which the resident received on 4/29/17 and 5/2/17.

The facility policy titled Behavior Monitoring Policy (antipsychotic medications) stated under PROCEDURE: Nursing 6. Evaluation by a mental health professional will be completed for all residents that are: a. Admitted on an antipsychotic mediation used to control behavior 7. "A mental health profession will determine the

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F 428	Continued From page 53 proper diagnosis for antipsychotic medications. The diagnosis "will be sent to medical records and to the pharmacy." Concerns were discussed with the administrator and DON during a summary meeting on 5/4/17. The DON stated there was no further information to offer concerning the lack of a psychiatric evaluation after the physician agreed with the recommendations in January, February, and March 2017.	F 428		
F 502 SS=D	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: 2. The facility staff failed to obtain physician ordered laboratory test CMP (comprehensive metabolic panel) for Resident #4. Resident #4 was admitted to the facility on 5/24/16 with diagnoses that included but not limited to: high blood pressure, stroke, osteoporosis, anxiety, asthma, dysphagia and heart failure. A review of Resident #4's clinical record revealed on the most recent significant change minimum data set (MDS) with an assessment reference date of 3/3/17, the facility staff assessed the resident to understand and to be understood. She was assessed to have a cognitive summary score of 15.	F 502		

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On 5/3/17, a review of Resident #4's clinical record revealed that the physician had given an order on for a CMP. The original order date of 7/23/16 read as follows: Rouline CMP Q (every) 6 months Jan/July one time a day every 6 months starting on the 26th 1 day for CVA/HTN."

A review of the laboratory reports in Resident #4's clinical record revealed no results for the laboratory test.

On 5/3/17, approximately 3:00pm, the director of nurses (DON) was asked to assist with locating the missing lab test. She said she would check the chart.

On 5/4/17, during a meeting with the administrator, and director of nurses, the DON told the surveyor at 11:20 the lab was not done.

Prior to exit on 5/4/17 at 12:00 noon, no further information related to the laboratory test was provided.

Based on clinical record review and staff interview, it was determined that the facility staff failed to obtain physician ordered labs for 2 of 21 Residents in the sample survey, Resident #3 and Resident #4.

The Findings Included:

1. For Resident #3 the facility staff failed to obtain physician ordered PT/INR's on 4/24/17, 3/31/17 and 3/13/17. Furthermore the facility staff failed to obtain a physician ordered T3, T4 and TSH on 4/6/17.

Resident #3 was an 84 year old female who was

F 502 Administration/Lab

1. Facility residents #4 & #3 had labs reviewed and additional lab orders obtained per practitioner if indicated. 5/4/2017
2. All facility residents have the potential to be affected by this deficit practice. 5/4/2017
3. Facility nursing staff will be educated on laboratory process and confirmation of practitioner orders. 6/9/2017
4. DON or designee will audit 100% of residents weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter. 6/24/2017

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admitted on 12/02/16. Admitting diagnoses included, but were not limited to: diaphragmatic hernia with gangrene, dysphagia, cognitive communication deficit, acute renal failure, major depression, breast cancer, hypothyroidism, cataracts and glaucoma.

The most current Minimum Data Set (MDS) located in the clinical record was a 14 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 3/19/17. The facility staff coded that Resident #3 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #3 required extensive assistance (3/3) with Activities of Daily Living (ADL's).

On May 2, 2017 at 3:05 p.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced a physician's order for Coumadin 4 mg by mouth daily. Continued review of the clinical record produced physician orders to obtain a PT/INR on 4/24/17, 3/31/17 and 3/13/17. The clinical record also produced a physician order to obtain a T3, T4 and TSH on 4/6/17.

Continued review of the clinical record failed to produce the results for the physician ordered PT/INR's for 4/24/17, 3/31/17 and 3/13/17. Furthermore the results for the physician ordered T3, T4 and TSH to be obtained on 4/6/17 were not contained in the clinical record.

On May 3, 2017 at 10:55 a.m. the surveyor notified the Director of Nursing (DON) that Resident #3 had physician orders to obtain PT/INR's on 4/24/17, 3/31/17 and 3/13/17. The surveyor also notified the DON that the physician

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ordered for a T3, T4 and TSH to be drawn on 4/6/17. The surveyor notified the DON that review of the clinical record failed to produce the results of the physician ordered PT/INR's for 4/24/17, 3/31/17 and 3/13/17 and failed to produce the results of the physician ordered T3, T$ and TSH on 4/6/17. The surveyor reviewed the clinical record with the DON. The DON was unable to locate the results for the physician ordered labs.

On May 3, 2017 at 2:15 p.m. the surveyor notified the Administrator (Adm) and DON that the facility staff failed to obtain physician ordered labs on Resident #3. The surveyor notified the Administrative Team (AT) that the facility staff were supposed to obtain PT/INR's on 4/24/17, 3/31/17 and 3/13/17. The surveyor notifled the AT that the facility staff were also supposed to obtain a T3, T$ and TSH on 4/6/17. The surveyor notified the AT that the results of the physician ordered labs could not be located in the clinical record.

No additional information was provided prior to exiting the facility as to why the facility staff failed to obtain physician ordered labs on Resident #3.

F 504 SS=D 483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN — F 504

(a) Laboratory Services

(2) The facility must-

(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.

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This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, it was determined that the facility staff failed to obtain a physician order prior to obtain labs for 2 of 21 Residents in the sample survey, Resident #3 and Resident #11.

The Findings Included:

1. For Resident #3 the facility staff failed to obtain a physician order prior to obtaining a PT/INR on 3/30/17.

Resident #3 was an 84 year old female who was admitted on 12/02/16. Admitting diagnoses included, but were not limited to: diaphragmatic hernia with gangrene, dysphagia, cognitive communication deficit, acute renal failure, major depression, breast cancer, hypothyroidism, cataracts and glaucoma.

The most current Minimum Data Set (MDS) located in the clinical record was a 14 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 3/19/17. The facility staff coded that Resident #3 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #3 required extensive assistance (3/3) with Activities of Daily Living (ADL's).

On May 2, 2017 at 3:05 p.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced the results of a PT/INR obtained on 3/30/17.

Continued review of the clinical record failed to produce a physician's order to obtain the PT/INR

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On May 3, 2017 at 10:55 a.m. the surveyor notified the Director of Nursing (DON) that Resident #3 had the results of a PT/INR obtained on 3/30/17 in the clinical record. The surveyor notified the DON that review of the clinical record failed to produce a physician's order to obtain the PT/INR on 3/30/17. The surveyor and DON reviewed Resident #3's clinical record. The surveyor specifically pointed out the results of the PT/INR obtained on 3/30/17. The DON reviewed the clinical record and was unable to locate a physician's order to obtain the PT/INR on 3/30/17.

On May 3, 2017 at 2:15 p.m. the surveyor notified the Administrator (Adm) and DON that the facility staff had obtained a PT/INR on 3/30/17 without a physician's order.

No additional information was provided prior to exiting the facility as to why the facility staff obtained a PT/INR on 3/30/17 without a physician's order.
2. The facility staff failed to obtain a physician order prior to obtaining laboratory tests for Resident #11. The facility staff obtained a basic metabolic panel (BMP), a urinalysis (UA) and culture and sensitivity (C&S) on 3/31/17 without a physician order.

The clinical record of Resident #11 was reviewed 5/2/17 and 5/3/17. Resident #11 was admitted to the facility 11/17/16 with diagnoses that included but not limited to lower limb cellulitis, anemia, morbid obesity, dysthymic disorder, hypertension, cardiomyopathy, ventricular tachycardia, lymphedema, diverticulosis of large intestine, constipation, and long term use of anticoagulants.

F504 Lab SVCS only when ordered by physician

1. Facility residents #3 & #11 had labs reviewed and additional orders obtained per practitioner as prescribed.

5/4/2017

2. All facility residents have the potential to be affected by this deficit practice. 5/4/2017

3. Facility nursing staff will be educated on laboratory process and confirmation of practitioner orders.

6/9/2017

4. DON or designee will audit 100% of residents weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.

6/24/2017

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Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/18/17 assessed the resident with a cognitive summary score of 12 and without evidence of behaviors, delirium or psychosis.

The laboratory section of the clinical record revealed results of a urinalysis (UA), a urine culture and sensitivity (C&S) and a basic metabolic panel (BMP) all obtained on 3/31/17. The surveyor reviewed both the computer generated physician orders and the handwritten physician orders but was unable to locate the physician orders for the tests. The surveyor reviewed the physician visit notes. The clinical record contained a physician note dated 3/24/17; however, the note had no documentation about the order for the laboratory tests.

The surveyor requested the assistance of the unit manager licensed practical nurse #1 on 5/3/17 at 10:45 a.m. After reviewing the clinical record, the unit manager L.P.N. #1 stated she was unable to locate an order for the urinalysis, the culture and sensitivity or the BMP all obtained 3/31/17.

The surveyor informed the administrator and the director of nursing of the above concern on 5/3/17 at 2:12 p.m. and again on 5/4/17 at 11:20 a.m.

No further information was provided prior to the exit conference on 5/4/17.

F 514 SS=D 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

(i) Medical records.

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NAME. OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY. STATE, ZIP COOE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGI JLATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
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(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vl) Laboratory, radiology and other diagnostic services reports as required under §483.50.
Thls REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facillty staff failed to document indications for administration of PRN medications for 2 of 21 resident s in the survey sample (Resldents #5, 12).

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495421	A. BUILOING _____ B. WING _____	05/04/2017

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1. For Resident #5, facility staff failed to follow physician ordered parameters for administering antihypertensive medications.

Resident #5 was admitted to the facility on 8/13/16 with diagnoses including hypertension, anxiety, and pathological fracture of right femur. On the quarterly minimum data set assessment with assessment reference date 2/20/17, the resident scored 14/15 on the brief interview for mental status and was assessed as without signs of delirium, behavior, or psychosis.

During clinical record review on 5/3/17, the surveyor noted a physician order dated 9/21/16 for clonidine 0.1 mg (milligram) Give 1 tablet every 8 hours as needed for antihypertensive Give 1 tab PO Q 8 hrs if SBP>170 (systolic blood pressure greater than).

The Medication administration record (MAR) for April 2017 documented 2 dates when the systolic blood pressure was not greater than 170 and clonidine was administered. On 4/6/17 at 14:00, the documented blood pressure was 158/70. At 16:40, administration of the medication was documented. On 4/7/17 at 06:00, the documented blood pressure was 146/66. At 07:30, administration of the medication was documented.

The concern was reported to the director of nursing on 5/3/17. On 5/4/17, the director of nursing offered a copy of a eMAR Medication Administration Note indicating that on 4/7/17 at 07:31 the resident's blood pressure was 200/90. The director of nursing also offered a hand-written blood pressure for 4:39 on 4/6/17 of 199/65. The surveyor was unable to confirm the

F 514 Records
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#1

1. Facility Resident #5 order for blood pressure parameters were reviewed for clarification for compliance of practitioner order. 5/17/2017
2. All facility residents with an order for blood pressure medication with parameters have the potential to be affected by this deficient practice.

5/17/2017

3. Facility nursing staff will be educated on following practitioner orders. 6/9/2017
4. DON or designee will audit 100% of residents with orders for blood pressure medication with parameters for compliance, weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.

6/24/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 62 blood pressure in the clinical record. The administrator and director of nursing (DON) were notified of the concern during a summary meeting on 5/4/17. 2. For Resident #12, facility staff failed to document indication and effectiveness for administration or PRN (as needed) Clonazepam. Resident #12 was admitted to the facility on 11/19/16 with diagnoses including end stage renal disease, generalized muscular weakness, diabetes mellitus type II with complications affecting kidneys, circulation, and eyes, pain, and hypertension. On the most recent MDS assessment with assessment reference date 1/30/17, the resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others. During clinical record review on 5/3/17, the surveyor noted physician orders dated 4/27 for Clonazepam tablet 0.5 mg by mouth one time a day for @HS (hour of sleep) anxiety and Clonazepam Tablet 0.5 mg by mouth every 12 hours as needed for anxiety. The Clonazepam was a new medication. The surveyor was unable to locate documentation of symptoms requiring the medication. There were no orders for behavior monitoring of symptoms or of potential side effects of the medications. Nurse's notes for April and May 2017 did not mention anxiety. The surveyor was unable to locate physician notes documenting diagnoses of anxiety.	F 514	#2 1. Facility Resident #12 had monthly review of psychotropic medication completed with target behavior observation assessment. 5/2/2017 2. All facility residents receiving Psychotropic medications have the potential to be affected by this deficient practice. 5/25/2017 3. Facility nursing staff will be educated on Behavior Monitoring Policy, including documentation requirements when prn medications are provided. 6/9/2017 4. DON or designee will audit 100% of residents on psychotic medications for behavior monitoring program weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter. 6/24/2017	

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The Medication Administration Record (MAR) for April 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 4/29/17 at 0442. The MAR for May 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 5/2/2017 at 0507. The surveyor was unable to locate nursing documentation of the symptoms for which the medication was administered or whether the resident was offered non-pharmacologic interventions.

The surveyor discussed concerns with the director of nursing (DON) on 5/4/16. After investigation, the DON reported that the physician was diagnosing psychosis when signing the monthly order summary. The DON obtained a Geriatric Psychiatry Consult Note dated 4/26/17. Under Nursing Report, the physician wrote"Depressed. Patient currently on Seroquel with no supporting diagnosis. Anxious with transportation to dialysis". Under the Chief Complaint/reason for visit section, the physician wrote "f/u (followup) for chronic depression. Under the section HPI, the physician wrote "Pt's current TX reviewed. C/O staying bed "depressed', worrying, tired, and Also c/o being unable to sleep at night. States she still experiences auditory hallucinations (including her husband's voices). Trazodone not helping at all. Klonopin worked well previously. Under Medication Changes "1) d/c Trazodone 2)Clonazepam 0.5 mg qhs 3) [change] Zoloft to 150 mg qd (every day) 4) [change] seroquel to 50 mg qhs.

The surveyor was unable to determine when the physician ordered the Clonazepam 0.5 mg every 12 hours as needed for anxiety which the resident received on 4/29/17 and 5/2/17.

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The concern about the lack of documentation was discussed with the administrator and DON during a summary meeting on 5/4/17.